

**Aviation Safety Investigation Report
198800734**

Beech A36

10 October 1988

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NOTE: All air safety occurrences reported to the ATSB are categorised and recorded. For a detailed explanation on Category definitions please refer to the ATSB website at www.atsb.gov.au.

Occurrence Number: 198800734

Occurrence Type: Accident

Location: Pickertaramoor NT

Date: 10 October 1988

Time: 931

Highest Injury Level: Nil

Injuries:

	Fatal	Serious	Minor	None
Crew	0	0	1	1
Ground	0	0	0	-
Passenger	0	0	0	7
Total	0	0	0	8

Aircraft Details: Beech A36

Registration:

Serial Number:

Operation Type: Private

Damage Level: Substantial

Departure Point: Darwin NT

Departure Time: 0909

Destination: Pickertaramoor NT

Approved for Release: March 28th 1989

Circumstances:

On arrival at his destination, the pilot joined the circuit on the downwind leg and used the pitch lever to signal his arrival to the ground party. He then distracted himself by cancelling his SAR watch by radio. By this time he had flown past the windsock and it was no longer in view. This distraction continued while he tried to recall the wind direction and decide if he should go around and check the windsock. Deciding to continue the approach, he positioned the aircraft on final but only carried out his final approach checks in a perfunctory manner and did not positively check the gear down indications. The aircraft subsequently landed wheels up and neither the pilot nor the passengers recalled hearing the undercarriage warning horn sound. Detailed investigation showed that the warning horn microswitch actuator on the throttle assembly was defective and of a faulty design. The subject component had been redesigned by the manufacturer, however, the modified component still bore the same identification number as the superceded item. In addition, the component of faulty design was still available in the spares inventory.

Significant Factors:

The following factors were considered relevant to the development of the accident

1. The pilot was distracted by a self-imposed high workload at a critical time in the operation of the aircraft.
2. The pilot did not complete his downwind checks.
3. The pilot was complacent in his attitude to his final approach checks.
4. Gear warning horn actuator unserviceable.
5. Component of faulty design installed.

6. Faulty component not withdrawn from service and modified component issued with same identification number.

Reccomendations:

1. That the CAA inform owners and operators of the relevant Beech aircraft types, of the design weakness of the gear warning microswitch actuator.
2. That the CAA take action to redress the anomaly of redesigned components bearing the same identification number as superceded items.