Aviation Safety Investigation Report 198900903

Aerocommander 681

19 May 1989

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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: 198900903 **Occurrence Type:** Incident
Location: Tindal NT
Date: 19 May 1989 **Time:** 1627
Highest Injury Level: Nil
Injuries:

	Fatal	Serious	Minor	None
Crew	0	0	0	0
Ground	0	0	0	-
Passenger	0	0	0	0
Total	**0**	**0**	**0**	**0**

Aircraft Details: Aerocommander 681
Registration: VH-JWO
Serial Number: 6039
Operation Type: Charter
Damage Level: Minor
Departure Point: Delamere NT
Departure Time: 1514
Destination: Tindal NT

Approved for Release: 5th December 1990

Circumstances:

The pilot had positioned at Tindal from Victoria River Downs and embarked eight passengers for Delamere. On arrival at Delamere, the nosegear would not extend. Despite all attempts to extend the gear, the landing gear position indicator continued to indicate an unsafe position for the nosegear. The pilot elected to return for a landing at Tindal. A flypast of the tower revealed that the maingear wheels and nosegear doors were extended but the nosegear was still fully retracted. The pilot decided to land with the gear in that configuration. A successful landing was carried out and the runway under the aircraft was foamed when the aeroplane came to rest. A subsequent inspection revealed that the front right-hand nosegear door was installed incorrectly. This door had been installed in a position one hinge serration rearward of its correct position. That door then fouled the rear right-hand nosegear door which in turn prevented the nosegear leg from extending. On removal of the front right-hand nosegear door, the nosegear leg fell free and locked into the DOWN position. The aircraft logbook showed no entry for the removal and replacement of the nosegear door but the aircraft showed evidence of having been recently repainted.

Significant Factors:

The following factors were considered relevant to the development of the incident:

1. Incorrect installation of the front right-hand nosegear door.

2. A fouling of the nosegear doors prevented the nosegear leg from extending.

3. Inadequate supervision of maintenance.