

**Aviation Safety Investigation Report
198803508**

Piper PA28-R180

20 December 1988

Readers are advised that the Australian Transport Safety Bureau investigates for the sole purpose of enhancing transport safety. Consequently, Bureau reports are confined to matters of safety significance and may be misleading if used for any other purposes.

Investigations commenced on or before 30 June 2003, including the publication of reports as a result of those investigations, are authorised by the CEO of the Bureau in accordance with Part 2A of the Air Navigation Act 1920.

Investigations commenced after 1 July 2003, including the publication of reports as a result of those investigations, are authorised by the CEO of the Bureau in accordance with the Transport Safety Investigation Act 2003 (TSI Act). Reports released under the TSI Act are not admissible as evidence in any civil or criminal proceedings.

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: 198803508 **Occurrence Type:** Accident
Location: Narayen (74km NNE of Taroom) QLD
Date: 20 December 1988 **Time:** 1008
Highest Injury Level: Nil
Injuries:

	Fatal	Serious	Minor	None
Crew	0	0	1	1
Ground	0	0	0	-
Passenger	0	0	0	1
Total	0	0	0	2

Aircraft Details: Piper PA28-R180
Registration: VH-PXL
Serial Number: 28R-30338
Operation Type: Aerial Work
Damage Level: Substantial
Departure Point: N/A
Departure Time: N/A
Destination: Wandoan QLD

Approved for Release: March 8th 1989

Circumstances:

During the taxi phase before take-off, the nosegear collapsed and the nose settled slowly. After the aircraft was evacuated, the pilots noticed that the nosewheel had struck a slightly raised termite mound located near the centre of the flight strip. The pilots commented that no impact was felt and they were surprised that such a small protrusion (4-5 cm) would lead to a nosegear collapse. Later inspection of the broken nosegear downlock revealed that the fracture was consistent with an overload failure. This accident was not the subject of an on-site investigation.

Significant Factors:

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

1. Neither pilot saw the termite mound, probably because it was hidden by variations in the strip surface.
2. Nosegear failed through overload.