Aviation Safety Investigation Report 198901549

Fuji FA-200-160

14 August 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: 198901549 **Occurrence Type:** Accident
Location: 10 km SW of Beulah VIC
Date: 14 August 1989 **Time:** 1445
Highest Injury Level: Fatal
Injuries:

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

Aircraft Details: Fuji FA-200-160
Registration: VH-FJN
Serial Number: FA-200-44
Operation Type: Private
Damage Level: Substantial
Departure Point: Private airstrip 16 km WSW of Beulah VIC
Departure Time: 1441
Destination: 16 km WSW of Beulah VIC

Approved for Release: 29th November 1989

Circumstances:

The pilot carried out one spray run at about 10 feet above the ground in an easterly direction over his own barley crop. The weather was fine with a north-easterly wind of about three knots. The area was very open with large, slightly undulating paddocks. About 40 metres beyond a fence marking the end of the spray run, the left wing struck a single strand power line about 18 feet above the ground. Without breaking, the wire severed a small portion of the upper surface of the wing, near the wing tip. Impact marks on the leading edge of the wing indicate that the aircraft was banked about 30 degrees to the right when it struck the wire. The wire was pulled off three adjacent poles which were about 400 metres apart. The aircraft collided with the ground inverted and nose first about 80 metres beyond the wire. At ground impact there was negligible ground slide. The engine partially dislodged from the airframe and the cabin was partially crushed. The sliding canopy slid open and the home-made hopper ruptured. An estimated 100 litres of herbicide spilled from the hopper. The pilot was not a trained, approved, agricultural pilot. The aircraft was not approved for agricultural operations, nor was the hopper installation. The wire was difficult to see because of the large distance between poles.

Significant Factors:

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

1. The pilot was performing an operation for which he was not authorised.

2. The single strand power line was difficult to see.

3. It is possible the the pilot forgot about the wire.

4. It is possible that the pilot misjudged horizontal clearance from the wire during entry to a procedural turn.