

**Aviation Safety Investigation Report
198701430**

Piper PA 28-140

31 March 1987

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: 198701430
Location: Swan Hill VIC
Date: 31 March 1987
Highest Injury Level: Nil
Injuries:

Occurrence Type: Accident

Time: 1010

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

Aircraft Details: Piper PA 28-140
Registration: VH-PBR
Serial Number:
Operation Type: Aerial Work (Instructional
Dual)
Damage Level: Substantial
Departure Point: Swan Hill VIC
Departure Time: 1010
Destination: Swan Hill VIC

Approved for Release: October 29th 1987

Circumstances:

The student was being instructed in crosswind techniques, and several circuits and landings had been completed without incident. On the final circuit a normal approach and touchdown were made, but during the landing roll the right wing lowered and the aircraft swung through 90 degrees. Initial inspection found that the lower torque link bolt on the right gear had failed, allowing the wheel assembly to detach. Engineering investigation revealed that the torque link bolt was of defective manufacture in that stress raisers existed near the thread root. This condition resulted in a slow progressive fatigue fracture originating from the stress raisers. There is no inspection requirement for this bolt and the defect is considered an isolated case.