Aviation Safety Investigation Report 199504285

Glasflugel Gmbh & Co Kg Hornet

04 December 1995

Aviation Safety Investigation Report 199504285

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 Executive Director 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 Executive Director 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.

199504285

The Bureau did not conduct an on scene investigation of this occurrence. The information presented below was obtained from information supplied to the Bureau.

Occurrence Number: 199504285 Occurrence Type: Accident

Location: Benalla, Aerodrome

State: VIC Inv Category: 4

Date: Monday 04 December 1995

Time: 1600 hours **Time Zone** ESuT

Highest Injury Level: Minor

Injuries:

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

Aircraft Manufacturer: Glasflugel Gmbh & Co Kg

Aircraft Model: Hornet

Aircraft Registration: VH-GEZ Serial Number:

Type of Operation: Non-commercial Pleasure/Travel

Damage to Aircraft:SubstantialDeparture Point:Benalla VicDeparture Time:1600 ESuTDestination:Benalla Vic

Crew Details:

	Hours on			
Role	Class of Licence	Type Hour	rs Total	
Pilot-In-Command		40.0	6000	

Approved for Release: Tuesday, September 10, 1996

The glider was being test flown after major maintenance had been completed. During lift off the pilot lost control and the aircraft cartwheeled. The pilot received minor injuries and the glider was substantially damaged.

Investigation found that the ailerons had been connected in the reverse sense. During the maintenance, reassembly, rigging and preflight the glider had passed through four stages of inspection, all of which failed to detect the incorrect rigging of the ailerons.

It was found that 10 types of glider operated in Australia are fitted with common aileron drive gimbals that can be physically fitted to the incorrect side of the aircraft, thereby reversing the sense of the control.

Immediately after the accident the Gliding Federation of Australia issued an Operations Advice Notice advising details of the accident. The notice made the point that crossed controls had occurred before and that an Airworthiness Advice Notice had been issued in 1980 covering the subject. This notice stated 'this incident emphasises the dangers of complacency; we have come to expect things to operate correctly and therefore assume that if something is working, it is working correctly'.

The Operations Advice Notice made three recommendations relating to the principles of assuring correct sense and the avoidance of external distraction during preflight inspections.

The Gliding Federation also issued an Airworthiness Directive requiring, on the subject gliders, gimbals for the left wing to be painted bright red and for the gimbals for the right wing to be paint bright green. This action is to be performed at the next annual inspection.