**Aviation Safety Investigation Report 199402974** 

Robinson Helicopter Co R22

15 October 1994

## Aviation Safety Investigation Report 199402974

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.

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: 199402974 Occurrence Type: Accident

**Location:** Rosewood Station

State: WA Inv Category: 4

**Date:** Saturday 15 October 1994

Time: 1030 hours Time Zone WST

Highest Injury Level: None

Aircraft Manufacturer: Robinson Helicopter Co

**Aircraft Model:** R22 BETA

Aircraft Registration: VH-JVJ Serial Number: 1343

**Type of Operation:** Instructional Other Training

**Damage to Aircraft:** Substantial

**Departure Point:** Rosewood Station WA

**Departure Time:** 1020 WST

**Destination:** Rosewood Station WA

**Crew Details:** 

	Hours on		
Role	<b>Class of Licence</b>	Type Ho	ours Total
Other Pilot	Commercial	100.0	1000
Pilot-In-Command	Commercial	5500.0	6000

**Approved for Release:** Monday, December 12, 1994

An approved training pilot was conducting mustering endorsement training with another company pilot. At the time of the accident they were practising autorotational approaches with power termination prior to touchdown.

The training pilot had demonstrated a number of autorotational approaches from low and medium altitudes. He had also followed the trainee pilot through on the controls for a number of similar approaches. The trainee had exhibited problems with airspeed and rotor rpm control.

During the final practice, with the training pilot again following through on the controls, the trainee misjudged the approach. The training pilot decided to terminate the approach at 50 - 70 feet above ground level and with 30 - 35 knots forward speed. Although recovery action was taken the aircraft continued to descend, touching down heavily before the action had any significant effect on the rate of descent. The aircraft slid for approximately 30 feet before overturning.

It is possible that the training pilot was distracted by his instructional duties and he misjudged the height required to recover from the autorotational descent.