COMMONWEALTH OF AUSTRALIA DEPARTMENT OF TRANSPORT

AIRCRAFT ACCIDENT INVESTIGATION SUMMARY REPORT

Publication of this report is authorised by the Secretary under the provisions of Air Navigation Regulations 283 (1)

Reference No. SI/802/1031

1. LOCATION OF OCCURRENCE

	Height a.m.s.l.	Date	Time (Local)	Zone
40Km East of Rylestone, NSW	About 2000ft	6 April'80	1030	EST

2. THE AIRCRAFT

Make and Model	Registration	Certificate of Airworthiness
Bell 206B	VH-FHF	Issued 10 September 1976

Certificate of Registration issued to	Operator	Degree of damage to aircraft	Other property damaged
		Nil	Nil

Defects discovered

Excessive side clearance between the spring sleeve and the adjustable spring collar of the Breeze model 16600 hoist.

3. THE FLIGHT

Last or intended departure point	Time of departure	Next point of intended landing	Purpose of flight	Class of operation
Mount Coricudgy	1010	Rylstone	Medical Evaluation	Aerial work

4. THE CREW

Name	Status	Age	Class of licence	Hours on type	Total hours	Degree of injury
[redacted]	Pilot in command	32	Commercial Helicopter	1230	1630	Nil

5. OTHER PERSONS (All passengers and persons injured on ground)

Name	Status	Degree of injury	Name	Status	Degree of injury
	Crewman Doctor	Nil Serious			

6. RELEVANT EVENTS

The helicopter was engaged in the rescue of an injured bushwalker from Mount Coriaday, 40 km east of Rylestone. A guide had been collected at Rylestone and after locating the accident site, the guide was left at Mount Coricudgy, about nine [redacted]etres to the south west. The helicopter then returned to the accident site.

It was intended to lower the doctor by winch into a clearing as there was no suitable landing area nearby. The doctor was to treat the patient who would then be winched out and transported to Rylestone.

The pilot completed the appropriate power and hovering checks above the clearing then stabilised the helicopter at approximately 150 feet above ground level. There was 110 feet of cable on the winch and it was intended to lower the doctor to the limit of the winch cable then the pilot would descend the helicopter until the doctor reached the ground.

The crewman helped the doctor on to the left skid of the helicopter then operated the winch switch to lower him towards the ground. The switch was held to the down position and the crewman awaited the operation of the automatic down limit switch which was intended to stop the winch while there were three turns of cable left on the winch drum. The switch did not operate and the cable unwound from the winch drum.

allowing the doctor to drop about 20 feet to the ground.

Subsequent examination of the Breeze model 16600 hoist revealed that the cable had not broken but had fully unwound from the winch drum. It was noted that the spring on the down limit switch arm was not in its normally installed position. It had partially unwound and there was insufficient spring load to cause the down limit switch to operate. The reason for the spring not being in its normal position was probably due to the excessive clearance between the spring sleeve and the adjustable spring collar. It was not determined how the excessive clearance came to exist.