Aviation Safety Investigation Report 198901887

Cessna 404

6 October 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: 198901887 Occurrence Type: Incident

Location: Near Mitta Mitta VIC

Date: 6 October 1989 **Time:** 1

Highest Injury Level: Nil

Injuries:

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

Aircraft Details: Cessna 404
Registration: VH-ARQ
Serial Number: 4040219
Operation Type: Charter
Damage Level: Nil

Departure Point: Sydney NSW

Departure Time: N/A

Destination: Melbourne VIC

Approved for Release: 31st August 1990

Circumstances:

The flight to Melbourne was planned via Canberra Corryong and Eildon Weir with a cruising level of 8000 feet. The weather forecast for the route included scattered cumulus cloud to 10000 feet and areas of broken stratocumulus cloud from 3000 to 7000 feet. The forecast freezing level was 6500 feet. The aircraft was not equipped with wing or propeller deicing systems but had the standard pitot heater as well as a stall warning vane heater. The flight at an indicated airspeed of 150 knots proceeded uneventfully apart from some ice buildup on the windscreen and wings which seemed to clear when the aircraft exited from cloud. However shortly after passing Corryong the pilot felt a vibration through the aircraft. The auto-pilot was disengaged but the vibrations rapidly worsened and the aircraft suddenly rolled and began to lose height. At this stage the airspeed was still indicating 150 knots and the aircraft was turning right in a right wing low attitude. The pilot recalled applying left rudder and moving the yoke forward and sensing that the airspeed which was then indicating zero was increasing. Control of the aircraft was regained at about 5500 feet (Lowest Safe Altitude for the sector was 6700 feet). The pilot found later that the pitot heat circuit breaker had popped thus deactivating the pitot heater. This would have allowed the pitot head to become iced up and cause false airspeed indications. It was not until after the incident that the pilot thought to look at the No 2 Air Speed Indicator (ASI) on the right instrument panel. This instrument which operates independently of the ASI on the left instrument panel was operating normally. Normal operation of the pilot's ASI did not return until the aircraft was on descent to Melbourne.

Significant Factors:

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

1. The aircraft was operating at a height and in weather conditions conducive to airframe icing.

- 2. The pitot heat circuit breaker had popped allowing the pitot head to ice up and cause a false airspeed indication.
- 3. The pilot was not aware that the airspeed indication was incorrect.
- 4. The pilot lost control of the aircraft when it stalled because of an excessive buildup of airframe ice.