

**Aviation Safety Investigation Report
199904719**

**Cessna Aircraft Company
310R**

26 September 1999

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.

During the second approach attempt, the Tower controller reported that JZW was established on the localiser at 10 DME. During this sequence, the pilot noticed that the glide slope needle was still fluctuating unpredictably with intermittent fail flag indications. The pilot then elected to conduct a LLZ/DME approach. The Tower controller observed the aircraft on radar to deviate to the right and then track between the 16L and 16R localisers. When the Tower controller advised the pilot of these deviations, the pilot attempted to track towards the 16L localiser. JZW failed to intercept final and crossed the 16L centreline at 6 nm on a south-easterly heading at 2,000 ft and descending. The Tower controller instructed JZW to execute a missed approach to ensure that JZW avoided an area of high buildings along its projected track. During the second approach sequence, the pilot stated that there were difficulties contacting Sydney Tower and that the DME lock had inadvertently been activated.

The pilot elected to conduct a third approach to runway 16 right. The pilot was radar vectored to intercept the localiser but experienced ongoing and excessive glide slope indications coupled with general anxiety and uncertainty about radio communications and the aircraft's DME unit. Consequently, the pilot elected to divert to Bankstown and landed without incident. The high workload, limited instrument flying experience, and the distractions precipitated by the radio communications difficulties and a failure of the aircraft's glide slope contributed to this incident.

A post-flight inspection revealed that the aircraft's glide slope unit was faulty. The glide slope unit was repaired and functioned correctly when the pilot conducted an ILS approach into Sydney two days after the current incident. The operator is considering installing a new ILS unit in the aircraft in addition to providing the company line pilots with a CASA approved PC-based synthetic IFR trainer to help improve pilot instrument flying skills.

