

**Aviation Safety Investigation Report  
198900247**

**Motor Falke SF25C**

**1 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](http://www.atsb.gov.au).**

**Occurrence Number:** 198900247  
**Location:** Cunderdin WA  
**Date:** 1 October 1989  
**Highest Injury Level:** Fatal  
**Injuries:**

**Occurrence Type:** Accident

**Time:** 800

	Fatal	Serious	Minor	None
Crew	1	0	0	0
Ground	0	0	0	-
Passenger	0	0	0	0
<b>Total</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>

**Aircraft Details:** Motor Falke SF25C  
**Registration:** VH-GXM  
**Serial Number:** Not Available  
**Operation Type:** Aerial Work/Gliding  
**Damage Level:** Destroyed  
**Departure Point:** Cunderdin WA  
**Departure Time:** N/A  
**Destination:** Cunderdin WA

**Approved for Release:** 15 January 1990

**Circumstances:**

The pilot carried out a daily and preflight inspection prior to boarding the aircraft for the first flight of the day in the self-launching glider. He started up, taxied to the end of the runway and carried out a short run-up before taking off. At approximately 100 feet after take-off, the engine stopped and the aircraft was seen to enter a left hand spiral descent until it crashed on the edge of the sealed flight strip, approximately two thirds of the way along the strip. The pilot was dead when the rescuers arrived at the aircraft. The fuel cock was found selected to the OFF position. With the fuel cock selected OFF fuel was still leaking through the lines. The effect of the fuel leaking past the fuel cock would have been to extend the period of time between start up and engine failure if the fuel cock was left in the OFF position. Previous experience with VH-GXM indicates that there is sufficient fuel in the system, when the fuel cock is selected OFF, to permit a start-up, DEPARTURE and climb out to approximately 500 feet. On the accident flight the pilot taxied further than normal and he carried out a short run-up. This could have accounted for the engine stoppage at a lower height than previous experience indicated. At the time of the engine stoppage there were two options open to the pilot. One was to land in the runway length remaining and the other was to turn left and land in the open paddock beside the strip. Either option would have been acceptable and the pilot, who was experienced, should have been able to glide to a safe landing. The pilot's injuries were insufficient to cause death. The pilot did have extensive pre-existing cardiac damage. The factors which led to the loss of control could not be positively determined. It is possible that the pilot omitted to turn the fuel on prior to start up and the sudden loss of power at a critical point during the take-off caused a heart problem and subsequent loss of control. No evidence was found which indicated that the pilot had suffered heart pain prior to the accident. The extended operation of the engine, with the unserviceable fuel cock selected OFF, could have lulled the pilot into a false belief that the aircraft was performing normally and that all checks had been completed correctly.

**Significant Factors:**

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

1. Inadequate pre-flight preparation - the fuel selector was not placed in the ON position.
2. Defective fuel cock.
3. Loss of control in flight, possibly due to physical incapacitation.