



Australian Government

Australian Transport Safety Bureau

Aircraft proximity event between a Cessna 172, VH-WYG and a Cessna 185, VH-OZX

near Bankstown Airport, New South Wales, 6 June 2013

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Addendum

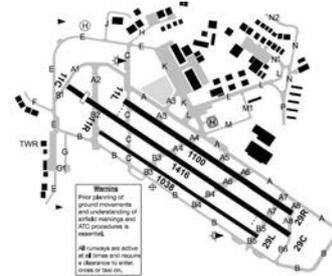
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Aircraft proximity event between a Cessna 172, VH-WYG and a Cessna 185, VH-OZX

What happened

On 6 June 2013, a flight instructor and a student pilot of a Cessna 172 aircraft, registered VH-WYG (WYG), were conducting a navigation training flight from Bankstown to Goulburn, New South Wales. At 1325 Eastern Standard Time,¹ WYG was cleared to take-off from runway 29 Right (29R). Immediately after this, a Cessna 185 aircraft, registered VH-OZX (OZX), was cleared to line up on runway 29 Centre (29C). There was also active circuit traffic using runway 29 Left (29L) at the time.

Bankstown Airport



Source: Airservices Australia

The pilot of OZX was conducting a ferry flight from Bankstown to Moruya and was cleared for takeoff from 29C at 1326, just as WYG became airborne on runway 29R. Thirty seconds after this, the pilot of OZX was given WYG as traffic.

OZX then took off and as it climbed through about 600 ft, the pilot lost sight of WYG. When the tower controller asked him whether he still had the Cessna 172 in sight, the pilot of OZX replied in the negative and commenced looking for it to his right. In looking right, the pilot believed he may have rolled the aircraft to the right. OZX then crossed over and above WYG, which was maintaining a track slightly to the north of the extended centreline of runway 29R.

The pilot of OZX reported that he had already reached the departure altitude of 1,000 ft crossing the upwind threshold prior to losing sight of WYG. WYG appeared below him and to his left. The pilot of OZX continued to climb to 1,200 ft to ensure separation with WYG.

WYG was climbing through about 700 to 800 ft above ground level when the instructor sighted OZX above the right wing. He estimated that OZX was then about 30 ft above WYG and 15 m to his right.

At 1327, the tower controller gave OZX as traffic to the pilot of WYG, by which time OZX had passed over WYG.

Pilot comments (VH-WYG)

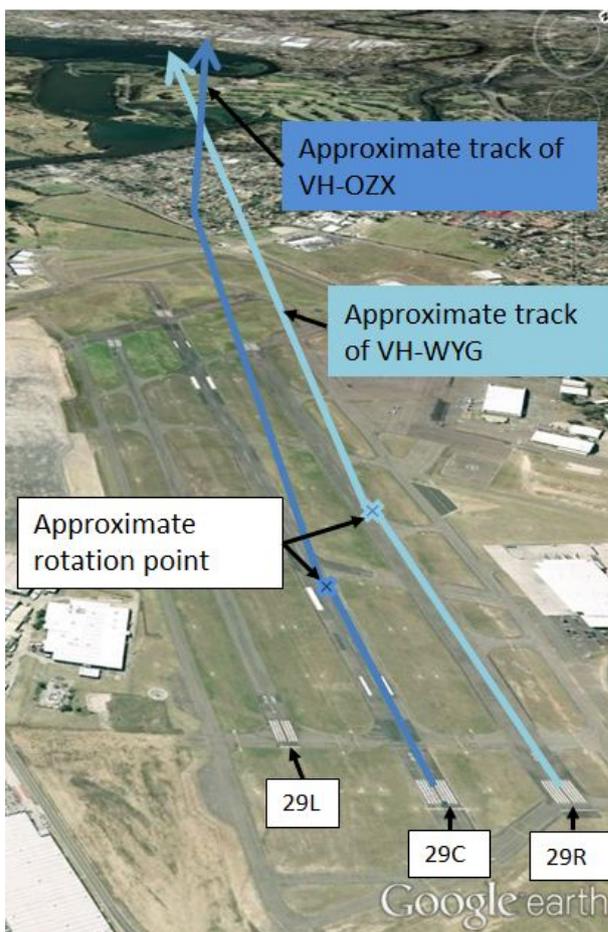
The flight instructor in WYG stated that he was aware of OZX and had instructed his student to maintain a heading to the right of the centreline of 29R to ensure separation from the aircraft on 29C. He believed that if there had been a short delay prior to the departure of OZX, it would have been easier for the pilots of the two aircraft to maintain visual separation.

Pilot comments (VH-OZX)

The pilot of OZX commented that he did consider staying low to keep WYG in sight but wanted to gain altitude in case of engine failure over the built up area. He believed that OZX would rapidly out climb and overtake WYG. As he had done a lot of formation flying, he did not consider that the aircraft were in an unsafe situation.

¹ Eastern Standard Time (EST) was Coordinated Universal Time (UTC) + 10 hours.

Figure 1: Bankstown Airport and approximate tracks of VH-WYG and VH-OZX



Source: Google earth

Safety message

In Class D airspace, pilots of visual flight rules (VFR) aircraft are responsible to maintain their separation from other aircraft. It is important to keep other aircraft in sight at all times, irrespective of the aircraft performance. The Class D airspace booklet is available at www.casa.gov.au/wcmswr/assets/main/pilots/download/classd_booklet.pdf.

General details

Occurrence details

Date and time:	6 June 2013 – 1330 EST	
Occurrence category:	Serious incident	
Primary occurrence type:	Aircraft proximity event	
Location:	Near Bankstown Airport, New South Wales	
	Latitude: 33° 55.47' S	Longitude: 150° 59.30' E

Cessna 172, VH-WYG

Manufacturer and model:	Cessna Aircraft Company 172	
Registration:	VH-WYG	
Type of operation:	Flying training	
Persons on board:	Crew – 2	Passengers – Nil

Injuries:	Crew – Nil	Passengers – Nil
Damage:	Nil	

Cessna 185, VH-OZX

Manufacturer and model:	Cessna Aircraft Company 185	
Registration:	VH-OZX	
Type of operation:	Private	
Persons on board:	Crew – 1	Passengers – Nil
Injuries:	Crew – Nil	Passengers – Nil
Damage:	Nil	

About the ATSB

The Australian Transport Safety Bureau (ATSB) is an independent Commonwealth Government statutory agency. The Bureau is governed by a Commission and is entirely separate from transport regulators, policy makers and service providers. The ATSB's function is to improve safety and public confidence in the aviation, marine and rail modes of transport through excellence in: independent investigation of transport accidents and other safety occurrences; safety data recording, analysis and research; and fostering safety awareness, knowledge and action.

The ATSB is responsible for investigating accidents and other transport safety matters involving civil aviation, marine and rail operations in Australia that fall within Commonwealth jurisdiction, as well as participating in overseas investigations involving Australian registered aircraft and ships. A primary concern is the safety of commercial transport, with particular regard to fare-paying passenger operations.

The ATSB performs its functions in accordance with the provisions of the *Transport Safety Investigation Act 2003* and Regulations and, where applicable, relevant international agreements.

The object of a safety investigation is to identify and reduce safety-related risk. ATSB investigations determine and communicate the safety factors related to the transport safety matter being investigated.

It is not a function of the ATSB to apportion blame or determine liability. At the same time, an investigation report must include factual material of sufficient weight to support the analysis and findings. At all times the ATSB endeavours to balance the use of material that could imply adverse comment with the need to properly explain what happened, and why, in a fair and unbiased manner.

About this report

Decisions regarding whether to conduct an investigation, and the scope of an investigation, are based on many factors, including the level of safety benefit likely to be obtained from an investigation. For this occurrence, a limited-scope, fact-gathering investigation was conducted in order to produce a short summary report, and allow for greater industry awareness of potential safety issues and possible safety actions.