

**Aviation Safety Investigation Report
199602566**

**Airbus
Airbus**

15 August 1996

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.

The Bureau did not conduct an on scene investigation of this occurrence. The information presented below was obtained from information supplied to the Bureau.

Occurrence Number: 199602566 **Occurrence Type:** Incident
Location: 167km N Pavko, (IFR)
State: NT **Inv Category:** 4
Date: Thursday 15 August 1996
Time: 1536 hours **Time Zone** CST
Highest Injury Level: None

Aircraft Manufacturer: Airbus
Aircraft Model: A340
Aircraft Registration: 9V-SJB **Serial Number:**
Type of Operation: Air Transport High Capacity International
Damage to Aircraft: Nil
Departure Point: Melbourne, VIC
Departure Time: 1304 CST
Destination: Singapore, Singapore

Approved for Release: Monday, January 20, 1997

FACTUAL INFORMATION

An A340 aircraft was enroute from Melbourne to Singapore and was approaching the boundary between the Melbourne and Brisbane flight information regions (FIRs). The aircraft would be transferred from Melbourne centre to Brisbane centre at PAVKO, a position northwest of Alice Springs.

The Melbourne sector controller co-ordinated the Alice Springs position and level with the appropriate Brisbane sector in accordance with air traffic control (ATC) procedures. The Brisbane sector was being manned by a controller undergoing a check after returning from a period of leave. He was being supervised by a rated controller who had completed an "on the job training" instructor course. The controller being checked had 14 years experience in ATC while the supervising controller had 12 months experience in ATC.

When the aircraft's position report for Alice Springs was passed by Melbourne, the Brisbane controller recorded the actual time and level in the box allocated on the flight progress strip (FPS) for the "previous position". The controller did not transfer the level recorded to the box on the FPS allocated for "altitude/flight level". Nor, did he "cock" the FPS in the strip bay.

Cocking of FPS is one of the means available to provide a reminder for further action by controllers. The supervising controller expected the controller being checked to cock the strip to act as a reminder to transfer the altitude to the appropriate box on the FPS. Controllers "cock" a FPS by placing it half out of the bay. In this way, the out of place FPS acts as a visual cue and requires a physical action for it to be restored to the correct location within a bay. The supervising controller did not notice that the controller had not completed the FPS correctly and that no reminder action had been taken.

The Melbourne controller instructed the crew of the A340 to contact Brisbane centre at PAVKO. The crew acknowledged the instruction but did not contact the Brisbane sector controller when the aircraft reached PAVKO. The two Brisbane controllers did not notice that the aircraft had not called at PAVKO as co-ordinated. Approximately 15 minutes after the A340 was estimated to have reached PAVKO the controllers handed over responsibility for the sector to a new controller. Traffic was light at the time and the handover/takeover of the sector was completed without any specific mention of the A340.

After the handover/takeover, the on-coming controller expected further co-ordination on the A340 as the "altitude/flight" level box did not have a level. Also, he was only scanning the last two digits of the PAVKO estimate and did not notice that it indicated that the aircraft should have already passed the position. He believed the aircraft had a further 25 minutes to go before reaching PAVKO.

Twenty minutes later the new controller noticed that the level on the FPS for the A340 had been annotated in the "previous position" box but had not been transferred to the "altitude/flight level" box. He commenced checks to establish communications with the aircraft. The controller sought confirmation from Melbourne that the aircraft had passed Alice Springs. He was advised that the A340 had passed Alice Springs an hour ago. The controller then requested the crew of another aircraft in his sector to attempt to contact the crew of the A340. The crew of this other aircraft were able to contact the crew of the A340 by radio and, shortly after, normal air-ground-air communications were restored. There was no conflicting traffic while the aircraft was out of communication with ATC.

ANALYSIS

The supervising controller expected the controller being checked to perform to a high degree of efficiency because of the latter's long period of ATC experience. Consequently, he did not monitor the controllers actions as closely as he would have for a less experienced controller.

The two Brisbane controllers were nearing the end of their shift and this may have caused them to relax their vigilance in completing tasks. Consequently, neither controller completed their respective tasks in a satisfactory manner.

The handover/takeover would appear to have been conducted in a cursory manner due to the low traffic levels and the supervising controllers expectations of the other controllers performance. This aspect of expectation carried across to the on-coming controller who did not check the FPS. However, once the new controller recognised the error on the FPS he was able to quickly recover the situation.

The reason for the crew of the A340 not contacting Brisbane centre at PAVKO as instructed could not be ascertained.

SIGNIFICANT FACTORS

1. The controller being checked did not annotate the FPS correctly.
2. The controller being checked did not ensure that all aspects relating to the sector were covered in the handover/takeover.
3. The supervising controller did not adequately monitor the actions of the controller being checked.
4. The crew of the A340 did not transfer to the Brisbane centre frequency at PAVKO as instructed.
5. The on-coming controller did not adequately check the flight progress strips after taking over responsibility for the sector.

