Aviation Safety Investigation Report 198803636

Boeing 737-376 Aero Commander 500S

4 May 1988

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 CEO 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 CEO 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 <u>www.atsb.gov.au</u>.

Occurrence Number: Location: Date: Highest Injury Level: Injuries:		Biboohra 34 kms W of Cairns QLI 4 May 1988			Occurrence Type: Incident Time: 1255	
-			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: Registration: Serial Number: Operation Type: Damage Level: Departure Point: Departure Time: Destination:	VH-TA 23485 Regular Nil Alice Sp	K · Public Tra prings NT	nsport	Aero Comman VH-PCO 3231 Aerial Work Nil Cairns QLD Georgetown Q		
2		L				

Approved for Release: July 5th 1988

Circumstances:

Both aircraft were tracking towards radio navigation aids at Biboohra from approximately opposite directions, and were the only aircraft using those tracks. VH-PCO's climb had initially been restricted to 4500 feet, to maintain separation with VH-TAK on descent. The controller responsible for separating the two aircraft became preoccupied with other traffic, and, overlooking the separation requirement, cleared VH-PCO to climb to 8000 feet and VH-TAK to descend to 6000 feet. VH-PCO had reached 8000 feet, VH-TAK had reached 7000 feet, and the two aircraft had passed before the mistake was realised. A breakdown in vertical separation standards had occurred in the vicinity of the radio navigation aids. However, the proximity of the two aircraft to one another at the time of passing was not established. The Cairns controller responsible for separating the two aircraft was performing an established traffic management function, which combines the dual responsibilities of Aerodrome and Approach control utilising a single radio communication frequency. This controller's workload at the time of the incident was subsequently assessed as being moderately high. Following this incident, emphasis was made on the requirement for air traffic control staff to process traffic within the limitations of the present air traffic control system, and in accordance with published standards and procedures. Additional traffic management procedures have also been instituted at Cairns, providing increased regulation of departing and arriving traffic. Other arrangements at Cairns are also being reviewed with the intention of making changes if appropriate. Matters under review include: the general management of airspace in the Cairns area; control tower management and staffing; and the adequacy of existing facilities.