



Australian Government

Australian Transport Safety Bureau

Landing on a closed airstrip involving a Piper PA-28R, VH-HKZ

Geelong (Grovedale), Victoria, 17 November 2012

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Landing on a closed airstrip involving a Piper PA-28R, VH-HKZ

What happened

On 17 November 2012, a Piper PA-28R aircraft, registered VH-HKZ, was prepared for a private flight from Bairnsdale to Geelong (Grovedale), Victoria.

The pilot obtained the weather forecast for the flight and submitted a flight plan to Airservices Australia. The aircraft then departed Bairnsdale with the pilot and a passenger on board.

During the cruise, the pilot heard broadcasts from aircraft operating at Barwon Heads and Torquay. The pilot also reported broadcasting several calls advising of his intention to land at Geelong, with no responses received.

When approaching Geelong, the pilot noted cloud at about 2,500 ft overhead the airstrip. He also began to feel apprehensive as he had not heard any broadcasts for aircraft operating at Geelong, but believed that the cloud may have been a deterrent.

On arrival at the airstrip (Figure 1), the pilot observed flags adjacent to the powerlines on the approach to runway 27. At the time, he believed that the flags may have been installed for increased awareness due to a wirestrike accident that occurred in 2010. Subsequently, the aircraft joined the downwind leg of the circuit for runway 18.

The pilot noted there were no aircraft visible on the ground, but did observe a number of cars and umbrellas. He suggested to his passenger that they should possibly divert to Barwon Heads. However, the pilot reported that he was not prepared for conducting a landing at Barwon Heads, nor was the most appropriate runway suitable under the given wind conditions. Consequently, and as he was more familiar with Geelong, he decided to continue. As a precaution, he elected to overfly the runway. Both the pilot and passenger examined the runway for any visible markings (cross markers) to indicate the airstrip was closed, but none were sighted. The pilot did, however, observe a light coloured section near the northern end of runway 18/36. Overall, the pilot reported that the runway appeared the same as it had on previous occasions.

A second circuit was conducted, during which the pilot and passenger inspected the condition of the runway and the aircraft was landed on runway 18.

After landing, the pilot noticed that the office buildings were unoccupied and a fence had been placed across runway 09/27. The pilot and passenger exited the aircraft and were subsequently advised by people on the ground that the airstrip had been closed and was being redeveloped. The pilot then contacted Airservices Australia via telephone to cancel his SARTIME¹; in acknowledging the cancellation, the Airservices employee made reference to Barwon Heads as the planned destination.

After returning to Bairnsdale, the pilot noted that he had a message on his home phone and mobile from Airservices Australia advising that Geelong was closed and his flight planned destination had been changed to Barwon Heads.

Geelong (Grovedale) airstrip



Source: Google earth

¹ Time nominated by a pilot for the initiation of Search and Rescue action if a report from the pilot has not been received by the nominated unit.

Airstrip information

The Geelong (Grovedale) airstrip was an uncertified, unregistered aeroplane landing area (ALA), located about 3 NM to the north of the Geelong Township. The airstrip, which had been operating for about 40 years, had two runways aligned 180°/360° and 090°/270°. The airstrip was privately owned and operated.

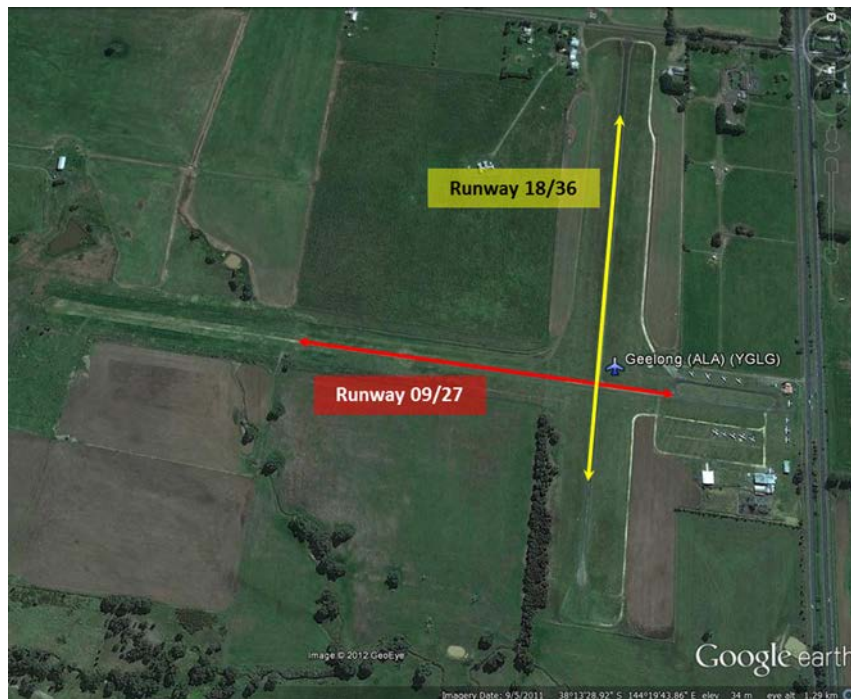
On 25 September 2010, a Rockwell International 114 aircraft, registered VH-CSH (ATSB investigation AO-2010-071) collided with high voltage powerlines while conducting an approach to runway 27. As a result of that accident, operations at Geelong were restricted and the airstrip was closed to visiting aircraft. The airstrip was initially scheduled for complete closure in June 2011; however, the lease was extended. The airstrip was subsequently closed in April 2012 for re-development as a residential estate.

The Aeronautical Information Publication AD 1.1 paragraph 4, subparagraph 3.3.2 stated that:

When an aerodrome that does not have 24 hour ATC [air traffic control] coverage is completely unserviceable for all operations, an unserviceability cross marker is displayed in the signal circle².

The pilot reported that neither he nor the passenger observed any markings on the runway to indicate the airstrip was closed. The pilot did, however, observe a marking at the northern end of runway 18/36. Prior to departing Geelong, the pilot visually inspected the runway and noted that the marking was a large square or rectangle covering the width of the runway, and was of a powder-like substance. The pilot could not recall sighting the windsock.

Figure 1: Geelong (Grovedale) airstrip



Source: Google earth

Pre-flight preparation

In preparation for the flight, the pilot looked at a number of potential landing areas including Barwon Heads and Geelong. The pilot initially referenced the En Route Supplement Australia (ERSA) and noted that there was airstrip information for Barwon Heads, but not Geelong. The pilot then referred to the Aircraft Owners and Pilots Association of Australia (AOPA) National Airfield Directory 2010/11 to obtain runway information for both airstrips.

² The signal circle is coloured circular area located near the windsock for displaying ground signals to pilots.

The pilot reported that the weather forecast indicated moderate to strong westerly winds in the afternoon. He determined that the length of the east-west runway at Barwon Heads may be insufficient under these conditions and consequently, selected Geelong as the destination. The AOPA Directory also stated that permission was required to operate at Geelong.

After the incident, the pilot referenced the Directory again and then noted that permission was required. The pilot stated that, in general, he contacts an airstrip operator to request permission and to gain an appreciation of the runway/s. He further stated that, if he had contacted the Geelong operator and received no response, he would have likely selected Barwon Heads.

The latest edition of the AOPA Directory (2012) was released at about the same time the incident occurred. That edition stated that the Geelong (Grovedale) airstrip was closed.

Pilot comment

The pilot reported that he had concerns with landing at Geelong when no aircraft were observed on the ground. However, as the runway appeared normal, with no cross markers sighted, the pilot elected to continue. The pilot further stated that he felt comfortable and familiar with landing at Geelong, which may have supported this decision.

Safety message

Before commencing a flight, the pilot in command should review all available information appropriate to the intended operation, including current weather reports and forecasts, and the condition and suitability of the selected landing area/s.

Furthermore, Civil Aviation Safety Authority Advisory Circular AC 91-225(0)³ stated that:

There is ownership and management of almost every potential landing place, with the possible exception of open areas of water. Unless a landing place is unambiguously open to public use for aviation the pilot should assume that approval is required before using land or water for an aircraft movement.

This incident highlights the importance of reviewing flight information in its entirety, ensuring that operational documents are current, and the benefits of contacting the airstrip operator to not only obtain landing permission, but to also receive information on the runway and its condition, any hazards and/or obstructions, and if there are any special procedures applicable to the airstrip.

General details

Registration:	VH-HKZ	
Manufacturer and model:	Piper Aircraft Corporation PA-28R-201T	
Type of operation:	Private	
Occurrence category:	Serious incident	
Primary occurrence type:	Runway events	
Location:	Geelong (Grovedale), Victoria	
	Latitude: S 38° 13.50'	Longitude: E 144° 20.98'
Persons on board:	Crew – 1	Passengers – 1
Injuries:	Crew – Nil	Passengers – Nil
Damage:	Nil	

³ www.casa.gov.au/newrules/parts/091/download/ac091-225.pdf

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.