



Australian Government

Australian Transport Safety Bureau

Airspace related event involving a Saab 340B, VH-ZLJ and parachutists

Moruya Airport, New South Wales, 12 September 2013

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Addendum

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Airspace related event involving a Saab 340B, VH-ZLJ and parachutists

What happened

On 12 September 2013, at about 0956 Eastern Standard Time,¹ a Cessna 185 aircraft, registered VH-OZA (OZA), departed Moruya, New South Wales for a parachute drop overhead the airport at flight level (FL)² 150.

At about 1013, the crew of a Regional Express Saab 340B aircraft, registered VH-ZLJ (ZLJ), broadcast on the common traffic advisory frequency (CTAF) advising that they were taxiing for runway 36 at Moruya, for a scheduled passenger service to Merimbula. In response, the pilot of OZA broadcast his intention to conduct a parachute drop overhead the airport from FL 150 and that he would delay the drop until ZLJ had departed. The crew of ZLJ acknowledged the broadcast.

About 3 minutes later, while maintaining FL 150, the pilot of OZA contacted the crew of ZLJ and queried whether they were waiting for him to conduct the parachute drop before they departed. The crew stated they had a technical issue and would commence the take-off in about 1 minute.

At about 1018, the crew of ZLJ broadcast that they had entered, and were rolling on runway 36, and intended to conduct a right turn after take-off, with a departure track of 178° (True), on climb to 9,000 ft above mean sea level (AMSL).³

At about 1020, the pilot of OZA asked the crew if they were departing on the downwind leg of the circuit, with no response received. Soon after, the parachute drop was completed. The pilot broadcast that the drop had been conducted and that three parachute canopies would be deploying below 5,000 ft.

At about 1021, the crew of ZLJ asked the pilot of OZA to confirm that the drop had been completed; the pilot replied 'affirm'. The crew then queried whether the pilot of OZA was aware that ZLJ was departing overhead the airport, to which the pilot replied 'negative'. At that time, ZLJ was climbing through 3,500 ft and tracking to overhead the airport (Figure 1).

The crew of ZLJ then questioned the altitude, time and position the parachutists had been dropped. The pilot of OZA advised that they had been dropped about 0.4 NM to the west of the airport, overhead the racecourse, about 30 seconds prior.

The crew of ZLJ immediately turned the aircraft left, attempted to establish the likely position of the parachutists, and advised the pilot of OZA that they would remain over the water. They continued to parallel their intended departure track over water until about 10 NM to the south of the airport. The flight continued without further incident.

Moruya Airport



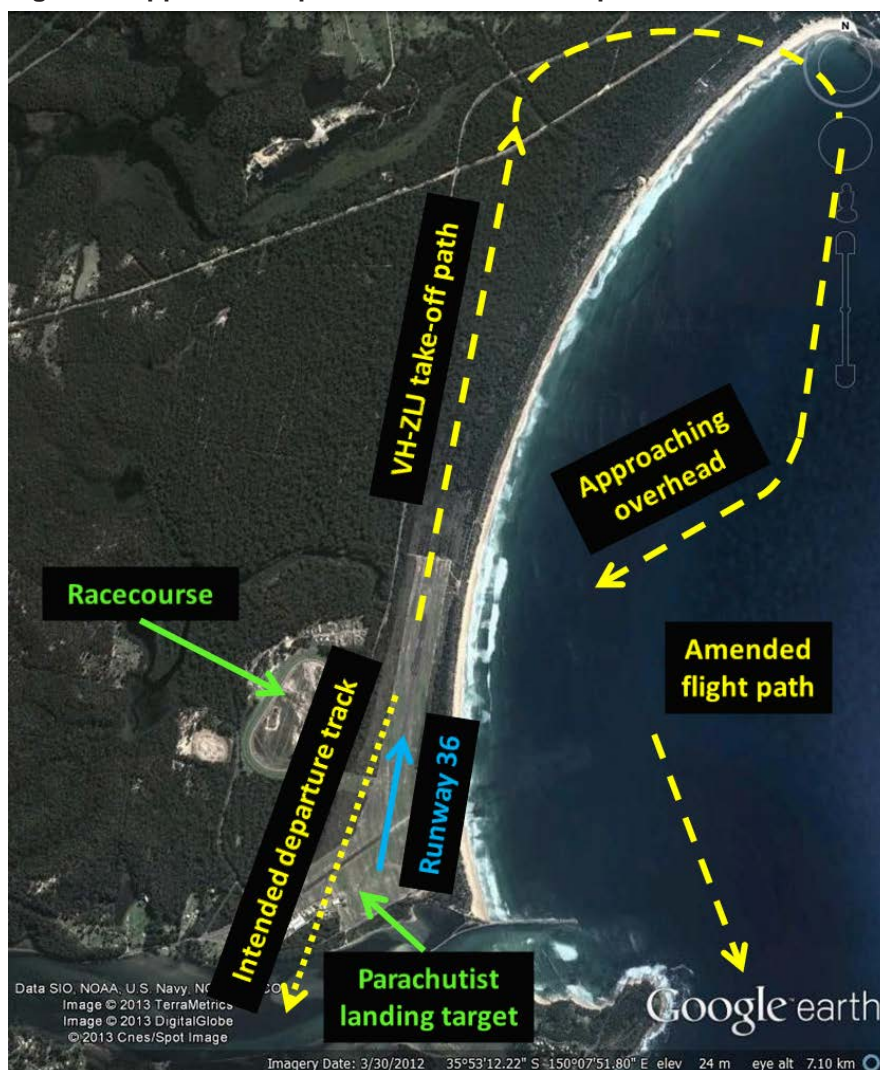
Source: Google earth

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

² At altitudes above 10,000 ft in Australia, an aircraft's height above mean sea level is referred to as a flight level (FL). FL 150 equates to 15,000 ft.

³ All broadcasts made on the CTAF by the pilots of OZA and ZLJ were verified by the ATSB.

Figure 1: Approximate position of VH-ZLJ and parachutists



Source: Google earth

Moruya parachute operations

The parachute operator's 'Cloud Jumping Manual' stated that:

Once a Regional Express aircraft has broadcast that it is taxiing for departure, the pilot in command must not allow parachutists to exit until the Regional Express aircraft is clear of 10 NM from the DZ [drop zone].

Regional Express had a Letter of Agreement (LOA) with the parachute operator in relation to operations at Moruya.

Pilot comments (VH-OZA)

The pilot provided the following comments regarding the incident:

- On most occasions, the scheduled passenger flights departing Moruya for Merimbula from runway 36 have conducted a left turn after take-off to intercept the departure track of 178° (True), remaining at least 2 NM away from the drop zone. The pilot stated that he had become complacent with applying the required procedures as he had conducted in excess of 400 parachute drops at Moruya in the previous 8 months and had expected ZLJ to depart as per previous occasions.
- He was experiencing time pressures due to holding at FL 150 for 8-9 minutes while ZLJ was taxiing, holding and departing.

Safety action

Whether or not the ATSB identifies safety issues in the course of an investigation, relevant organisations may proactively initiate safety action in order to reduce their safety risk. The ATSB has been advised of the following proactive safety action in response to this occurrence.

Parachute operator (VH-OZA)

As a result of this occurrence, the operator of VH-OZA has advised the ATSB that they have distributed a letter to all company pilots detailing the incident and highlighting the importance of not becoming complacent with procedures.

Safety message

Complacency, the feeling of satisfaction or contentment with what is happening, may occur from a pilot's overconfidence in performing a task that has been previously conducted numerous times, without incident. This may result in a pilot inadvertently overlooking important information or responding to a situation inappropriately.⁴

This incident highlights the impact complacency and time pressures can have on aircraft operations. It is important that pilots remain vigilant and alert, and be mindful that the even the most routine tasks must be conducted with care and concentration. Furthermore, when time pressures do occur, it is a useful strategy for pilots to take the time to re-evaluate the task and their priority.⁵

General details

Occurrence details

Date and time:	12 September 2013 – 1021 EST	
Occurrence category:	Serious incident	
Primary occurrence type:	Aircraft separation	
Location:	Moruya, New South Wales	
	Latitude: 35° 53.87' S	Longitude: 150° 08.67' E

Aircraft details: VH-ZLJ

Manufacturer and model:	SAAB Aircraft Company 340B	
Registration:	VH-ZLJ	
Operator:	Regional Express	
Serial number:	340B380	
Type of operation:	Air transport – low capacity	
Persons on board:	Crew – Unknown	Passengers – Unknown
Injuries:	Crew – Nil	Passengers – Nil
Damage:	Nil	

⁴ [www.skybrary.aero/index.php/Discipline_\(OGHFA_BN\)](http://www.skybrary.aero/index.php/Discipline_(OGHFA_BN))

⁵ http://asrs.arc.nasa.gov/docs/rs/43_Time_Pressure_as_a_Causal_Factor.pdf

Aircraft details: VH-OZA

Manufacturer and model:	Cessna Aircraft Company A185F	
Registration:	VH-OZA	
Serial number:	18503645	
Type of operation:	Private	
Persons on board:	Crew – 1	Passengers – Unknown
Injuries:	Crew – Nil	Passengers – Nil
Damage:	Nil	

About the ATSB

The Australian Transport Safety Bureau (ATSB) is an independent Commonwealth Government statutory agency. The ATSB 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.