Aviation Safety Investigation Report 199800462

Centrum Naukowo-Produkcyjne-PZL M-18B

10 February 1998

Aviation Safety Investigation Report 199800462

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.

Aviation Safety Investigation Report

199800462

Occurrence Number: 199800462 Occurrence Type: Incident

Location: Tamworth, Aerodrome

State: NSW **Inv Category:**

Date: Tuesday 10 February 1998

1042 hours **Time Zone ESuT** Time:

Highest Injury Level: None

Aircraft Manufacturer: Centrum Naukowo-Produkcyjne-PZL

Aircraft Model: M-18B

Aircraft Registration: VH-PHO **Serial Number:**

Type of Operation: Non-commercial Business

Damage to Aircraft: Nil

Departure Point: Departure Time:

Destination: Tamworth NSW

Approved for Release: Friday, September 4, 1998

The pilot of VH-PHO was not familiar with procedures in the Tamworth Control Zone (CTR). He had obtained a clearance from the tower controller to enter the CTR at 3,000 ft and had been instructed to report at 5 NM. After reporting at this position, the pilot was instructed to maintain 3,000 ft and to join the circuit upwind for runway 12 Right. At this time, there were four aircraft in the circuit. The pilot of PHO was then asked by to report sighting an aircraft on the upwind leg one mile ahead. He reported that he had the traffic sighted and was instructed to follow that aircraft. A short time later, the controller observed PHO descending and tracking for a mid-downwind position. This action conflicted with VH-YTQ which was on the downwind leg. The pilot of YTQ reported manoeuvring to avoid PHO. In response to aquery from the controller, the pilot of PHO reported that he was below 2,500 ft.

The pilot of PHO did not fully understand the procedure for upwind circuit entry. Further, he believed that the instruction to follow YTQ meant that he was cleared to descend from 3,000 ft. The pilot indicated that he operated inside controlled airspace infrequently.

Investigation revealed that the relevant publications do not include a definition for the term 'follow'.

SAFETY ACTION

As a result of this occurrence, the Bureau of Air Safety Investigation is investigating a perceived safety deficiency relating to the use of "sight and follow" procedures by air traffic controllers.

Any safety output issued as a result of this analysis will be published in the Bureau's Quarterly Safety Deficiency Report.