Aviation Safety Investigation Report 199501510

Airbus
A320
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A320

21 May 1995

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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.

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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: 199501510 **Occurrence Type:** Incident
Location: 148km W Melbourne
State: VIC **Inv Category:** 4
Date: Sunday 21 May 1995
Time: 1858 hours **Time Zone** EST
Highest Injury Level: None

Aircraft Manufacturer: Airbus
Aircraft Model: A320-211
Aircraft Registration: VH-HYG **Serial Number:** 029
Type of Operation: Air Transport Domestic High Capacity Passenger Scheduled
Damage to Aircraft: Nil
Departure Point: Melbourne VIC
Departure Time: 0850 EST
Destination: Perth WA

Aircraft Manufacturer: Airbus
Aircraft Model: A320-211
Aircraft Registration: VH-HYA **Serial Number:** 022
Type of Operation: Air Transport Domestic High Capacity Passenger Scheduled
Damage to Aircraft: Nil
Departure Point: Perth WA
Departure Time: 0609 EST
Destination: Melbourne VIC

Approved for Release: Thursday, June 29, 1995

VH-HYG departed Melbourne (ML) for Perth (PH) tracking ML - Yarrowee (YWE) - Q23 - CRENA cleared to climb to flight level (FL) 350. At approximately 20 nm from ML, VH-HYG was recleared direct to CRENA. VH-HYG contacted the Inner West (IW) radar controller 30 nm outbound from ML.

VH-HYA contacted the IW controller 120 nm inbound to ML, tracking from Mount Gambier (MTG) direct ADAMS - ML on descent to FL 210.

The controller was aware of the potential conflict with the tracks and the traffic disposition. He determined that both aircraft would pass with at least six miles separation and, in his judgement, would also have established vertical separation.

When the aircraft were approximately 10 nm apart (nose to nose) the outbound aircraft, VH-HYG, appeared to turn approximately 10 degrees to the right, towards the track of VH-HYA. The controller observed this but assessed that both aircraft would still pass abeam each other with minimum allowable lateral separation of five miles.

Both aircraft entered an area of potential separation conflict at approximately 60 nm from ML. Lateral separation reduced to 3.5 nm with no vertical separation.

The controller had used his experience to assess current/future positions of both aircraft but had failed to alter his plans to ensure separation after VH-HYG altered track. At the time of the loss of separation, the controller did not pass traffic information to either aircraft because of lack of time and because from the 3.5 miles nearest proximity the aircraft tracks began to diverge.

Significant Factors

The following factors were considered relevant to the development of the incident:

1. The controller failed to alter his plans to ensure separation standards were not infringed after VH-HYG turned approximately 10 degrees towards the track of VH-HYA.

SAFETY ACTION

Since this incident, the CAA has reminded all inner sector controllers of the importance of:

1. Separation assurance; specifically that profile separation is not separation assurance.

2. Radar technique and the action required when using minimum radar separation.