Australian Government
Australian Transport Safety Bureau

Collision after landing involving a Fletcher FU-24, VH-KXT and a Gippsland GA-200, VH-AGZ

13 km SW of Cootamundra, New South Wales, on 27 February 2015

ATSB Transport Safety Report
Aviation Occurrence Investigation
AO-2015-023
Final – 22 April 2015

Released in accordance with section 25 of the *Transport Safety Investigation Act 2003*

Publishing information

Published by: Australian Transport Safety Bureau
Postal address: PO Box 967, Civic Square ACT 2608
Office: 62 Northbourne Avenue Canberra, Australian Capital Territory 2601
Telephone: 1800 020 616, from overseas +61 2 6257 4150 (24 hours)
Accident and incident notification: 1800 011 034 (24 hours)
Facsimile: 02 6247 3117, from overseas +61 2 6247 3117
Email: atsbinfo@atsb.gov.au
Internet: www.atsb.gov.au

Addendum

Page	Change	Date

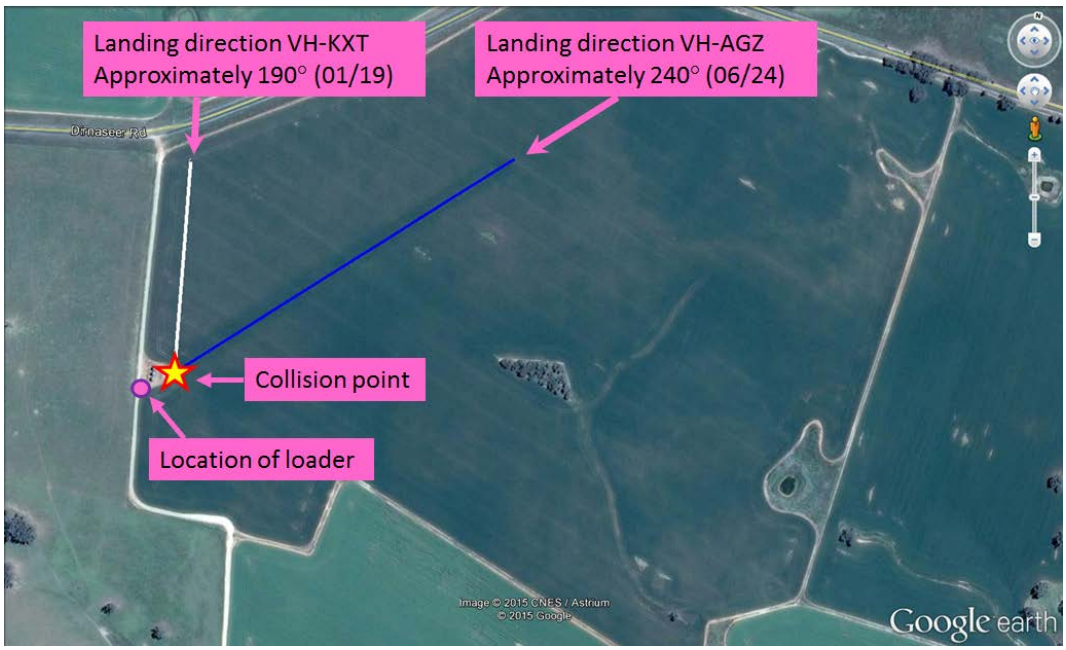
Collision after landing involving a Fletcher FU-24, VH-KXT and a Gippsland GA-200, VH-AGZ

What happened

On 27 February 2015, the pilot of a Fletcher FU-24 aircraft, registered VH-KXT (KXT), and the pilot of a Gippsland GA-200 aircraft, registered VH-AGZ (AGZ), were conducting aerial agricultural operations on a property 13 km south-west of Cootamundra, New South Wales.

The pilots commenced spreading fertilizer at about 0730 Eastern Daylight-saving Time (EDT) using two runways, one aligned in approximately the 01/19 direction, and the other 06/24 (Figure 1). Both of the aircraft were taking off from runway 06, however, AGZ was landing on runway 24, and KXT was landing on runway 19. Each load took about 6 minutes to spread. During about 90 minutes of flying operations, the pilot of AGZ had not seen KXT landing, but had observed it being loaded and taking off from runway 06. With both aircraft taking a similar amount of time to spread their load, they were in an alternating sequence and so did not need to hold and wait for the other aircraft to be loaded.

Figure 1: Accident location



Source: Google earth with details added by ATSB

At about 0900, the pilots shut the aircraft down, refuelled and had a break of about 30 minutes. During the break, the pilot of KXT reminded the pilot of AGZ that the loaded aircraft always had right of way over the landing aircraft. He also stated that KXT would remain to the west of AGZ and conduct all procedure turns to the west, AGZ was to remain east and conduct all turns to the east, to ensure separation between the two aircraft.

After resuming flying, the pilot of AGZ completed spreading on an area south-east of the landing area. He then reloaded the aircraft and departed, to locate the next paddock to be spread, which was about 1.5 NM to the north-east. It took about 5 minutes for the pilot of AGZ to determine the boundaries of the paddock and commence spreading. During this time, the pilot of KXT had returned, reloaded the aircraft and spread another load on an area about 2 NM to the north-west.

At about 1015, as KXT was on final approach for runway 19, the pilot looked towards the north-east to see whether he could sight AGZ on approach to runway 24, but did not see the aircraft. He then assumed that AGZ was still in the spreading area. At about the same time, AGZ was on approach to land on runway 24 and the pilot looked to see whether he could sight KXT approaching or on the runway, but did not sight that aircraft. He assumed that KXT was then out spreading and not in the vicinity of the landing area.

As KXT landed, the pilot observed the loader truck near the fence, which was not the normal loading position. He was momentarily distracted, as he became concerned that the truck had broken down. The loader driver had observed both aircraft approaching on different runways and had moved to a position from which he could load whichever aircraft arrived first. AGZ was in the landing roll on runway 24, and about 50 m from the loader truck when the pilot sighted KXT about 10 m from his right wing. KXT was then in the landing roll on runway 19 and the pilot of KXT returned his gaze from the loader to the front of the aircraft, just as the propeller collided with the right wingtip and then the tail of AGZ (Figure 2).

Both aircraft sustained substantial damage and the pilots were not injured.

Pilot comments

The pilots observed that the aircraft blended in with the brown countryside and were difficult to sight. The landing lights of both aircraft were on at the time of the collision. The pilot of AGZ reported that he had forgotten that KXT was landing on a different runway and assumed he was also landing on 24. The pilots had the aircraft radios switched off to reduce the likelihood of distraction.

Figure 2: Damage to VH-AGZ

Source: Aircraft owner

Safety message

The pilot of KXT commented that this incident highlights the importance of a thorough briefing between pilots prior to commencing operations. He also suggested that fitting aircraft with strobes or other light reflectors may improve the ability of pilots of other aircraft to sight them.

Operating without the use of radios for communication is known as unalerted see-and-avoid, and separation then depends on the pilot's ability to sight other aircraft. Limitations of the see-and-avoid principle are highlighted in the ATSB research report available at www.atsb.gov.au/publications/2009/see-and-avoid.aspx.

General details

Occurrence details

Date and time:	27 February 2015 – 1015 EDT	
Occurrence category:	Accident	
Primary occurrence type:	Taxiing Collision	
Location:	13 km SW Cootamundra Aerodrome, New South Wales	
	Latitude: 34° 41.28' S	Longitude: 147° 55.10' E

Aircraft details: VH-KXT

Manufacturer and model:	Airparts NZ FU-24A-950	
Registration:	VH-KXT	
Serial number:	178	
Type of operation:	Aerial work	
Persons on board:	Crew – 1	Passengers – Nil
Injuries:	Crew – Nil	Passengers – Nil
Damage:	Substantial	

Aircraft details: VH-AGZ

Manufacturer and model:	Gippsland Aeronautics GA-200	
Registration:	VH-AGZ	
Serial number:	2009722	
Type of operation:	Aerial work	
Persons on board:	Crew – 1	Passengers – Nil
Injuries:	Crew – Nil	Passengers – Nil
Damage:	Substantial	

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.