

**Aviation Safety Investigation Report**  
**199101257**

**Boeing 737**  
**Fokker F28**

**15 September 1991**

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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](http://www.atsb.gov.au).**

**Occurrence Number:** 199101257  
**Location:** Launceston TAS  
**Date:** 15 September 1991  
**Highest Injury Level:** Nil  
**Injuries:**

**Occurrence Type:** Incident  
**Time:** 1610

	Fatal	Serious	Minor	None
Crew	0	0	0	0
Ground	0	0	0	-
Passenger	0	0	0	0
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

<b>Aircraft Details:</b>	Boeing 737	Fokker F28
<b>Registration:</b>	VH-TJK	VH-EWD
<b>Serial Number:</b>	N/A	N/A
<b>Operation Type:</b>	Regular Public Transport	Regular Public Transport
<b>Damage Level:</b>	Nil	Nil
<b>Departure Point:</b>	Melbourne VIC	Launceston TAS
<b>Departure Time:</b>	N/A	
<b>Destination:</b>	Launceston TAS	Melbourne VIC

**Approved for Release:** 18th March 1992

#### **Circumstances:**

The Boeing 737 (B737) had been cleared from Cowes direct to Launceston via the 320 radial of Launceston VOR and to leave flight level 330 (33 000 ft) descending initially to 7000 ft before receiving further descent clearance to 6000 ft. The Fokker F28 (F28) had departed Launceston runway 32, followed by a left turn to intercept the 314 radial of the VOR with an altitude restriction of 5000 ft. At about 16 nm from Launceston, the B737 reported at 6000 ft, inbound on the 320 VOR radial in visual flight conditions. The Launceston Aerodrome Controller (ADC) advised the B737 to expect further descent shortly and to track to enter the circuit on a right downwind leg for runway 32. The F28 had become airborne about 2 min earlier with an amended clearance to intercept the 314 radial outbound instead of the normal 325 radial as specified in the Launceston Standard Instrument Departure procedure. At 13 nm from Launceston, the B737 was cleared by the ADC to continue descent to 5000 ft. The pilot undergoing command training in the B737 unintentionally veered slightly right of the 320 inbound radial towards the F28 tracking on the 314 outbound radial. The F28 was about 9 nm from Launceston on the 314 radial, breaking through broken cloud tops at about 4200 ft, when the aircrew first sighted the B737. The F28 veered slightly left to increase separation from the B737. Readout of the Digital Flight Data Recordings from both aircraft indicated that at 9.5 nm from Launceston, the B737 and the F28 had passed with a horizontal separation of 0.7 nm (i.e. 1.3 km) without vertical separation when both aircraft were at approximately 5000 ft. There were two qualified air traffic controllers performing ADC functions at Launceston at the time of the incident. One officer was a current controller monitoring familiarisation of the second experienced officer who had recently returned from leave. The monitoring ADC had sighted the B737 at approximately 20 nm from Launceston and verified that it was inbound on the 320 radial. He also visually assessed that the F28 was tracking outbound on the 314 radial in accordance with instructions. The monitoring ADC then discontinued visual surveillance of the B737 and the F28 for a short time. He became occupied with surveillance of two other aircraft departing towards the NE to ensure that the sequence planned by the

training ADC would ensure separation from the approaching B737. By this time, neither ADC was maintaining surveillance of the B737 or the F28. Neither sighted the B737 again until shortly after both aircraft had passed and the crews had exchanged comments on their proximity. The controllers then noticed that the B737 had unexpectedly veered slightly right of the 320 radial.

**Significant Factors:**

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

1. The use of visual separation standards may have been inappropriate at the time of application due to cloud and aircraft positions.
2. Vertical and lateral separation standards were replaced by visual separation standards without confirmation that the aircraft had safely passed.
3. Neither aircraft had been alerted of the proximity of the other. This incident was not the subject of an on-scene investigation.