Aviation Safety Investigation Report 199400097

Cessna Aircraft Company U206G Cessna Aircraft Company Cessna Skyhawk

12 January 1994

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Aviation Safety Investigation Report

199400097

Occurrence Number: 199400097 Occurrence Type: Incident

Location: Hobart/Cambridge

State: TAS **Inv Category:**

Wednesday 12 January 1994 Date:

1630 hours Time Zone **ESuT** Time:

Highest Injury Level: None

Aircraft Manufacturer: Cessna Aircraft Company

U206G Aircraft Model:

VH-MYS Aircraft Registration: Serial Number: U20605162

Type of Operation: Charter Passenger

Damage to Aircraft: Nil

Departure Point: Melalueca, TAS

Departure Time:

Destination: Cambridge, TAS

Aircraft Manufacturer: Cessna Aircraft Company

Aircraft Model: 172M

VH-DXO Serial Number: 17266792 Aircraft Registration:

Type of Operation: Instructional Dual

Damage to Aircraft: Nil

Departure Point: Cambridge, TAS

Departure Time:

Destination: Cambridge, TAS

Approved for Release: Sunday, June 19, 1994

VH-DXO was conducting crosswind circuits on runway 06 (circuit direction right hand). VH-MYS, inbound from the southwest, was given traffic on VH-DXO and instructed to join downwind for runway 14 (circuit direction also right hand). VH-MYS was also instructed to report "approaching the circuit".

As VH-DXO was about to turn onto right base for runway 06, VH-MYS passed in front of VH-DXO at right angles tracking on a right downwind leg for runway 14. The pilot in command of VH-DXO estimated that the two aircraft missed by about 10 metres. The pilot of VH-MYS reported on downwind immediately after the near collision but had not reported approaching the circuit as requested by air traffic control.

Significant Factors:

The following factors were relevant to the development of this occurrence:

1. The pilot of VH-MYS did not report approaching the circuit as requested by air traffic control.

- 2. Lookout by the pilots of both aircraft was ineffective.
- 3. The instruction issued to VH-MYS by air traffic control to report approaching the circuit was too vague as this is not a specific position and is open to individual interpretation.

Safety Action:

It was considered that this incident may have been averted if VH-MYS had been instructed to report at a specific location approaching the circuit rather than instructed to report approaching the circuit area which was vague and open to interpretation. This aspect was discussed with air traffic control supervisory personnel at Melbourne who will be taking standardisation action on the matter.