Aviation Safety Investigation Report 199301597

Avions Marcel Dassault Falcon

21 May 1993

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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: 199301597 **Occurrence Type:** Incident
Location: APOVO
State: SA **Inv Category:** 4
Date: Friday 21 May 1993
Time: 2102 hours **Time Zone** EST
Highest Injury Level: None

Aircraft Manufacturer: Avions Marcel Dassault
Aircraft Model: Mystere-Falcon 900
Aircraft Registration: **Serial Number:**
Type of Operation: Non-commercial Other (including military)
Damage to Aircraft: Nil
Departure Point: Paraburdoo WA
Departure Time:
Destination: Sydney NSW

Approved for Release: Wednesday, October 26, 1994

Royal Australian Air Force VIP aircraft, call sign NVOY606, was enroute Sydney from Paraburdoo in Western Australia. The aircrew had flight planned to cruise at flight level (FL) 370. However, enroute NVOY606 progressively requested higher levels to FL430. A Melbourne air traffic controller failed to enter the change of level on one of five flight strips. The strip missed was the APOVO position strip which is used for co-ordination with Sydney air traffic controllers. When NYOY606 made a position report at APOVO the pilot reported his actual altitude which was different from the entry on the flight progress strip. This was a chance for the controllers to correct strip entry but at the time the controllers did not react. The altitude error was not discovered until the aircraft was transferred to Sydney control. There was no breakdown in separation with other aircraft.

At the time of the incident, an experienced air traffic controller was undergoing supervised training on Sector 1 (Adelaide to Perth). She failed to make the appropriate entry on the flight progress strip. Air traffic was busy at the time. The supervisor did not notice the oversight.

The Civil Aviation Authority has subsequently conducted an internal investigation. It was noted that the air traffic controller responsible for the oversight had been on duty for three and a half hours without a break. The size of the airspace controlled and the depiction of the route structure on the console was seen as demanding careful attention because, depending on the route, some flights require only two strips whereas others need five. The training officer noted that the short length of cord on his headset did not allow him the freedom of movement he would like when supervising/checking another controller. The controller under training noted that it was difficult to physically move quickly enough when trying to record information received from aircraft because of the size of the display area . The training officer also said that he would like a more elevated chair to enable a better view of the console when supervising.

The headset cord has since been lengthened and a couple of tall chairs have been provided for training officers.

Significant Factors:

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

1. A change of level was not transcribed onto a position flight strip by the air traffic controller under training.

2. The training officer did not notice the failure of the controller under training to transcribe the flight level onto the flight progress strip.

3. Neither the training officer nor the trainee reacted to the different flight level reported by the pilot at the APOVO position report.

4. Air traffic was busy at the time of the incident.