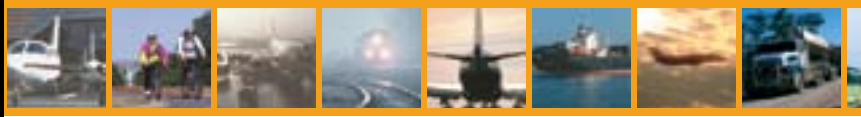
Australian Government
Australian Transport Safety Bureau

The Australian



Executive Director's Message

I am pleased to report that progress continues on the new direct reporting scheme for major airlines. The ATSB receives, on average, 300 such reports a week. Although immediately reportable matters must be reported as soon as reasonably practicable by telephone, and routine reportable matters have a 72-hour window, both require the submission of a written report. Reports received by phone, post, email and fax require manual processing, which involves scanning the record and adding specific data in order to create and save a new record to the ATSB's database. At present the manual process is both time consuming and resource intensive.

Work has been underway on an online-based reporting system that will automatically process electronic reports from major airlines, negating the need for manual processing. Each report will still be reviewed by ATSB staff, ensuring that nothing is overlooked, but the implementation of this system will reduce the manual workload by around 80%. This new system represents a great deal of work by a number of people and could not have been achieved without the on-going support of the airlines themselves.

Meanwhile, the introduction of the A380 aircraft into commercial service has prompted the International Civil Aviation Organization (ICAO) to review the wake turbulence categorisation scheme. To ensure that any amendments to the scheme have a solid foundation, ICAO has requested that all countries report all wake vortex encounters for all aircraft types. ICAO has produced two reporting forms, one for pilots and one for air traffic service providers. These forms identify specific data concerning wake vortex encounter events that will aid in the review of the categorisation scheme. Such events are already reported to the ATSB but on 1 July 2008 we will be placing the more detailed forms on the ATSB website. Pilots and air traffic service providers will be requested to forward the completed forms to the ATSB when filing the required wake vortex encounter notification. Alternatively, the ATSB may contact the pilot and/or air traffic service provider directly to seek this additional information.

Kym Bills, Executive Director

Fibre Composite Research

For many decades, fibre composites have been replacing traditional aluminium structures in a wide variety of aircraft types. Composites are formed from two materials – a reinforcing fibre which is woven into a ply, and a matrix material which bonds the plies together and provides the stiffness to shape the fibres into structures.

Since the first all-composite kit plane was released in 1957, composites have become widespread in today's aircraft. This is due to the cost and weight savings that such materials offer aircraft manufacturers over aluminium, while equalling or surpassing its strength and durability.

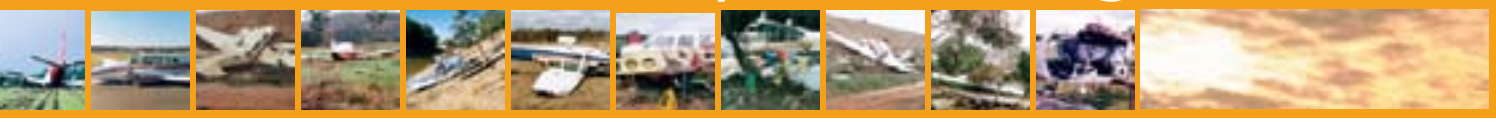
The ATSB's new study *Fibre composite aircraft – capability and safety* provides an overview of fibre composite use in aircraft and the associated issues, with a focus on aircraft operating in Australia that contain these materials. There are almost 2,000 aircraft on the Australian civil register made of, or containing, fibre composite materials. This includes most of the mainline jet fleet, effectively all sailplanes and gliders, many popular general aviation (GA) aircraft, and a third of the growing amateur-built aircraft category.

Currently, there is a great deal of conflicting or incorrect information in the aviation community regarding the safety and capability of fibre composite materials. Composite structures behave very differently under normal loads than equivalent metal structures. Fatigue and corrosion have been proven through trials of composite repair patches to be much less prevalent in composites compared with metals. Subsurface damage such as delamination, however, can go undetected for long periods and result in sudden catastrophic failure. It is important that operators of fibre composite aircraft be aware of correct detection and repair procedures for the unique types of damage that occur to composites.

Also, first responders involved in post-crash cleanup operations have expressed concerns about the long-term effects from exposure to carbon fibres released from burning composites. Fibre dust can pose an inhalation risk similar to asbestos. Released fibres or splinters are needle-sharp, and can cause skin and eye irritation. In the event of a post-crash fire, smoke and toxic gases are also released from decomposing composites, presenting further health risks.

It would be prudent for emergency services to review their aircraft accident response procedures, or develop specific procedures if they do not currently exist.

The entire report, *Fibre composite aircraft – capability and safety*, is available on the ATSB website. ■



Strikemaster In-Flight Break-up

At about 1215 EST on 5 October 2006, the pilot of a British Aircraft Corporation 167 Strikemaster aircraft, registered VH-AKY, took off from Bathurst, NSW, for a 25-minute adventure flight with one passenger. The aircraft was to depart Bathurst to an area to the north in order to conduct upper air work sequences, including steep turns and aerobatics, at a height of between about 8,000 and 10,000 ft. The plan was then to descend to an area to the north-east of Bathurst for a simulated low-level strike mission, using a geographical feature in the region where the accident occurred, followed by a further simulated strike mission on a dam to the east of Bathurst, prior to returning for landing.

The first low-level strike sequence involved simulation of an attack on an enemy position located on a terrain feature known as the 'Woolpacks' feature. This involved a low-level high-speed approach in a valley, followed by a rolling manoeuvre over the Woolpacks feature, for a simulated weapons release, before rolling upright and continuing at low level to the next target. A pilot who had previously flown those missions for the operator reported that the sequence was usually flown at a speed of about 300 kts and at a height of about 300 ft above the valley floor. The speed and height that the pilot flew the mission on the day of the accident could not be determined.

The aircraft failed to return, and a search was initiated. The aircraft wreckage was located in the Turon State Forest about 20 km to the north-east of Bathurst. The ground impact had started a fuel-fed fire that resulted in a large bushfire, which took several days to contain. The pilot and passenger were fatally injured.

The aircraft wreckage was located on the north-eastern side of the Woolpacks feature and in the valley floor, distributed over about 800 m of sloping, treed, terrain. The main wreckage, which consisted of the fuselage, engine and left wing, was located about halfway up the north-eastern side of the Woolpacks feature, and was mostly destroyed by impact forces and the subsequent post-impact fires. Witness marks on trees in the vicinity of the main wreckage indicated a downward impact angle of about 50 degrees. Other items of wreckage were damaged to varying degrees by impact with the ground and trees, and by the bushfire. The rudder mass balance weight, attached to part of the upper rudder, was the first item found in the wreckage trail, and was located about 120 m from other empennage items.

During the low-level simulated strike mission, the aircraft broke up in flight, with the right wing, tailplane, tail fin, elevators and rudder separating prior to impact with terrain. The available evidence was consistent with the break-up being initiated by the separation of the tail surfaces, with the rudder mass balance experiencing a vertical load that was sufficient to tear it off over the top of the rudder. It could not be conclusively determined from the wreckage what imparted the vertical load, however the evidence suggested that there may have been an alternating upward and downward bending load at the root of the tailplane.

With the loss of the rudder mass balance, the loads on the tail increased until it fractured and separated from the aircraft. The right wing, being weaker than the left due to fatigue cracks, subsequently fractured and separated from the aircraft. The engine was producing significant power at the time of impact and the wing flaps and landing gear were retracted.

As a result of this occurrence, the ATSB briefed the Civil Aviation Safety Authority (CASA) and the UK Civil Aviation Authority on findings relating to the separation of the wing and tail. CASA has released a number of Airworthiness Bulletins to alert Australian operators of issues relating to Strikemaster and Jet Provost aircraft. CASA has also approved the Australian Warbirds Association Limited to administer aircraft operating under the Limited Category. ■

Investigation briefs

Engine failure

Occurrence 200700357

On 2 February 2007, at about 1530 ED-ST, a Bell Helicopter 407 (407) emergency medical helicopter with a pilot, a crewman, a doctor and a paramedic on board departed Tamworth, NSW en route to a car accident. At about 1610, the pilot broadcast on both the area and common traffic advisory frequency (CTAF) radio frequencies that they were inbound to Warialda at 28 km south-west and on descent from 6,500 ft [above mean sea level].

The pilot reported that soon after the broadcast, the engine chip detector advisory capsule illuminated on the master caution panel. About five seconds later, he heard a loud noise and the helicopter developed a severe high frequency vibration with a complete loss of engine power. The pilot then broadcast a distress advisory on the area frequency with position, altitude, passenger information and the problem. During the subsequent autorotation emergency landing, the helicopter landed heavily and rolled onto its side.

None of the occupants were injured, but the helicopter was destroyed. The front passenger's windscreen was broken and the landing gear was destroyed. The main rotor and tail rotor blades sustained significant impact damage. The tail section separated from the helicopter.

The investigation determined that the engine sustained an in-flight catastrophic failure of the engine gearbox. This failure was due to the fracture and separation of a section of the helical torquemeter gear, which resulted in the loss of engine power.

Evidence of localised gear tooth spalling and uneven surface contact patterns were noted during the examination of the helical torquemeter gear teeth. The engine manufacturer found that the root radii were below the minimum engineering drawing requirements but considered it to be not contributory to the event. The engine manufacturer was unable to establish the initiator of the fatigue cracking, but has implemented an extensive engineering stress and modelling analysis project. ■

VFR flight into IMC

Occurrence 200703905

On 20 June 2007, at approximately 0615 WST, a Cessna Aircraft Company C208 Caravan float plane, registered VH-NRT, departed Broome Airport, WA on a Visual Flight Rules (VFR) charter flight to Talbot Bay. On board the aircraft were the pilot and 10 passengers.

About 35 to 40 minutes into the flight, the weather conditions deteriorated and the pilot elected to discontinue the flight and return to Broome. During the return flight, the aircraft entered an area of reduced in-flight visibility that resulted in the loss of the visual horizon.

Whilst manoeuvring the aircraft to regain visual meteorological conditions (VMC), the pilot became disoriented, and made a general radio broadcast seeking assistance. That broadcast was received by the crew of another aircraft that was approaching to land at Cone Bay, approximately 130 km to the north-east. The crew discontinued their approach in order to provide assistance. They provided advice and reassurance to the pilot, who was able to regain control of the aircraft and, shortly after, resume the remainder of the flight.

The approach to Broome required the non-instrument-rated pilot to descend through cloud before becoming visual and landing.

This incident highlighted the risks of inadvertent flight into Instrument Meteorological Conditions (IMC) and of the recovery from those conditions, particularly in respect of a pilot that does not hold an instrument rating.

As a result of this investigation, the ATSB has issued two safety recommendations, firstly suggesting that the operator assist pilots in the area of weather-related decision-making; and secondly provide guidance for recovery in the event of inadvertent entry into Instrument Meteorological Conditions (IMC).

This investigation report is particularly timely, given the approach of winter and the accompanying weather patterns in a large part of Australia. ■

Crew incapacitation

Occurrence 200700765

On 13 February 2007 at 1830 WDST, a Beech Aircraft Corporation 58 Baron was being used for instrument flight training. The flight was being conducted under the visual flight rules (VFR), with the pilot flying, simulating flight under the instrument flight rules (IFR). A second pilot was on board to act as a safety pilot and to lookout for other aircraft. During the conduct of a Busselton, WA non-direction beacon (NDB) approach, the pilot flying became incapacitated and the safety pilot assumed control of the Baron. The safety pilot landed the aircraft on runway 21 at Busselton and the incapacitated pilot received treatment from attending ambulance officers. The pilot was a 22 year old, Grade 2 flying instructor, with 1,422 hours total flying experience. Following a check by a Designated Aviation Medical Examiner and four days rest, the pilot was approved to return to work.

Initial medical testing following the event found no health problems and it is possible that the pilot's sustenance and fluid intake were inadequate. The pilot stated that he was a non-smoker, and was fit and healthy at the time of the event. He stated that he had travelled on commercial aircraft from Perth to Brisbane on the previous Friday and from Brisbane to Perth on the Monday, the day before the event. During those commercial flights, he did not eat or drink, spending most of the time sleeping.

The pilot stated that about 12 months previously, he had experienced a similar event and after a number of medical tests that did not find any physical problems, it was established that he had been dehydrated.

The pilot changed his eating and fluid intake habits, including using a water bottle while flying.

The Civil Aviation Safety Authority (CASA) Aviation Medicine section subsequently suspended the pilot's Class 1 medical and requested the pilot undergo further testing. That testing found that the pilot had epilepsy and CASA revoked the pilot's medical. ■

Navigation event

Occurrence 200700065

On 11 January 2007, at about 0718 ED-ST an Airbus A320 aircraft, registered ZK-OJB, departed at Sydney Airport, NSW for Auckland, New Zealand and was assigned a radar heading by Air Traffic Control (ATC).

The controller noticed that the aircraft turned onto an incorrect heading and informed the flight crew. A check of the aircraft's compasses by the flight crew found that they were reading approximately 40 degrees incorrectly, and that a GPS PRIMARY LOST message had appeared on the aircraft's multi-purpose control and display unit and navigational display. The flight crew advised ATC that the compass was unserviceable and that they were experiencing navigational difficulties. In addition, they believed that the aircraft's Instrument Landing System was affected.

The flight crew elected to return to Sydney and ATC provided radar vectoring in order to allow for a reduction in the aircraft's fuel load and, as a result, for a landing below the aircraft's maximum landing weight. The aircraft remained in visual meteorological conditions and was radar vectored for a visual approach and landing.

When the aircraft returned to the departure gate, the flight crew noticed that the inertial reference system (IRS) had been aligned to the incorrect longitude. The operator's investigation into the incident found that the IRS was aligned by maintenance staff prior to the crew boarding the aircraft. The incorrect alignment of the IRS was not noticed during a number of subsequent checks prior to departure.

The maintenance action to align the aircraft's (IRS), although not mandated, was in accordance with the operator's documented procedures. The reason for the input of incorrect position data in the IRS could not be determined.

The investigation was unable to determine why the incorrect positional data remained undetected by the flight crew, despite the four separate pre-take-off procedural defences.

As a result of this incident, the operator developed a training program for all company pilots that was designed to improve discussion and guidance in relation to threat and error management issues. ■

Engine power loss

Occurrence 200700358

On 4 February 2007, the owner-pilot of a Piper Aircraft Co. PA-30 Twin Comanche aircraft, registered VH-DIC, was conducting a private flight from Gold Coast Airport, Qld. The pilot was the sole occupant. Approximately 11 minutes into the flight, at 1622 EST, the pilot declared an emergency reporting an engine failure and some 15 seconds later that he was also experiencing problems with the 'left engine'. Approximately 14 minutes after departure, the aircraft impacted the water about 100 m off Kingscliff beach, adjacent to the suburb of Casuarina, NSW. The pilot received fatal injuries.

Witnesses located on or near the beach at Casuarina reported seeing the aircraft flying north at a low height, either over, or just off, the beach. Those witnesses reported that at that time there was very little engine noise.

The aircraft was then observed to pitch up and bank sharply to the right. The witnesses reported hearing a variety of sounds associated with the aircraft's pitch up including an increase in engine noise, a loud bang, and a noise like a 'bullroarer.'

Two days following the accident, the aircraft wreckage including most of the lower centre fuselage, wings, and both engines and propellers, was recovered and examined. The right propeller was recovered with the blades in the feathered position. The left propeller was recovered with the blades in the normal operating range with bending consistent with power being applied at the time of the impact with the sea.

The investigation determined that most probably, the right engine stopped operating with the propeller going to the feathered position, followed by an unexplained power loss of the left engine. The aircraft airspeed then decreased below the minimum controllable airspeed during the emergency landing before power suddenly returned to the left engine, causing the aircraft to pitch nose up and bank sharply to the right and impacting the water. Examination of the right engine confirmed bearing distress. However, examination of the left engine did not uncover any anomalies. ■

Engine power loss

Occurrence 200703662

On 13 June 2007 at about 1335 EST, a Bell Helicopter B206B helicopter, registered VH-JWM (JWM), departed Mackay, Qld on a charter flight to a container ship, located about 180 km offshore. The helicopter was engaged in the transfer of a marine pilot to an offshore ship. On board were the pilot and the marine pilot. The flight was operated under the visual flight rules (VFR).

The pilot later reported that at about 1423, while about midway between Mackay and the ship at about 1,500 ft above mean sea level, the helicopter sustained an engine power loss. The pilot reported that the first indication was a slight yaw kick in the helicopter. He reported that he immediately lowered the collective control and configured the helicopter descent profile for an auto-rotation emergency landing. The pilot reported that he broadcast a MAYDAY on both the operator's and air traffic control radio frequencies. The pilot reported that he then reduced the forward airspeed of the helicopter, confirmed the inflation of the pop-out floats on the helicopter's skids, flared the helicopter and landed in the ocean. He reported that at this point, the helicopter was floating on the ocean and the main rotor blades had nearly stopped rotating.

The 2-3 m sea swells caused the helicopter to roll to its left and become inverted. The two occupants sat on the overturned helicopter until they could inflate and enter a four-person life raft.

About one and one-half hours after ditching, they were recovered by another company helicopter and transported to the Mackay Base Hospital. They sustained only minor injuries. During the following days, the operator and the ATSB tried unsuccessfully to locate the helicopter. After several weeks floating on a partially inflated float bag, the helicopter eventually submerged and was not recovered until 26 September 2007. From the time of the ditching, until it submerged, the helicopter had floated approximately 84 km to the north-north-west.

Damage to the airframe, engine and all components was extensive due to salt-water immersion and exposure. The damage to the helicopter and engine prevented the investigation from obtaining any additional information in relation to the engine failure. ■

REPCON briefs

Australia's voluntary confidential aviation reporting scheme

REPCON is a voluntary confidential reporting scheme for aviation. It allows anyone who has an aviation safety concern to report it to the ATSB confidentially while protecting the reporter's identity. This could include a self-report about something the reporter was directly involved in. REPCON would like to hear from you if you have experienced a 'close call' and think others may benefit from the lessons you have learnt. These reports can serve as a powerful reminder that, despite the best of intentions, well-trained and well-meaning people are still capable of making mistakes. The stories arising from these reports serve to reinforce the message that we must remain vigilant to ensure the ongoing safety of ourselves and others. REPCON will also accept third-party reports where the reporter has a safety concern about, for example, training, cabin safety, flight operations, air traffic services, crew scheduling or maintenance practices.

What should not be reported to REPCON?

It is vital that REPCON can be used as an effective alternative for reporting safety concerns when other avenues for addressing such concerns are not achieving the desired results. To ensure the successful operation of the scheme, strict rules apply in respect of the careful handling and confidentiality of those reports. Because of the confidentiality requirements, some matters must be excluded from the scheme since it would be unable to properly address them. Such matters include situations that represent a serious and imminent threat to a person's health or life, acts of unlawful interference, and matters relating to a serious crime that would attract a penalty of life or more than two years imprisonment. REPCON staff are not in the best position to act on what may be very urgent and very grave reports. In cases where REPCON receives such reports, the reporter will be asked to report the matter to a more appropriate authority (e.g. CASA or the Police). However, if it seems unlikely that the reporter will pass on the information themselves or the matter is deemed to be time-critical and the reporter cannot be contacted in a timely manner, REPCON may release the information to the appropriate authority. All other reports of safety concerns though, will receive REPCON's legislative confidentiality protections for reporters and individuals referred to in reports.

In-flight airframe vibrations

R200700107

Report narrative:

It has been reported that a company [manufacturer model] aircraft has had airframe vibrations associated with the rudder for two months. The reporter has expressed concern that despite company engineering troubleshooting, the vibrations are getting worse although no faults have been found. The aircraft is believed to have diverted several times recently due to the severity of the vibration in flight and the lack of company engineering personnel at the planned destination.

REPCON comment:

REPCON contacted the aircraft operator and supplied them with the de-identified report. The operator responded that two aircraft were identified where the crew had reported airframe vibrations during the climb phase of flight. Both aircraft were extensively inspected and in both aircraft the rudder servo valve was replaced due to movement in the actuator rods. After the replacement of the rudder servo valves, no further reports were recorded of airframe vibrations

LAME schedule of experience

R200700112

Report narrative:

It has been reported that a person has recorded experience in their Aircraft Maintenance Engineer Schedule of Experience when they were not on shift.

Reporter comment: People are looking for employment outside of the operator and require gaining further qualifications quickly.

REPCON comment:

REPCON contacted the operator and supplied them with the de-identified report. The operator responded that they had not seen evidence of this type of activity occurring internally. It is the responsibility of the certifying LAME to ensure that what they are certifying for in respect of an individual is, in fact, correct. It is the LAME's responsibility to ensure the claimant has in fact completed the type of experience detailed in the Schedule of Experience (SOE). The SOE system is not controlled by [operator] Engineering.

ATC short breaks

R200700118

Report narrative:

The reporter expressed concerns that at [ATC location] Centre during short breaks of up to twenty minutes, the ATC position was being covered by controllers that were not endorsed, rated or current on the position.

REPCON comment:

REPCON contacted Airservices and supplied them with the de-identified report. Airservices provided the following response.

'Airservices utilises controllers who are rated and endorsed on other positions to provide communication services to facilitate short breaks where an appropriately endorsed break relief is not available. These breaks are provided utilising very strict guidelines which are detailed below.

In formulating these instructions Airservices utilised its Safety Management System and the process included two hazard identification workshops. The issue has also been raised with the Civil Aviation Safety Authority in respect of the regulations and it has been determined that Airservices is compliant with the regulations.'

Short Breaks from a Console or Position when Relief Staff are not appropriately endorsed

Application

This instruction applies to all shifts.

Circumstances

To facilitate short breaks from an active console or position, a supervisor or Shift Manager may approve a person who holds an Air Traffic Controller licence and who holds a valid Class 3 Medical Certificate, but who is not currently endorsed for the position/function, to:

a. maintain a listening watch at the relevant console or position; and/or

b. relay to an aircraft verbatim recorded

instructions issued by an appropriately~ endorsed Controller for that console or position.

'Short break' defined

As a guide, a 'short break' would not be expected to exceed 20 minutes and take account of pending activity. Whenever possible, delay the short break until a time of little or no expected activity.

Endorsed Controller responsibilities

The endorsed Controller is responsible for:

a. conducting a normal comprehensive handover and takeover prior to vacating the position and upon return to the position
b. recording verbatim instructions in the same way that the handover/takeover is recorded
c. advising what Eurocat inputs [radar inputs] must be recorded on a scratch pad for use by the non-endorsed Controller
d. advising adjacent units that he/she is vacating the position
e. advising adjacent units when he/she has returned to the position
f. being on call to return to the console if required
g. the endorsed Controller must resolve and/or handle any situation which occurred during the short break which did not constitute an immediate comprise to the safety of air navigation, and was thus handled by the non- endorsed Controller in their absence.

Non-endorsed Controller Responsibilities

The non-endorsed Controller:

a. must follow the instructions recorded on the scratch pad by the endorsed Controller
b. must record all transmissions received on the scratch pad noting time, callsign and response
c. is permitted to provide a flight information service
d. must not initiate communication in the absence of specific instructions from the endorsed Controller
e. must limit replies to phrases, such as STAND BY or WILL ADVISE
f. must not provide any clearances or instructions to aircraft (except as permitted) unless there is a threat to the safety of air navigation.

Airport safety concerns

R200800005

Report narrative:

The reporter has expressed concerns about requirements for aircraft to taxi via active runways and inadequate signage for taxiways at the [location] airport. Approximately two years ago at the [location] airport, the portion of taxiway Charlie between taxiways Hotel and Kilo was declared not to be suitable for aircraft greater than 5,700 kg MTOW or with a greater than 15 m wingspan. It is reported that many aircraft park on the general aviation apron that are greater than those dimensions. For those aircraft to get to the general aviation apron they are required to taxi via an active, busy runway (RWY 30). It is reported that there have been serious occurrences involving aircraft taxiing via the runway to get to or from the general aviation apron and requiring action to be taken to avoid a collision. There have also been other incidents where aircraft have missed taxiways due to inadequate signage and entered active runways. Reporter comment: Hopefully now we have had another similar incident we will see some action – before we have a collision.

REPCON comment:

REPCON contacted the airport operator and supplied them with the de-identified report. The operator responded that they had reviewed the details of the report and that it will be taken into consideration with the master grading plan for all aprons which will soon be completed as part of the new terminal development works. In November 2006 Movement Area Guidance Signs were installed.

Low level aerobatics

R200800006

Report narrative:

The reporter expressed safety concerns at low level aerobatics being performed at [location] by a [aircraft type] aircraft registered [aircraft registration], during passenger carrying charter operations with other aircraft traffic in the circuit area. The reporter alleges that the aerobatics included a sharp pull up and snap roll at approximately 200 ft above ground level (AGL) after takeoff from runway [#]. The aircraft then took up a position to the northwest of the aerodrome and further aerobatics were conducted above approximately 1,500 ft but partially over built-up areas. This follows reported repeated incidents, over several months, of prohibited aerobatic manoeuvres within or in very close proximity to an active circuit area.

REPCON comment:

REPCON contacted the aircraft owner and supplied them with the de-identified report. The owner responded that the aircraft is operated in 'limited' category and charter flying is not performed in this aircraft. The aircraft is operated under a 'Special Certificate of Airworthiness' under which approval is given to conduct Aerobatic Adventure flights. The owner holds approval to conduct aerobatics down to 500 ft AGL. The approval allows the carriage of passengers while conducting aerobatics down to 500 ft AGL. The owner advised that 'snap' rolls are not conducted in the aircraft at any altitude. This manoeuvre places a lot of stress on the airframe and there is no reason to perform this manoeuvre. If there are no aircraft in the circuit, the pilot will make the appropriate broadcasts and conduct aerobatics over the airfield. An aerobatic routine may occasionally start with a steep climb after takeoff and an aileron roll when climbing through 500 ft AGL. Aerobatics are permitted over the airfield as per the Airfield User agreement and the aerobatics cease when an aircraft either calls inbound or lines up for takeoff. Regular airfield user meetings are held at [location] and any irregularities with operations at the airfield are supposed to be raised at those meetings or with the airfield managers and/or operator at the time. The owner has not heard of any reports complaining of aerobatics in the circuit area or conflicts with other aircraft. The area to the northwest of the airfield is not built up, it is vacant farmland.

REPCON reports received	
Total 2007	117
First quarter 2008	27
April/May	16
What happens to my report?	
For Your Information issued	
Total 2007	58
First quarter 2008	16
April/May	9
Alert Bulletins issued	
Total 2007	1
First quarter 2008	4
April/May	2
Who is reporting to REPCON?#	
Aircraft maintenance personnel	28.7%
Air Traffic controller	4.4%
Cabin crew	1.3%
Facilities maintenance personnel /ground crew	0%
Flight crew	25.0%
Passengers	6.9%
Others*	33.7%

29 Jan 2007 to 29 May 2008

* examples include residents, property owners, general public

How can I report to REPCON?

On line: ATSB website at www.atsb.gov.au
telephone number: 1800 020 505
by email: repcon@atsb.gov.au
by facsimile: 02 6274 6461
by mail: Freepost 600, PO Box 600, Civic Square ACT 2608.