

REPORT

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Telefax: + 47 64 84 57 70 Date: 18 January 2001

All times given in this report are UTC.

Aircraft

-type & reg.: Cessna C 650, LN-NLD and Airbus A 320, HS-IPZ

Radio call sign: NOO 03, SWR 417

Date and time: 02 june 2000, 1525 UTC

Location: Approximately 20 NM south of ENGM

Type of occurrence: Air traffic incident, AIRPROX

Type of flight: Ambulance flight / commercial airline operation

Light cond.: Daylight

Flight cond.: IMC, both aircraft IFR, both aircraft

Information sources: Report from ATC, Commanders reports and AAIB/Ns own

investigations.

SUMMARY

Oslo Airport Gardermoen, ENGM, is located north of the city of Oslo Norway. The Terminal Control Area (TMA), is divided into 2 sectors by a line running roughly north - south through the centre of the airport. The sectors are named APPROACH SECTOR EAST and APPROACH SECTOR WEST. A separate ATC controller controls the traffic in each sector. A system of STARs (Standard Instrument Arrivals), and SIDs (Standard Instrument Departures), has been established to orderly regulate the arriving and departing traffic (see Appendix 1).

NOO 03 was operating a domestic flight from Sandefjord Airport Torp, ENTO, to ENGM. The aircraft was under the control of Oslo APP, TMA EAST on freq. 119.65 MHz, cleared to fly STAR TOR 2F and at the time of the incident maintaining FL 100. The aircraft was flown in accordance with clearance.

SWR 417 was operating an international flight from ENGM to Zurich Airport, LSZH. The fly SID SKI 2C but also cleared to deviate from track to avoid CB (Cumulonimbus). At the time of the incident SWR 417 was in a right turn leaving FL 100 for FL 190. The aircraft was flown in accordance with the controller's instructions.

The weather in the area at the time of the incident included moderate to heavy CB activity, requiring considerable deviation from published SIDs in order to avoid CBs.

At time 1525:17 SWR 417 reported a TCAS Warning to TMA WEST indicating a lateral distance of 2 NM to the other aircraft and at almost same flight level. The commander of SWR 417 indicated that a formal report would be submitted.

The commander of NOO 03 was later informed about the incident by CAA and asked to submit a report.

The incident was investigated by OSLO ATCC and a report submitted to AAIB/N.

The STAR TOR 2F and SID SKI 2C are located in different sectors of OSLO TMA. The STAR and the SID are located close to the common border between the two sectors.

A separate controller in each sector, utilising a separate radio frequency provides air Traffic Control.

A system for provision of altitude separation between aircraft on STAR TOR 2F and SID SKI 2C is in force in DEP AREA 19R. The local Oslo ATCC regulation, part 3, chap. 2 and part 3, chap. 3 contains the maximum and minimum altitudes to be maintained by north- and south bound traffic until clear of DEP AREA 19R.

The incident took place approximately 10 NM south of DEP AREA 19R.

AAIB/N COMMENTS AND ANALYSIS

SID SKI 2 C contains a noise abatement procedure involving a left turn after take off, bringing the tracks of SID SKI 2C and STAR TOR 2F closer than 5 NM from each other at a point approximately 8 NM south of the departure end of RWY 19L. The result is a situation that may cause insufficient lateral separation between aircraft operating on the STAR and SID respectively. Close co-ordination between the two controllers in order to ensure sufficient vertical separation is therefore a requirement when both procedures are in use simultaneously.

At the time of the Airprox, an agreement between the two controllers were in force, specifying altitude limits for inbound and outbound traffic in order to provide separation.

Due to high workload in connection with CB avoidance, co-ordination between the two controllers broke down. The controllers started to assume that the other controller had taken certain actions without taking the time to verify it. Instructions given to the two aircraft where based on assumptions and this eventually led to the incident.

The incident was caused by ATC controller overload and breakdown of co-ordination in a situation requiring extensive re-routing of aircraft due to CB avoidance.

The incident does however indicate a weakness in the STAR - SID system at Oslo Airport Gardermoen.

One STAR and one SID, located in different sectors, frequently used simultaneously and not providing sufficient lateral separation, constitutes a potential safety hazard. This problem is normally solved by a general agreement between the controllers involved and by individual improvisation in each separate case. At times of high workload, such as at the time of this incident, controllers can easily be overloaded, resulting in a breakdown in coordination between the controllers. Reliable safeguards to prevent this from happening are not found in the system at present time.

The conflict between optimal safety and noise abatement is often present when STARs and SIDs are constructed. The AAIB/N will emphasise the need for extensive risk analysis whenever such conflicts are identified and that a conservative policy is followed.

Unless there is sufficient lateral separation between the different procedures in use, a rigid set of rules for ascertaining proper co-ordination between controllers will be required in order to obtain an acceptable level of safety.

RECOMMENDATIONS

The AAIB/N recommends that the CAA/N consider a revision of all aspects concerning the STAR and SID procedures at Oslo Airport Gardermoen in order to ensure adequate separation between arriving and departing aircraft (Recommendation no. 4/2001).



