Flightdeck Party Line Issues: An Aviation Safety Reporting System Analysis

Albert Rehmann

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16. Abstract

This document describes an analysis of the Aviation Safety Reporting System (ASRS) database with regards to human factors aspects concerning the implementation of data link into the flightdeck. The ASRS database contains thousands of reports concerning actual or potential deficiencies which may compromise the safety of aviation operations in the National airspace System (NAS). The purpose of this study was to determine the relative frequency of errors and consequences of decisions based on incorrect information received from the party line.

Detailed analysis of the reports revealed two types of errors: Those attributed to incorrect transmission of party line information (14 percent error rate) and those resulting from flight crew actions/decisions based on the reports concerninthe transmitted information (26 percent error rate). Almost half (46 percent) of the reports concerning incorrect flight crew actions were a result of executing unauthorized clearances due to similar call signs. Further analysis of the incident reports also reveals party line informational (PLI) elements that are determined useful by the flight crews. Based on the reports provided, conclusions are made with regards to the loss of the party line in a data link implementation.

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FOREWORD

This report documents work performed by Crew System Ergonomics Information Analysis Center (CSERIAC) on subtask 3 out of three of the task entitled "Aviation Safety Reporting System Analysis." The task was a provision of an Interagency Agreement between the Federal Aviation Administration (FAA) Technical Center (Department of Transportation (DOT)) and the Defense Technical Information Center (DTIC). It was conducted under DOD Contract Number DLA900-88-D-0393, and the CSERIAC Task Number was 93956- 19. The CSERIAC Program Manager was Mr. Don Dreesbach. The CSERIAC Task Leader was Mr. Michael C. Reynolds. The FAA Technical Program Manager (TPM) was Mr. Albert J. Rehmann, and the FAA project engineer was Mr. Pocholo Bravo.

Special thanks to all personnel at the Aviation Safety Reporting System (ASRS), located at National Aeronautics and Space Administration (NASA) Ames Research Center, for their cooperation.

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EXECUTIVE SUMMARY

This document describes the third of three studies relating to the analysis of the Aviation Safety Reporting System (ASRS) with regards to human factors aspects concerning the implementation of data link into the flightdeck. The ASRS database contains thousands of reports concerning actual or potential deficiencies which may compromise the safety of aviation operations in the National Airspace System (NAS). The purpose of this study was to determine the relative frequency of errors and consequences of decisions based on incorrect information received from the party line. Further analysis of the incident reports also reveals party line informational (PLI) elements that are determined useful by the flight crews.

A list of words relating to party line and situational awareness (SA) was provided to National Aeronautics and Space Administration (NASA) Ames ASRS research analysts for the purpose of searching the database. Approximately 300 incident reports were provided by ASRS. After analysis by Crew System Ergonomics Information Analysis Center (CSERIAC), a total of 85 reports were considered relevant to the task.

Detailed analysis of the reports revealed two types of errors: (1) those attributed to incorrect transmission of party line information (14 percent error rate), and (2) those resulting from. flight crew actions/decisions based on the transmitted information (26 percent error rate). Almost half (46 percent) of the reports concerning incorrect flight crew actions were a result of executing unauthorized clearances due to similar call signs.

Additional analysis yielded two types of PBI elements; instructional or advisory. Instructional elements were normally conveyed by air traffic control (ATC) and involved clearances; e.g., altitudes, headings, etc. Advisory type information was normally conveyed by other aircraft, such as position and ride reports.

The majority of reports (89 percent) were near or on the airport surface. The party line was used; e.g., to obtain useful information about landing/departing aircraft and runway/taxi instructions. Information regarding current weather conditions, such as icing, winds, and runway braking reports was also evident in the reports. Based on the reports provided, conclusions are made with regards to the loss of the party line in a data link implementation.

1. INTRODUCTION.

1.1 GENERAL.

The Aviation Safety Reporting System (ASRS, database is a convenient way to assess, from a pilot's/controller's point-of-view, the problems which exist in the National Airspace System (NAS). The information can be used; e.g., to suggest design enhancements for a variety of onboard control/display systems. This analysis identifies the advantages and disadvantages of the party line. Situational awareness contributions as a result of the party line will be the focus of this report.

According to Midkiff, et al., (1992), crews routinely listen to the party line to gain information regarding traffic around them, but rarely make decisions based on the information alone. Presently, there are systems such as the Traffic Alert and Collision Avoidance System (TCAS) that are available which aid the crew in acquiring an awareness of the current traffic situation. Crews can supplement party line information with TCAS and/or visually acquire traffic themselves prior to making decisions. Onboard weather (WX) radar devices provide current but not necessarily complete weather information. Crews utilize the party line for information regarding turbulence, icing, etc. The radio transmissions provide, in some instances, voice inflections or a sense of urgency that you could not get with a radar device.

Without the aid of other systems, such as TCAS, a concern is that pilots sometimes construct a false mental picture of what is happening. This may sometimes be provoked by false, misleading, or incomplete information or may simply be due to incorrect assumptions or interpretations of the party line. The lack of a complete picture may result in incorrect actions by the flight crew.

Therefore, the focus of this report was to ask two basic questions: (1) what information is conveyed over the party line? and, (2) what crew actions, correct or incorrect, are taken as a result of listening to the party line?

1.2 ORGANIZATION OF THE REPORT.

First, the report will provide a brief introduction of the ASRS reporting system (section 1.3), its history and function within the NAS. Section 3. (Objective) describes the analysis

objective and section 4. (Procedure) provides a comprehensive explanation of the tasks performed to formulate this report, from the initial contact with ASRS to the receiving and analyzing of the incident reports.

Section 5. (Results and Discussion) contains the analysis and discussion of the party line informational (PLI) elements. The section is broken into three parts. The first section (5.1 Classification of Data) provides a general description of the various categorizations of the PLI elements discovered in the analysis. The second section (5.2 Party Line Analysis) introduces various descriptive and summary statistics along with a discussion on the PLI elements. The third section (5.3 Further Discussion) provides further discussion on reported incidents that were not conducive to analysis, but were, nonetheless, considered useful to the overall discussion of the party line and the effects on the flight crew.

Section 6. (Conclusions) will provide conclusions based on the analysis of the PLI elements. Conclusions will be drawn on the problems that may arise without the party line in a data link environment. The report concludes with recommendations for future work (section 7.) to further investigate issues of the party line.

1.3 ASRS DATABASE.

The ASRS was established in 1975 under a Memorandum of Agreement (MOA) between the Federal Aviation Administration (FAA) and National Aeronautics and Space Administration (NASA). The FAA provides most of the program funding, while NASA administers the program and sets its policies. This cooperative safety reporting program invites pilots, controllers, and other users of the NAS to report to NASA actual or potential deficiencies involving the safety of aviation operations. At the time of this search, the ASRS database contained 48,193 full-form reports received since January 1, 1986.

ASRS data are used to support planning and improvements to the NAS, and strengthen aviation human factors safety research. All submissions to ASRS are completely voluntary and are held in strict confidence. Furthermore, the FAA determined that ASRS would be more effective if receipt, processing, and analysis were performed by NASA. This would ensure the anonymity of all reporters, as well as those involved in the incident. Consequently, this anonymity has increased the flow of information necessary for the effective evaluation of the safety and efficiency of the NAS.

The FAA offers ASRS reporters further guarantees to report safety incidents. It is committed not to use ASRS information in enforcement actions. It has also chosen to waive fines and penalties for unintentional violations of Federal Aviation Regulations (FARs) which are reported to ASRS. The FAA's initiation of ASRS and its agreement to waive penalties prove the importance it puts on gathering information about potential aviation, safety deficiencies.

Incident reports are read and analyzed by ASRS aviation safety analysts. Each report is read by at least two analysts. Their first task is to look for any aviation hazards discussed in the reports. When a hazard is identified, an alerting message is sent to the appropriate FAA office. The analyst's next task is to classify reports and determine the causes underlying each reported incident. Once analysis is completed the ASRS reports are ready to be de-identified and entered into the database. The de-identification process involves generalizing or eliminating information that could be used to infer an identity of the reporter.

2. BACKGROUND.

Many aviation accidents that are investigated by the National Transportation Safety Board (NTSB) are caused by breakdowns in information transfer--the communication among crew members and from a larger degree, between aircraft and ground-based facilities. Analysis of these accident reports has resulted in many design changes, from aircraft display issues to changes in communication procedures.

Nonetheless, it is not always the case that the cause of an error is known, thereby robbing the research community of an explanation for such accidents. In an attempt to gain further information with regards to deficiencies and discrepancies in the NAS, the ASRS was established to collect anonymous accounts of incidents that have safety implications that have not, necessarily, resulted in a catastrophic event. The review and analyses of the ASRS data has resulted in a further understanding of the pilot/crew and controller environments and the problems associated with both.

A frequently reported problem in the ASRS database is communication errors; errors resulting from communications between pilots and controllers and those among crew members themselves (Wiener, 1988; Lee and Lozito, 1989). The advent of digital communications (data link) into the NAS, in part, may alleviate communication errors by: (1) providing more efficient data routing and increase rates of information transfer, (2) eliminating crowded frequencies and congestion over the airwaves,

and (3) reducing ambiguity in communication between pilots and controllers (Kerns, 1990). However, in spite of the many advantages, data link has the potential to increase the crew's task workload which, in turn, increases the potential for error and/or reduce situational awareness.

Maintaining situational awareness during piloting operations is essential for safe flight. Situational awareness is defined by one researcher as the following:

> "Situational awareness is the pilot's internal model of the world around him at any point in time" (Endsley, 1988).

A component of situational awareness, the "party line," is used by pilots to help construct this internal model. The party line is a source of information that is provided through an open, active voice radio frequency. Pilots use the party line, for example, to acquire information about other nearby aircraft, weather information, etc. The discrete addressing nature of data link eliminates the availability of party line information which reduces a pilot's overall situational awareness.

The goal of researchers then is to determine what party line information is useful to the flight crews and in what ways can the information be conveyed in a data link environment. Previous surveys (Brown, 1991; Midkiff, et al. 1993) of the airline pilot industry have determined that the importance of party line information is greatest near the terminal environment and that caution should be exercised when implementing data link in this environment. It is anticipated that this ASRS analysis will reveal similar findings.

3. OBJECTIVE.

The ASRS database was constructed to allow flight crews to report incidents or conditions that compromise safety of flight. The database is used extensively by researchers, for example, to address crew design concepts and in turn, formulate design recommendations.

The arrival of data link communications in the NAS is imminent. Many issues regarding the design of a pilot and controller digital link have been published (Boucek, SAE, 1991; ATA, 1989) One of these issues is the proposed loss of crew/controller situational awareness. In the current voice radio communications environment, flight crews claim to derive useful information from listening to the communications between controllers and other aircraft. Information regarding current weather conditions, such as ride reports generated by other aircraft, can be useful to

flight crews. This potential loss in situational awareness may have an adverse effect on the flight crews.

This report analyzes the results of a search of the ASRS database. The focus was on the crew's use of the party line, the actions and frequency of errors attributed to its use. The results, both positive and negative, will be judged in the context of a data link environment.

4. PROCEDURE.

An inquiry of the ASRS database requires a list of keywords which convey the topic search of interest. To help in identifying keywords, a list of candidate keywords were identified by the Crew System Ergonomics Information Analysis Center (CSERIAC) FAA staff from previous knowledge of situational awareness and the party line. These keywords were then tested by conducting searches of a variety of databases, such as the National Technical Information Service (NTIS), in order to obtain scientific research reports on the topic areas. Relevant reports were further screened for additional keywords. The original list and keywords obtained from the scientific research were then combined and reduced to a more specific list. Table 1, below contains the keyword list as it was sent to ASRS.

TABLE 1. SITUATIONAL AWARENESS/PARTY LINE KEYWORD LIST

Situational Awareness and Workload
Party Line
Situational Awareness and TCAS
Situational Awareness and Air Traffic Control (ATC)

This list was faxed to ASRS along with a cover letter describing that situational awareness/party line was the area of concern for our search. A followup phone call was placed to ASRS to discuss any problems or concerns with the keyword list for the search. After receiving our keyword list, ASRS needed 4 weeks to perform our search and send us the results in electronic form.

Upon receipt of the ASRS search results, each report (300 total) was read by two CSERIAC staff members. Selection of valid reports were based on two criteria: (1) the report contained actual voice transmissions heard over the party line, or (2) if not an actual transmission, then at least a reference to its use. Based on the first criteria, a total of 85 individual PLI elements were extracted from 78 reports; 7 reports contained 2 PLI elements. These will be discussed in section 5.2 (Party Line Analysis). Based on the second criteria, a total of seven reports were collected. These will be discussed separately in section 5.3 (Further Discussion).

A roundtable discussion with group members resulted in the development of a PLI classification scheme. Based on the classification scheme, additional information was gathered on each PLI element. A table, complete with information regarding each PLI element, was created and is provided in appendix A (PLI Element Classification Table). For the interested reader, the entire list of useful reports is provided in appendix B (Full Form Reports).

5. RESULTS AND DISCUSSION.

The reports selected for analysis contained a variety of different uses of party line information. A select few, for example, were more prevalent than others. Although this is so, the reader is reminded that the reports are voluntary and that they do not reflect the total population of party line information used by flight crews. Research, such as that conducted by Midkiff and Hansman (1993), report more exhaustive surveys. In addition, the sampling characteristics of the ASRS database preclude any inferential analysis of the data; only descriptive statistics, expressed as percentages will be provided.

Further, flight crew actions based on the party line may or may not have contributed to the resultant safety incidents that were reported; other factors, out of the scope of this report were involved.

Nevertheless, the party line was used primarily to maintain traffic awareness and to help avoid more serious conflicts; this global mindset of the crews was so appropriately put in the words of one pilot as the following:

> "I hate to think what would have happened if I had not been listening to the radio and noticed the other plane coming in" (ASRS, 188555).

This section is divided into three sections. The first section provides introductory information, including definitions of the data extracted from the report narratives. The second section provides the analysis of the PLI elements and the third section contains a general discussion on party line issues not contained in the analysis.

5.1 CLASSIFICATION/DEFINITION OF DATA.

When a safety incident is sent to the ASRS, analysts file the report according to a standard format. This format contains various kinds of information about each incident, from facility

state to aircraft type, etc.; this information is straightforward and easy to compile. However, for the purposes of the CSERIAC analysis, most of the information was derived from the narrative section of the reports; the narratives varied in length and descriptiveness. Discussion sessions were used to identify the PLI elements, which were less straightforward and required more interpretation.

The analysis of the reports resulted in the defining of specific terminology. These terms are used throughout the report to describe the results and are operationally defined below. Bolded text within the definitions refer to additional terms that are defined in the list.

Party Line Informational Element (PLI)

A type of information that was conveyed over the party line.

Instructional

Information provided to the **receiver** (typically a pilot) which required an immediate control action or execution of a clearance.

Advisory

Information which did not require an immediate control action. For example: a weather report, position/traffic report, etc.

Listener

The flight crew or controller who overhears the **party line information**. For example, flight crew A (the **listener**) hears flight crew B receive an altitude clearance

Receiver

The flight crew or controller who received an **instructional** or **advisory** message. In the example above, flight crew B would be the **receiver**.

Transmitter Source

The person (ATC or pilot) who transmitted the **party line information.**

Listener Action

The action of the **listener** immediately subsequent to and based on the information heard over the party line.

Resulting Incident

The safety incident or event which was reported. The actual safety incident may or may not have been a direct result of the **party line information**.

Table 2 provides a description of the data that was obtained from the ASRS reports. The items listed are extensions of the terminology used above whereas others, such as type of aircraft, weather conditions, etc., are self-explanatory. In any case, table 2 contains a complete summary of the classification of data (ordered by report section) that was gathered for each of the 85 PLI elements discovered in the analysis.

TABLE 2. CLASSIFICATION OF DATA

Description	Definition
Transmitter Frequency: Section 5/2/1	The frequency or controlling agency in which the party line information was conveyed. Usable frequencies: AIR Airport, non-tower, non-controlled), APP Approach), CTAF (Common Traffic Advisory Frequency), CTR (Center), DEP (Departure) GND (Ground) and TWR (Tower).
Type of Aircraft: Section 5.2.1	This was derived from the Aircraft Type section of the ASRS reports. Where appropriate, the report narrative was also used to determine the aircraft involved in the party line transmission.
Party Line Informational Element (PLI): Section 5.2.2.	A type of information that was conveyed over the party line.
Transmitter Source: Section 5.2.2	The person (ATC or pilot) who transmitted the party line information.
L-R/T Environment: Section 5.2.2	This category identifies the configuration(Air vs. Ground) of the aircraft involved during the party line transmission. For example: A-A represents that the listener (L, before hyphen) was in the air when hearing the party line transmission. The receiver (R), or transmitter (T) of the party line was also in the air.
Listener Action: Section 5.2.3	The action of the listener immediately subsequent to and based on the information heard over the party line.
Resulting Incident: Section 5.2.4	The safety incident or event which was reported. The actual safety incident may or may not have been a direct result of the party line information.
Transmission Correct/Incorrect: Section 5.2.5	An indication of whether the transmitted PLI element was correct or incorrect.
Listener Action Correct/Incorrect: Section 5.2.5.	The correctness or incorrectness of the listener action based on the transmitted PLI element.
Weather Conditions: Section 5.2.5	This was derived from the Flight Conditions section of the ASRS reports. Allowable conditions are: VMC(Visual), IMC (Instrument) and MXD (Mixed).

5.2 PARTY LINE ANALYSIS.

A total of 85 PLI elements (reports) were identified as useful to this task. These were obtained from 300 individual reports which equates to an overall hit rate of 28 percent. Due to the large number of reports, it is impossible to discuss each incident individually. Consequently, the focus of the following sections will be to describe summary information about the data. Graphs, tables, etc., will be used to help convey the information. In some instances, example narratives will be used to provide emphasis.

5.2.1 Controlling Agency/Type of Aircraft.

A key element in the analysis is the identification of the controlling agency. The amount of party line information increases with proximity to the ground and airport surface. The information is reportedly used to preprogram flight management systems (FMS) and to help maintain traffic awareness. Weather information, such as ride reports, is also used to the flight crews advantage.

Figure 1 shows the distribution of controlling agencies involved in the reports. Sixty percent of the incidents reported party line transmissions over the tower frequency. The tower controller's (or local controller's) responsibility is for operations on the active runway for both departing and arriving traffic.

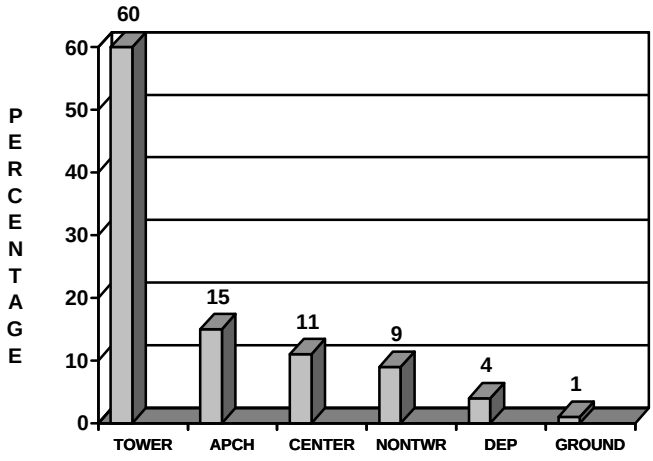

FIGURE 1. CONTROLLING AGENCY

Responsibilities for departing aircraft include providing departure procedures, traffic information, takeoff clearances and taxi instructions such as position and hold, hold short, etc.

Arrival responsibilities include, among others, landing clearances and runway exiting procedures. Advisory type information, such as runway braking reports, surface wind conditions and parked vehicles (e.g., snow removal trucks) are also the responsibility of the tower controller (Air Traffic Control Handbook, 1982).

Only 11 percent of the reports involved the center frequency. The majority of these reports involved altitude instructions that were incorrectly taken because of missed call signs. The others involved either position reports, holding instructions, or traffic information. When considering all but the center frequency, the percentage of PLI elements conveyed at or near the airport increases to 89 percent. This supports the research literature of Brown, 1991 and Midkiff, et al., 1993, in that the party line is used more extensively near the airport.

Figure 2 portrays, in order of occurrence, the various types of aircraft involved in the incidents. Note: The aircraft of both the listener and the receiver of the party line information were counted in the data. The majority of aircraft involved in the incidents were Small Aircraft (SMA) (30 percent) flying under Visual Flight Rule (VFR) conditions.

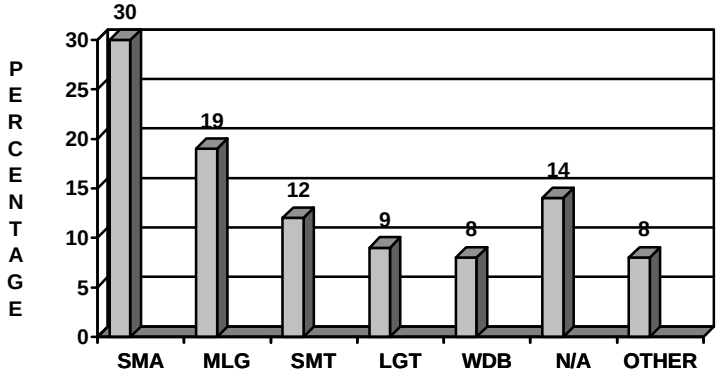

FIGURE 2. TYPE OF AIRCRAFT

The rest, in order of their occurrence: Medium Large Transport (MLG) (19 percent), Small Transport (SMT) (12 percent), Large Transport (LGT) (9 percent), Wide Body (WDB) (8 percent) and Other (8 percent). Fourteen percent of the aircraft were unable to be determined from the report.

Systems such as the Traffic Alert and Collision Avoidance System (TCAS) can help pilots determine the usefulness of party line transmissions. Only 4 of the 85 reports contained references to the use of TCAS. When considering the large number of small aircraft, this is not hard to infer given that many small aircraft do not have TCAS. To examine the data even further,

almost 60 percent of the reported incidents that involved incorrect flight crew actions involved small aircraft. This may be due to single pilot operations versus multiperson crews, absence of available support systems (TCAS), and so on.

5.2.2 Type of Information.

Each of the 85 PLI elements were categorized as instructional (61 percent) or advisory (39 percent) type information. Examples of instructional elements are altitude, headings, takeoff, and taxi clearances/instructions. Examples of advisory messages are weather information, position reports, and traffic reports.

Figure 3 depicts the distribution of the advisory PLI elements found in the reports. The breakdown is as follows: Runway/Landing Intentions (27 percent), Position Report (25 percent), Weather Information/Conditions (18 percent), Traffic Reports (12 percent), Go-around Intentions (9 percent) and Other (9 percent). Traffic reports were considered separate and distinct from position reports as they were information conveyed by air traffic control; position reports were conveyed by flight crews.

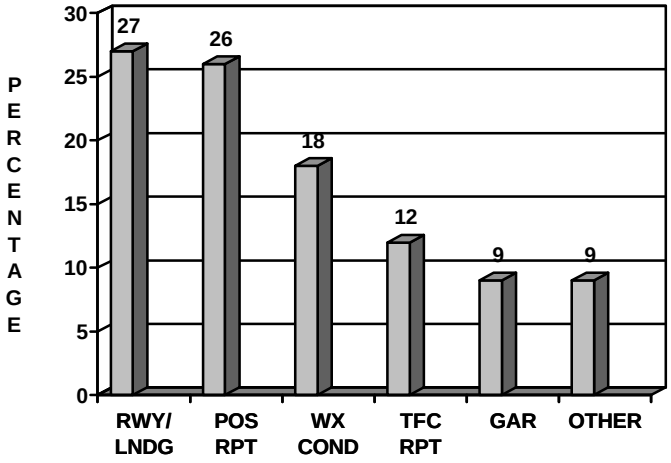

FIGURE 3. ADVISORY PLI ELEMENTS

Figure 4 depicts the distribution of the instructional PLI elements. The breakdown is as follows: Takeoff/Departure Clearances (27 percent), Altitude Clearances (17 percent), Taxi/Runway Clearances (17 percent), Approach/Landing Clearances (14 percent), Heading/Vector Clearances (l1 percent) and Other (14 percent). The other category contained less prevalent elements such as information regarding missed approaches, touch and goes, holdings, etc. Three of the top four categories involved operations at or near the airport surface; this again,

portrays the prevalence of party line information in the terminal environment.

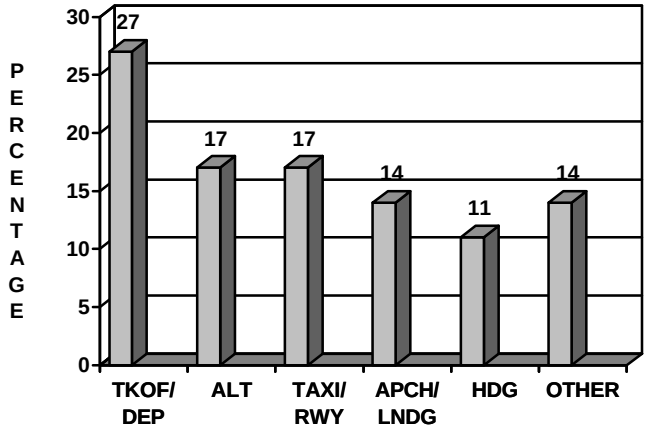

FIGURE 4. INSTRUCTIONAL PLI ELEMENTS

Table 3 provides percentage data of the breakdown of the two types of PLI elements, either advisory or instructional, and the person/source who transmitted the information. The most revealing characteristic is that flight crews provided mainly advisory information (96 percent), whereas ATC provided mainly instructional information (86 percent).

TABLE 3. SOURCE BY TYPE

	Advisory	Instructional
Air	96%	4%

	Advisory	Instructional
ATC	14%	86%

Table 4 provides an indication of the configuration of the parties involved. Specifically, the first column indicates the environment of the listener (first letter) and the receiver (second letter) at the time of the party line transmission. For example, A-G, represents that the party line listener was airborne, whereas the receiver was on the ground. This would represent, e.g., an arrival aircraft on final overhearing another aircraft receive a takeoff clearance on the same runway. The second and third columns are as before; the data is separated into both informational types. The last column depicts the overall percentage distribution of the four available configurations.

TABLE 4. AIRCRAFT CONFIGURATION

L-R	Advisory	Instruction	Overall
A-A	67%	48%	55%
A-G	9%	10%	9%
G-G	12%	32%	25%
G-A	12%	10%	11%

Overall, 80 percent of the party line transmissions involved aircraft in the same environment. Either both were in the air, or on the ground. Most controlling agencies control aircraft in one or the other environment. On the other hand, tower responsibilities include both environments. This is why some reports revealed mixed configurations. The importance of party line information near the airport is further exemplified when considering just tower operations. Seventy percent of all tower transmissions involved at least one ground component (A-G, G-G, and G-A).

To summarize, the data does not represent the total population of PLI elements; a formal questionnaire or survey of the pilot industry may provide more information. Nonetheless, it would be safe to say that the PLI elements found in these reports would all be considered useful to the flight crews.

5.2.3 Listener Action.

This section summarizes the different actions executed by the listener of the party line information. The actions were based directly on the PLI element and were further designated as either incorrect or correct. Section 5.2.5 (Error Analysis) expands on this section by providing illustrative examples of flight/crew narratives.

Figure 5 provides a distribution of the listener actions that were based on the party line. The following actions were identified: Evasive Action (EVA) (33 percent), Continued Clearance (CC) (28 percent), Query Controller (QC) (12 percent), Executed Unauthorized Clearance (EUC) (11 percent), Query Aircraft (QA) (6 percent), Weather Awareness/Avoidance (WXA) (6 percent) and Other (OTHR) (4 percent). Actions that were not as prevalent (e.g., request clearance, programming of the FMS) were combined into the Other category.

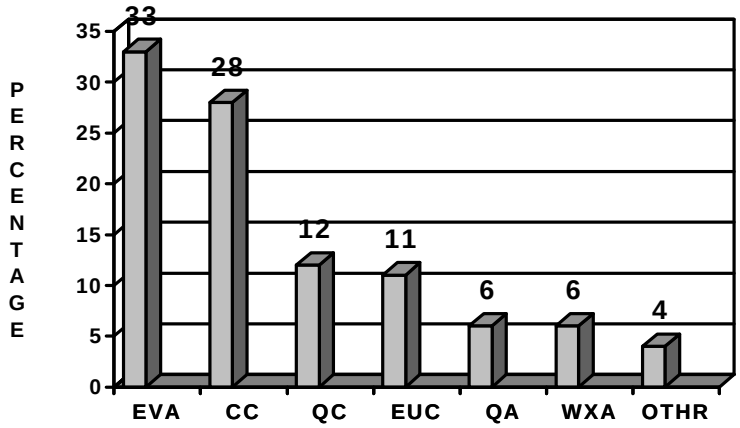

FIGURE 5. LISTENER ACTIONS

Table 5 shows the percentage of correct and incorrect actions for each listener action. The highlighted cell, indicates that the majority of incorrect actions by the flight crews were attributed to execution of unauthorized clearances. These were counted as incorrect actions because the flight crews accepted clearances that were intended for someone else. Similar call signs and radio clutter added to the confusion.

TABLE 5. LISTENER ACTIONS - CORRECT/INCORRECT

	EVA	CC	QC	EUC	QA	WXA	OTHR	Overall
Correct	97%	64%	100%	9%	100%	100%	50%	74%
Incorrect	3%	36%	0%	100%	0%	0%	50%	26%

As is evident from the data, the majority of flight crew actions were correct (74 percent). In fact, the party line was used in some instances to correct potential errors that may have gone undetected in a data link environment. Flight crews would either query the controller or other aircraft to amend the situation.

Also, the majority of correct flight crew actions were to execute evasive maneuvers. Some examples of evasive maneuvers were: (1) executing a go-around or missed approach because of aircraft on

runway, (2) runway traffic avoidance to avoid conflict with landing aircraft and/or taxiing aircraft, and (3) aborted takeoff. Flight crews were able to avoid conflicts by performing the evasive maneuvers; if it was not for the party line, they may never have been aware of the potential conflicts.

5.2.4 Resulting Incident.

The previously mentioned data represents a portion of the narrative reports. To completely summarize each report, the ASRS analysts provided a brief description of the safety incident, such as, airborne conflict, near midair collision (NMAC), etc. In all cases, the description denotes a “negative" connotation--which it should. However, “positive" contributions owing to the party line were evident throughout the reports.

Each of the reports were further screened by CSERIAC to assess the positive and negative contributions owing to the party line in the context of the safety incidents that were reported. Specifically, flight crews which performed an evasive action based on the party line were denoted as “positive” resulting incidents. This was so because they avoided a potential conflict, even if the incident as noted by ASRS was a NMAC or ground conflict. Altitude deviations, track deviations, etc., resulting from flight crews taking another aircraft's clearance were denoted by CSERIAC as “negative" resulting incidents.

Table 6 depicts the percentage distribution of the resulting incidents. The first column identifies the incident that was reported and the second column denotes whether the incident was positive (P) or negative (N).

TABLE 6. RESULTING INCIDENT

Resulting Incidents	P/N	%
Conflict Avoidance/Air (CA/A)	P	22
Conflict Avoidance/Ground (CA/G)	P	17
Ground Conflict (GC)	N	12
Air Conflict (AC)	N	9
Near Mid-Air Collision (NMAC)	N	8
Runway Transgression (RTG)	N	7
Undetermined (N/A)	-	7
Weather Avoidance/Awareness (WXA)	P	5
Altitude Deviation (AD)	N	5
Heading Deviation (HD)	N	3
Other	N	2
Unauthorized Takeoff (UT)	N	2
Track Deviation	N	1

To conclude, while it is true that incorrect listener actions (EUC) always led to “negative" resulting incidents, it is possible for correct listener actions (EVA, QC, QA, etc.) to result in either positive or negative resulting incidents. The latter is true, because of other factors such as controller error, system error, etc., that were involved in the incidents.

5.2.5 Error Analysis.

The discussion that follows expands on the previous sections by showing how all the information is related to one another. This was accomplished through an error analysis; taking each component of the party line, from the transmission of the information to the actions performed by the flight crews and determining where the problems lie. The results of this analysis are depicted in the error analysis tree shown in figure 6.

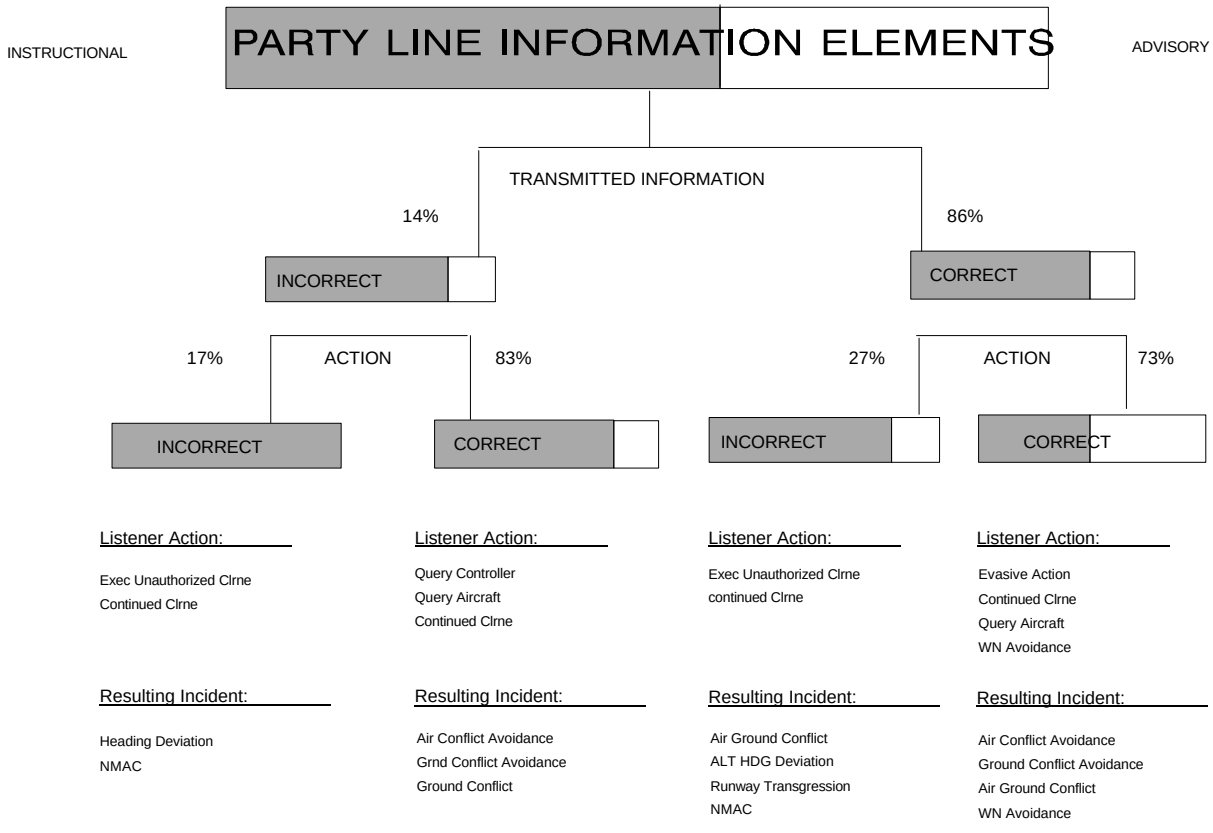

FIGURE 6. ERROR ANALYSIS TREE

There are two different kinds of errors that are directly attributed to the information conveyed over the party line. They are as follows: (1) errors attributed to incorrect transmission (first level branch); and (2) errors resulting from incorrect actions by the flight crews (second level branch).

The numbers along the branches (outside the boxed areas) are percentages of the various conditions. For example, 14 percent of the PLI elements were transmitted incorrectly. Continuing down the same branch, 17 percent (of the incorrect transmissions) resulted in an incorrect listener action and 83 percent resulted in a correct listener action. The shaded area within the boxes represents the percentage of instructional PLI elements and the nonshaded area represents the advisory PLI elements.

What unfolds on the second level branch then, are four separate error categories, from left to right: (1) Incorrect Transmission, Incorrect Action (II); (2) Incorrect Transmission, Correct Action (IC); (3) Correct Transmission, Incorrect Action (CI); and (4) Correct Transmission, Correct Action (CC). Table 7 provides the number of occurrences and overall percentages for each condition. The percentages are based on the entire list of 85 individual PL elements used in the analysis.

TABLE 7. ERROR CATEGORY PERCENTAGES

	Error Category				
Statistic	II	IC	CI	CC	Total
n	2	10	20	53	85
%	2	2	12	24	62

The third and fourth levels of the tree are the listener action and the resulting incident, respectively. The lists provide a summary of those actions and incidents which occurred most often for each of the four error categories; the first listed item occurred the most often, the second listed item next, and so on down the list.

To illustrate further, each of the error categories described in table 7, is discussed below along with example narratives to provide emphasis.

Incorrect Transmission, Incorrect Action

Two situations resulted in an incorrect action based on an incorrect transmission. Both incidents involved the controller issuing an instruction. The incident that follows was a situation where two successive departing aircraft, under tower control, passed within 1 1/2 miles of each other. The tower controller was decertified for not providing legal separation of

the two departing aircraft. However, one aircraft (the listener of the party line) did not help matters any:

> "IFR weather, runways 7 and 15L/R in use. SMA X was on ILS approach/missed approach runway 7. Missed approach instructions were nonstandard and coordinated by radar controller. Runway heading until 700', then turn right heading 200 degrees, climb and maintain 2000'. SMA Y called for departure IFR to VFR on top runway 15L. Release was obtained from radar. SMA Y was given traffic (SMA X) 2 mile final runway 7 and cleared for takeoff runway 15L runway heading climb to VFR on top 2000'. SMA X executed missed approach 1/2 mile final, was instructed to fly runway heading until departure end then turn to 200 degrees. SMA Y was now 2 miles south at 1300' talking to departure. SMA X began turn to 200 degrees approximately 1/2 mile beyond departure end...Radar controller gave SMA X right turn to 130 degrees while aircraft was still on local frequency. SMA Y heard the heading issued the SMA X and turned left to 100 degrees..." (ASRS, 109535).

In the preceding example, the SMA Y aircraft incorrectly took a heading clearance intended for the SMA X aircraft, and compounded matters even further by turning the wrong direction. The heading clearance was transmitted incorrectly for reasons cited before; i.e., controller separation error.

Incorrect Transmission. Correct Action

This category conveys the importance of the party line, in that flight crews would either question the controller or another aircraft in response to the information heard over the party line. In terms of the data, 83 percent of incorrectly transmitted information resulted in the correct action of the flight crew. The following example illustrates the most common action taken by the flight crews--querying the controller.

> "I was captain on ACR X, Boston to Miami. We were holding at the published pattern at CCE on the Collier 2 arrival into Miami at FL260...During this time the controller was giving an expect further clearance (EFC) to all aircraft in the pattern of XX05Z. I thought this was rather strange as I had always observed each aircraft receiving an individual time. As we were inbound on holding (10 mile legs over the VOR) the controller issued a descent clearance to an ACR Y flight to FL250. I thought this strange as we should have been next to FL250. I asked the controller if he was handling any other holding patters. He said no...After a brief pause, another voice came over the radio telling us to

> turn immediately to a heading of 180 (south and away from the holding pattern)...then were given a turn to 360, then a turn to join the inbound leg of the pattern of the VOR. In my opinion, the controller descended the ACR Y through our altitude block." (ASRS, 191230).

The pilot later commented:

> "Even though you can't see aircraft, it's good to listen up on the radio and make a mental picture of the aircraft around you, i.e., holding on approach, etc." (ASRS, 191230).

This incident eventually led to two aircraft with less than standard separation apart. The resulting incident, conflict avoidance/air, was positive even though it was another alert controller who initiated the vectors away from the holding pattern.

Correct Transmission, Incorrect Action

This category was a result of flight crews executing an incorrect action based on a correct transmission. Overall, 24 percent of the reports met this criteria. The action most commonly taken was execution of unauthorized clearances, this occurred almost half (45 percent) of the time. An artifact of the party line, because it is an open transmission, is that flight crews will sometimes inadvertently take clearances intended for other aircraft. The consensus in the reports, was that similar call signs added to the confusion.

A third (33 percent) of the actions were a result of the flight crews continuing their present clearance. Flight crews chose to continue their present clearance even after hearing the party line transmission. Flight crews very seldom make decisions based on party line information alone, yet in these instances, their action of omission was wrong. As in the following example, these types of problems were compounded further by having a false mental picture of the situation:

> "After landing on runway 16R in Seattle we were cleared to cross runway 16L and told to contact ground when crossed. While we are approaching and very close to runway 16R on the 'high speed' ACR Y was cleared for takeoff. We both thought he was cleared for takeoff on runway on 16R. He was taking off on runway 16L. By that time we were on 16L. We cleared the runway ASAP, and ACR Y aborted his takeoff" (ASRS, 115928).

Similarly, inexperienced pilots who are unfamiliar with airport surroundings may act too abruptly when confronted with information over the party line. To conclude this error category, the following example describes an incident where an inexperienced pilot reacts too quickly, and in so doing, transgressed an active runway:

> "Contacted LGB W for landing and informed on initial contact that pilot was unfamiliar. Was instructed to enter right downwind for 25R. Landed and during rollout was instructed, 'Left Next Taxiway,' but at this point was unable to positively ident the next opening as a taxiway...Immediately after receiving this instruction, another aircraft (which was already holding position on 25R) was cleared for takeoff 25R. Hearing this caused me to panic. I was afraid of crossing runway 30 which I had been given landing instructions to hold short of, but with the plane behind me cleared for takeoff I didn't have enough time to verify my position with the tower as so took the next left to clear the runway, which turned out to be the approach end of 16R...This situation occurred partly due to my lack of experience as a pilot, and limited experience with unfamiliar airports." (ASRS, 103105).

Correct Transmission, Correct Action

The majority of incidents (62 percent) fell into this category; i.e., both the transmitted information and listener action were correct. This supports the use of the party line in that flight crews used the information to maintain traffic awareness in order to avoid potential conflicts.

The most common action reported was EVA (53 percent); the second most occurring action was continued clearance (25 percent). Unlike the previous category, continued clearance actions were considered correct actions; pilots had no reason to depart from their present clearance given the information that was presented over the party line. The following narrative describes such a situation:

> "Flight was cleared for a visual approach to runway 14 to follow an ACR Y LGT Y. Approach advised us to slow to 210 kts until reaching PORGY intersection and to contact tower at PORGY. Approach control asked commuter SMT if it had our LGT in sight. SMT replied it had us in sight. Approach control then issued a clearance to follow our LGT to runway 14 and cleared it for a visual approach and to contact tower frequency. Approximately 1100' MSL (3 miles from end of runway) we noticed SMT on our L and slightly above us (approximately 200' separation both lateral and vertical)

> turning from a left base to final. At the point, evasive action was taken by rapidly descending to 800' MSL and accelerating with execution of missed approach. After clearing traffic we climbed up to 2000' MSL and returned to field with no further action." (ASRS, 153054).

The crew in the above incident was aware of traffic in the area and eventually had to perform an EVA. However, the EVA was executed at a later time when the potential conflicting situation unfolded. Tower was blamed in this incident for not advising the LGT of traffic and/or a traffic conflict. As is evident from this report, other factors not directly attributed to the party line transmission were involved in the incident. The resulting incident, airborne conflict, was negative even though the listener action, continued clearance, was correct.

The next example illustrates the flight crew performing an EVA (aborted takeoff) based directly on the information conveyed over the party line:

> "Approaching runway 25R, tower cleared us (ACR AB XYZ) for takeoff. We began our takeoff roll when we heard the tower advise ACR CB XYZ to hold short of 25R after landing. He was landing on 25L. The FO was making the takeoff and because of the common flight number he hesitated very briefly advancing power levers until I mentioned the transmission was not for us. As we were accelerating, I noticed CB XYZ turning off 25L at a fairly rapid speed and thought he might not be stopping short of our runway. I watched him and at about 115 kts it was clear to me CB XYZ wasn't stopping, so I aborted the takeoff. At about the same moment CB XYZ made an abrupt stop with his nose slightly extending onto runway 25R. We stopped short of his position and without incident” (ASRS, 202475).

The aforementioned categories indicated the types of errors that were found in the incident reports. Other factors independent of the party line may contribute to these errors. For instance, a pilot’s ability to "see and avoid” can be affected during adverse weather wherein the visual component cannot be used to confirm the information conveyed over the party line.

Table 8 provides a capsule look at the various error categories and the percentage distribution of weather conditions that were reported. The data reflects that the majority of incidents reported were under Visual Meteorological Conditions (VMC). Furthermore, the data suggests that incorrect actions were not necessarily the result of Instrument Meteorological Conditions (IMC). In fact, the reverse is true; even when conditions were VMC, pilots still made errors.

TABLE 8. WEATHER CONDITIONS

	Error Category			
Weather	II	IC	CI	CC
IMC	50%	40%	10%	26%
VMC	50%	60%	90%	74%

In summary, the analysis has shown that flight crew errors occur with the use of the party line; those attributed to incorrect. transmission of information (14 percent) and those resulting from incorrect actions (26 percent). The majority of errors (46 percent) were a result of flight crews accepting clearances intended for other aircraft; these were compounded further by the presence of similar call signs. Thirty-three percent of all pilot actions involved evasive maneuvers. Without the party line, these incidents may have been more serious. Furthermore, it was shown that adverse weather conditions did not significantly contribute to the errors reported.

5.3 FURTHER DISCUSSION.

Section 5.2 provided an analysis of incident reports containing explicit party line transmissions. A few reports did not contain party line information, however, they did contain information which supports its use. The majority of these reports involved incidents where two aircraft, operating in close proximity, were on different frequencies. To best describe the problem, short excerpts from a few of these reports are provided:

> "...Had we been on the same frequency (UHF vs. VHF), we would have known about the problem..." (ASRS, 98555).
>
> "...I feel this incident occurred because the tower did not advise MLG Y of my position and also because 2 different frequency bands were being used. Had Y been on VHF, they would have heard my transmissions. I feel that in the interest of safety, all aircraft operating in close proximity under ATC control be on the same radio band and frequency" (ASRS, 100007).
>
> "...After speaking with TRACON after landing, it seems to me that the problem was with the handoff from tower to approach/departure. When we first sighted the other aircraft, he was still on tower frequency, so neither of us had the advantage of hearing the radio transmissions to each other." (ASRS, 128730).

The absence of the party line in these situations was definitely a factor in the safety incidents that occurred; all three resulted in near midair collisions.

It was mentioned that many flight crew errors were a result of similar call signs. The congestion over the airwaves sometimes produces much confusion, and in some cases, abbreviated transmissions. It can be very easy to inadvertently take other aircraft clearances.

To conclude this section, there is another form of clutter that affects the transmission of party line information; clutter influenced by different languages. One pilot, who had no specific safety incident to describe, provided the following:

> "You mentioned you wanted international comments. Both in parts of Canada and in France the controllers regularly speak French to French speaking carriers. They do this in all areas of flight (taxi, takeoff, approach, etc.). In bad weather and/or overseas when you are unsure of routines, VORs, etc., it is very disturbing. Much is gained by hearing clearances given to other aircraft, not only in

knowing what to expect, but to be able at times to verify that you are preceding as you thought cleared." (ASRS, 142041).

6. CONCLUSIONS.

6.1 GENERAL.

This study revealed that the majority of PLI elements were transmitted near or on the airport surface, which supports previously cited literature. As traffic is funneled into or released from the terminal environment, conditions are more favorable for accidents and/or incidents that compromise flight safety. Therefore, pilots use the party line to help construct a mental picture of their immediate environment in hopes to avoid these situations. In some cases, false or misleading information can distort this mental picture. However, this report revealed an overwhelming tendency for flight crews to question false transmissions over the party line, whether transmitted by controllers or other aircraft; the so-called "buddy-buddy' system was at work.

It was also shown, based on the actions exhibited by the flight crews, that the ability to "see and avoid" was aided by transmissions over the party line; a large majority of flight crew actions were evasive maneuvers. They were used to avoid conflicts in both the air and on the ground.

Many additional factors, other than transmissions conveyed over the party line, caused the incidents that were reported. System breakdowns, similar call signs, pilot and controller trainees, etc., were all involved in the incidents. Regardless of whether information was transmitted correctly or whether crew actions were correct, the party line was not enough to compensate for some incidents that were reported; this was reflected in the large number of negative resulting incidents that were reported.

The ASRS standard format does not provide the number of crew members and this was not always evident in the report narratives. Nonetheless, a large number of reports involved small aircraft--probably single pilot operations. It was also shown that the majority of incorrect flight crew actions involved aircraft of this type; the availability of an additional crew member or the presence of an onboard TCAS system could have been used to aid the pilot in these situations.

To conclude, the party line has been, and continues to be an excellent source of useful information to the flight crews. It has been shown that errors attributed to its use can occur, as is evident with other communication systems. The question is, what

kind of errors, if any, will occur without it?. The next section deals with this issue.

6.2 DATA LINK INTERPRETATIONS.

The usefulness of the party line has never been more addressed within the research community as it is today. The reason is primarily due to the advent of a digital data link system. An aspect of a digital data link system is that aircraft will be uniquely addressed as opposed to a broadcast over a voice frequency, as is today. An artifact of this, is that transmissions heard over the party line will be eliminated. Potential positive and negative effects, attributed to the loss of the party line will be discussed below.

Early stages of domestic data link are likely to provide ATC services, such as altitude assignments, frequency changes, etc., within the en route environment. Based on the data obtained in this report, only 11 percent of the reported party line transmissions involved the CTR controlling agency. Given the low percentage of PLI elements in this environment, the loss of the party line may not be as much of a concern to flight crews compared to other environments. In this report, over half of the information conveyed by center was altitude clearances (55 percent). Given that early planned services are to provide altitude clearances, one might infer that this would have a negative effect; quite the contrary, the majority of those transmissions were incorrectly taken by other aircraft. In a data link environment, errors attributed to similar call signs would be eliminated. A negative aspect is that information regarding ride reports from other aircraft would also be eliminated. Ride reports are used by flight crews; e.g., to request a different altitude to avoid turbulence, icing, etc.

On the other hand, care should be taken when implementing data link in the terminal environment. Information regarding departing or landing aircraft, aircraft or vehicles on runway, braking action reports, missed approach or go-around aircraft, etc., were all important information used by the flight crews. Regardless of weather conditions, pilots still use the party line to gain information about other traffic. Without some other flightdeck system/device (such as a real-time display of ground operations) to supplement the loss of the party line, pilots would be blind to potential hazardous situations. Furthermore, in both environments, flight crews were able to correct controller errors by using the party line system. Without the party line, these errors may go unnoticed.

To conclude, data link is not the cure-all for the safety incidents that have been reported within. Some errors, such as

similar call signs, will be eliminated; others, such as runway transgressions, may be increased. The dual frequency problems identified earlier represents a problem which will still exist even in a data link environment. The solutions are more complex and require a global assessment, beyond the capabilities of a data link system, of the NAS.

7. RECOMMENDATIONS FOR FUTURE WORK.

Further research should be conducted on the ASRS database. As data link is primarily geared toward the airline community, subsequent searches should be tailored towards those types; eliminating the small aircraft (SMA, SMT, etc.) may reveal a different class of PLI elements and actions exhibited by the large transport flight crews.

Data link aside, additional open-ended surveys may provide a better understanding of the benefits or deficiencies inherent with the party line.

Further research may also result in more reports containing references to the TCAS system. Knowing how the TCAS system helps (or hurts) the crew with information conveyed over the party line, designers can use this information to suggest additional improvements or modifications to the TCAS display that will aid the flight crews. Design improvements may result in additional systems separate and distinct from the TCAS system.

Followup surveys should be conducted after data link has been introduced into the NAS. Early planned implementation calls for a mixed environment; not all aircraft will be data link equipped. The followup surveys may reveal additional problems related to this environment.

Research using, e.g., the Reconfigurable Cockpit System (RCS) at the FAA Technical Center, can be conducted to identify the impact that data link will have on the party line. The most commonly used PLI elements (both reported here and in other surveys? can be evaluated within both a data link and voice environment. The testing environment will help isolate the problems and will provide more definitive design solutions.

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9. ACRONYMS AND ABBREVIATIONS.

AC	Airborne Conflict
AD	Altitude Deviation
APP	Approach
ASRS	Aviation Safety Reporting System
ASRS	Aviation System Reporting System
ATC	Air Traffic Control
CC	Continued Clearance
CC	Correct Transmission, Correct Action
CI	Correct Transmission, Incorrect Action
CSERIAC	Crew System Ergonomics Information Analysis Center
CTAF	Common Traffic Advisory Frequency
CTR	Center
DEP	Departure
DOD	Department of Defense
DOT	Department of Transportation
DTIC	Defense Technical Information Center
EFC	Expect Further Clearance
EUC	Executed Unauthorized Clearance
EVA	Evasive Action
FAA	Federal Aviation Administration
FARs	Federal Aviation Regulations
FMS	Flight Management System
FO	First Officer
GC	Ground
HD	Heading Deviation
GC	Incorrect Transmission, Correct Action
IFR	Instrument Flight Rules
II	Incorrect Transmission, Incorrect Action
ILS	nstrument Landing System
IMC	nstrument Meteorological Conditions
KTS	nots
LGT	arge Transport
MLG	edium Large Transport
MOA	emorandum of Agreement
MSL	ean Sea Level
MZD	ixed
NAS	ational Airspace System
NASA	ational Aeronautics and Space Administration
NMAC	Near MidAir Collision
NTIS	National Technical Information Service
NTSB	National Transportation Safety Board
PL	Party Line
PLI	Party Line Informational Element
QA	Query Aircraft
QC	Query Controller
RCS	Reconfigurable Cockpit System
RTG	Runway Transgression
SA	Situation Awareness

SAE	Society of Automotive Engineers
SMA	Small Aircraft
SMT	Small Transport

9. ACRONYMS AND ABBREVIATIONS (cont'd).

TCAS	Traffic Alert and Collision Avoidance System
TD	Track Deviation
TPM	Technical Program Manager
TRACON	Terminal Radar Control
TWR	Tower
UHF	Ultra High Frequency
UT	Unauthorized Takeoff
VFR	Visual Flight Rules
VHF	Very High Frequency
VMC	Visual Meteorological Conditions
VOR	VHF Omni-directional Range
WDB	Wide Body
WX	Weather
WXA	Weather Awareness/Avoidance

APPENDIX A

PLI Element Classification Table

REPORT NUMBER	WX COND	TR FREQ	AIRCRAFT CONFIGURATION			TYPE OF AIRCRAFT	PARTY LINE INFORMATIONAL ELEMENT	(C)ORRECT OR (I)NCORRECT			LISTENER ACTION	RESULTING INCIDENT
			ENV L-R/T	TR SRC	RCV POS			TR	L INT	L ACT		
Advisory Party Line Elements: Correct Transmission, Correct Action												
121920	VMC	AIR	A-A	Air	Air	SMA, Glider,?	Runway Information /Intentions	A	C	C	CC	CA/A
193844	VMC	AIR	A-A	Air	Air	LTT,SMA	Landing/Runway Intentions	A	C	C	CC	GC
160654	VMC	TWR	A-A	ATC	Air	SMA(2)	Traffic Report	A	C	C	CC	NMAC
161078	VMC	CTR	A-A	Air	Air	WDB,?	Position Report	A	C	C	CC	NONE
142920B	VMC	TWR	G-A	Air	Air	SMT(2)	GAR	A	C	C	EVA	CA/A
151948	VMC	CTAF	A-A	Air	Air	SMA(2)	Landing Intentions	A	C	C	EVA	CA/A
160210B	VMC	CTAF	A-G	Air	Grnd	SMA(2)	Landing Intentions	A	C	C	EVA/GAR	CA/A
93273	VMC	APP	A-A	ATC	Air	LTT,SMA	Parachute Jumpers	A	C	C	EVA	CA/A
151548	VMC	TWR	A-A	Air	Air	SMA(2)	Position Information	A	C	C	EVA	CA/A
141056	VMC	AIR	A-A	Air	Air	SMA(2)	Position Report	A	C	C	EVA	CA/A
153480	VMC	TWR	A-A	Air	Air	SMA(2)	Position Report	A	C	C	EVA	CA/A
177457	VMC	TWR	A-A	Air	Air	MLG(2)	RWY Intentions	A	C	C	EVA	CA/A
190783	IMC	DEP	A-A	ATC	Air	MLG,?	Traffic Report	A	C	C	EVA	CA/A
174511	VMC	TWR	G-G	ATC	Grnd	MLG,SMT	Freq. Contact /Traffic Advisory	A	C	C	EVA/AT	CA/G
102190B	IMC	TWR	G-A	Air	Air	MLG,?(3)	GAR Intentions	A	C	C	EVA/RTA	CA/G
184839	VMC	TWR	A-A	ATC	Air	SMA	Land Short	A	C	C	EVA/RTA	CA/G
142110	VMC	TWR	G-A	Air	Air	MLG,SMT	Position Information	A	C	C	EVA/RTA	CA/G
157890	VMC	TWR	G-G	ATC	Grnd	SMA,MDT	Transmission Interrupted	A	C	C	EVA	CA/G0
102190A	IMC	TWR	A-G	Air	Grnd	MLG,?(3)	WX Information	A	C	C	EVA/GAR	CA/G
185329B	VMC	TWR	A-A	Air	Air	SMA(2)	Position Report	A	C	C	QA,EVA	CA/A
105191	VMC	AIR	A-A	Air	Air	?(2)	Landing Information /Intentions	A	C	C	QA	NONE

Note: Acronym Key for Header and Table contents is at the end of the table

REPORT NUMBER	WX COND	TR FREQ	AIRCRAFT CONFIGURATION ENV L-R/T	TR SRC	RCV POS	TYPE OF AIRCRAFT	PARTY LINE INFORMATIONAL ELEMENT	(C)ORRECT OR (I)NCORRECT TR	L INT	L ACT	LISTENER ACTION	RESULTING INCIDENT
Advisory Party Line Elements: Correct Transmission, Correct Action (cont'd)												
188555	VMC	TWR	G-A	Air	Air	SMA, LGT	Landing/Runway Intentions	A	C	C	QC,EVA/RTA	CA/G
133393	MXD	APP	A-A	Air	Air	SMA(2)	WX Information /Avoidance	A	C	C	RC	CA/A
169841	IMC	APP	A-A	Air	Air	SMA, ?	WX Conditions,Icing	A	C	C	WXA	WXA
149017	MXD	APP	A-A	Air	Air	SMA	WX Information	A	C	C	WXA,QC	WXA
182661	IMC	TWR	A-A	Air	Air	MLG,?	WX Information	A	C	C	WXA	WXA
103715	VMC	TWR	G-G	ATC	Grnd	WDB,SMT	WX Information/Winds	A	C	C	WXA,CC	OTHER
Advisory Party Line Elements: Correct Transmission, Correct Action												
129866	VMC	TWR	A-G	Air	Grnd	MLG,?	Flock of Birds	A	C	I	CC	AC
199428	IMC	TWR	A-A	Air	Air	MLG,HVT	Approach/Landing Intentions	A	C	C	CC	GC,RTG
160210A	VMC	CTAF	G-A	Air	Air	SMA(2)	Departure Intentions	A	C	C	CC	NMAC
181915	VMC	TWR	A-A	Air	Air	SMA,?	GAR	A	C	C	CC	NMAC
Advisory Party Line Elements: Correct Transmission, Correct Action												
166711	IMC	TWR	A-G	ATC	Grnd	LGT	RWY Traffic Information	A	I	C	CC	GC
163786	VMC	CTAF	A-A	Air	Air	SMA(2)	Position Report	A	I	C	S-Turns	NMAC
Advisory Party Line Elements: Incorrect Transmission, Incorrect Action...None Reported												

Note: Acronym Key for Header and Table contents is at the end of the table

REPORT NUMBER	WX COND	TR FREQ	AIRCRAFT CONFIGURATION			TYPE OF AIRCRAFT	PARTY LINE INFORMATIONAL ELEMENT	(C)ORRECT OR (I)NCORRECT			LISTENER ACTION	RESULTING INCIDENT
			ENV L-R/T	TR SRC	RCV POS			TR	L INT	L ACT		
Instructional Party Line Elements: Correct Transmission, Correct Action												
202138	VMC	DEP	A-A	ATC	Air	LGT(3)	Altitude Clearance	I	C	C	C	CC	AC
153054	VMC	APP	A-A	ATC	Air	LGT,SMT	Approach and Landing Clearance	I	C	C	C	CC	AC
145775	VMC	TWR	A-A	ATC	Air	WDB,BMB	Landing Clearance	I	C	C	C	CC	AC
149191	VMC	CTR	A-A	ATC	Air	WDB,MLG	Vector for Traffic	I	C	C	C	CC	AC
217638B	VMC	TWR	G-G	ATC	Grnd	LTT,MLG	Cancel Takeoff Clearance	I	C	C	C	CC	GC
164636	VMC	TWR	G-A	ATC	Air	SMT,?	GAR	I	C	C	C	CC	GC
160299B	VMC	TWR	G-G	ATC	Grnd	WDB,?	Hold Short	I	C	C	C	CC	GC
184688A	IMC	APP	A-A	ATC	Air	MLG(2)	Altitude Clearance	I	C	C	C	CC	NONE
142920A	VMC	TWR	G-A	ATC	Air	SMT(2)	Landing Clearance	I	C	C	C	CC	NONE
109866	VMC	TWR	A-A	ATC	Air	SMA(2)	Landing Clearance	I	C	C	C	EVA/GAR	CA/A
104390	IMC	TWR	A-A	ATC	Air	MLG,LTT	Missed Approach	I	C	C	C	EVA	CA/A
102921	VMC	TWR	G-A	ATC	Grnd	LTT,SMA	Takeoff/Departure Instructions	I	C	C	C	EVA	CA/A
142265	VMC	TWR	G-A	ATC	Air	MLG,SMA	Touch and Go	I	C	C	C	EVA	CA/A
202475	VMC	TWR	G-G	ATC	Grnd	LGT,MLG	Hold Short	I	C	C	C	EVA/AT	CA/G
115635B	VMC	TWR	A-G	ATC	Grnd	MLG,SMA	Hold Short	I	C	C	C	EVA/MA	CA/G
85529	VMC	TWR	G-A	ATC	Air	LGT,SMT	Landing Clearance	I	C	C	C	EVA/RTA	CA/G
121909	MXD	TWR	A-G	ATC	Grnd	?(2)	Position and Hold	I	C	C	C	EVA/GAR	CA/G
159370	VMC	TWR	G-G	ATC	Grnd	MLG,MDT	RWY Crossing Clearance	I	C	C	C	EVA/AT, QC	CA/G
235833	IMC	TWR	A-G	ATC	Grnd	MLG,WDB	Takeoff Clearance	I	C	C	C	EVA/GAR	CA/G
112175	VMC	TWR	A-G	ATC	Grnd	SMT(2)	Takeoff/Departure Instructions	I	C	C	C	EVA/GAR	CA/G
185329A	VMC	TWR	A-A	ATC	Air	SMA(2)	Approach Clearance	I	C	C	C	QA	CA/A
100348	IMC	TWR	A-A	Air	Air	MLG(2)	Other	I	C	C	C	QC	CA/G
181950	VMC	TWR	G-A	ATC	Air	LGT,LTT	Position and Hold	I	C	C	C	QC	CA/G

Note: Acronym Key for Header and Table contents is at the end of the table

REPORT NUMBER	WX COND	TR FREQ	AIRCRAFT CONFIGURATION ENV L-R/T	TR SRC	RCV POS	TYPE OF AIRCRAFT	PARTY LINE INFORMATIONAL ELEMENT	(C)ORRECT OR (I)NCORRECT TR	L INT	L ACT	LISTENER ACTION	RESULTING INCIDENT
Instructional Party Line Elements: Correct Transmission, Correct Action (cont'd)												
171242	VMC	APP	A-A	ATC	Air	SMA,SMT	Departure Instructions	I	C	C	QC	NMAC
207989	MXD	APP	A-A	ATC	Air	LGT	Vectors for Traffic	I	C	C	QC	OTHER
769615	IMC	APP	A-A	ATC	Air	WDB,SMT	Vectors for WX	I	C	C	WXA	WXA
Instructional Party Line Elements: Correct Transmission, Incorrect Action												
119378	VMC	TWR	G-G	ATC	Grnd	SMA(3)	Hold Short	I	C	I	CC	GC,RTG
115928	VMC	TWR	G-G	ATC	Grnd	MLG(2)	Takeoff/Departure Instructions	I	C	I	CC	GC,RTG
102994	VMC	GND	G-A	ATC	Air	SMA,SMT	Touch and Go	I	C	I	CC	GC,RTG
210241	IMC	APP	A-A	ATC	Air	SMT,SMA	Approach Vectors	I	C	I	CC	NMAC
109950	VMC	APP	A-A	ATC	Air	SMA(2)	Vectors for Traffic	I	C	C	DROP JUMPERS	AC
159430	VMC	CTR	A-A	ATC	Air	MLG	Altitude Clearance	I	C	I	EUC	AD
196903	VMC	CTR	A-A	ATC	Air	LTT	Altitude Clearance	I	C	I	EUC	AD
110010	VMC	CTR	A-A	ATC	Air	MLG,?	Altitude Clearance	I	C	I	EUC	AD
154200	VMC	APP	A-A	ATC	Air	LGT	Altitude Clearance	I	C	I	EUC	AD,TD
190584	VMC	DEP	A-A	ATC	Air	WDB,?	Heading Clearance	I	C	I	EUC	HD
204663	VMC	TWR	G-G	ATC	Grnd	MLG	Takeoff/Departure Instructions	I	C	I	EUC	HD
147237	VMC	TWR	G-G	ATC	Grnd	MLG,?	Position and Hold	I	C	I	EUC	RTG
217637	VMC	TWR	G-G	ATC	Grnd	MLG	Takeoff Clearance	I	C	I	EUC	UT
103001	VMC	TWR	G-G	ATC	Grnd	SMT(2)	Takeoff/Departure Instructions	I	C	I	EUC	UT
103105	VMC	TWR	G-G	ATC	Grnd	SMA,MST	Takeoff/Departure Instructions	I	C	C	EVA/RTA	GC,RTG
241011	VMC	CTR	A-A	ATC	Air	SMT,WDB,?	Crossing Restriction	I	C	C	FMS	AC

Note: Acronym Key for Header and Table contents is at the end of the table

REPORT NUMBER	WX COND	TR FREQ	AIRCRAFT CONFIGURATION			TYPE OF AIRCRAFT	PARTY LINE INFORMATIONAL ELEMENT	(C)ORRECT OR (I)NCORRECT			LISTENER ACTION	RESULTING INCIDENT
			ENV L-R/T	TR SRC	RCV POS			TR	L INT	L ACT		
Instructional Party Line Elements: Incorrect Transmission, Correct Action												
160299A	VMC	TWR	G-G	ATC	Grnd	WDB,?	Cross Active Runway	I	I	C	C	CC	GC
217638A	VMC	TWR	G-G	ATC	Grnd	LTT,MLG	Takeoff Clearance	I	I	C	C	EVA/RTA	CA/G
184723	IMC	CTR	A-A	ATC	Air	WDB (2)	Holding Instructions	I	I	C	C	QA	CA/A
134748	VMC	CTR	A-A	ATC	Air	MLG,?	Altitude Clearance	I	I	C	C	QC	AD
191230	VMC	CTR	A-A	ATC	Air	LGT(2)	Altitude Clearance	I	I	C	C	QC	CA/A
100800	VMC	TWR	A-G	ATC	Grnd	SMA,SMT	Takeoff/Departure Instructions	I	I	C	C	QC	CA/A
184688B	IMC	APP	A-A	ATC	Air	MLG(2)	Altitude Clearance	I	I	C	C	QC	NONE
115584	MXD	TWR	G-G	ATC	Grnd	LGT,WDB	Takeoff/Departure Instructions	I	I	C	C	QC	WXA
Instructional Party Line Elements: Incorrect Transmission, Incorrect Action												
187752	VMC	TWR	G-G	ATC	Grnd	SMA(2)	Departure Clearance	I	I	I	I	CC	NMAC
109535	IMC	TWR	A-A	ATC	Air	SMA(2)	Heading Clearance	I	I	I	I	EUC	HD,AC

Non-Specific Party Line Incidents	
98555	Dual Frequency
100007	Dual Frequency
128730	Dual Frequency
149385	Dual Frequency
220645	Dual Frequency
123431	G/S Incident
142041	U.S. Flights in Foreign Countries

ACRONYM KEY

WX COND - Weather Conditions

IMC - Instrument Meteorological Conditions
MXD - Mixed IMC/VMC Conditions
VMC - Visual Meterological Conditions

TR FREQ - Transmitter Frequency

AIR - Airport Frequency, non-controlled
CTAF - Common Traffic Advisory Frequency, non-controlled
CTR - Center Frequency (ARTCC)
DEP - Departure Frequency
GND - Ground Frequency
TWR - Tower Frequency

AIRCRAFT CONFIGURATION

ENV L-R/T-Environment (Air or Ground(of the Listener and Receiver/Transmitter, respectively
TR SRC - Transmitter Source,Conveyer(ATC or Air/Pilot)of Party Line Information
RCV, POS - Receiver Position,

TYPE OF AIRCRAFT

A-5

REPORT NUMBER	WX COND	TR FREQ	AIRCRAFT CONFIGURATION			TYPE OF AIRCRAFT	PARTY LINE INFORMATIONAL ELEMENT	(C)ORRECT OR (I)NCORRECT			LISTENER ACTION	RESULTING INCIDENT
			ENV L-R/T	TR SRC	RCV POS			TR	L INT	L ACT		

HVT - Large Transport (over 300,000 lbs)
LGT - Large Transport (150,001 - 300,000 lbs)
LTT - Light Tranqport (14,501 - 30,000 lbs)
MDT - Medium Transport (30,001 - 60,000 lbs)
MLG - Medium Large Transport 60,001 - 150,000 lbs)
SMA - Small Aircraft (Less than 5000 lbs)
SMT - Small Transport (5001 - 14,500 lbR)
WDB - Wide Body (over 300,000 lbs)

PARTY LINE INFORMATIONAL ELEMENT

A general description of the PLI element is provided along with an indication of whether it was and Instructional (I) or Advisory (A) message

CORRECT OR INCORRECT

Based on the incident reports, the correctness or incorrectness of the following were determined:
TR - Transmitted PLI Element
L INT - Interpretation of the PLI Element
L ACT - Action of the Listener

LISTENER ACTION

AT - Aborted Takeoff
CC - Continued Clearance
EUC - Executed Unauthorized Clearance
EVA - Evasive Action
FMS - Flight Management System Programming
GAR - Go Around
MA - Missed Approach
QA - Query Aircraft
QC - Query Controller
RC - Request Clearance
RTA - Runway Traffic Avoidance
WXA - Weather Awareness, Avoidance

RESULTING INCIDENT

AC - Airborne Conflict
AD,HD,TD - Altitude, Heading,Track Deviation,
CA/A - Conflict Avoidance/Airborne
CA/G - Conflict Avoidance/Ground
GC - Ground Conflict
NMAC - Near Mid-Air Collision
RTG - Runway Transgression
UT - Unauthorized Takeoff
WXA - Weather Awareness/Avoidance

APPENDIX B

ASRS FULL FORM REPORTS

The full form reports as received from ASRS are provided in the following appendix. Refer to the following guide for help in locating the various incident reports. NOTE: the reports are numbered sequentially by accession number for each category of incidents.

B-1

ADVIS0RY PLI ELEMENTS: Correct Transmission, Correct Action

ACCESSION NUMBER: 93273
DATE OF OCCURRENCE: 8808
REPORTED BY: FLC; ; ; ;
PERSONS FUNCTIONS: FLC,FO; FLC,PIC.CAPT; TRACON,AC; FLC, PLT;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID: SLC
FACILITY STATE: UT
FACILITY TYPE: TRACON; ARPT;
FACILITY IDENTIFIER: SLC; SLC;
AIRCRAFT TYPE: LTT; SMA;
ANOMALY DESCRIPTIONS: OTHER; NON ADHERENCE LEGAL RQMT/FAR;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION; NOT RESOLVED/INSUFFICIENT TIME;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: ON IFR FLT PLAN, WE WERE ON APCH ON HIGH DOWNWIND LEG AND 5 MI S OF ARPT. FREQ WAS EXTREMELY CONGESTED AS CTLR TRNEE, UNDER SUPERVISION, WAS HANDLING 2 FREQS WITH 1 XMITTER. WE HEARD ATC TELL AN SMA THAT A PARACHUTE JUMP WAS NOT AUTHORIZED DUE TO AIRSPACE CONGESTION. WE DID NOT HEAR A REPLY, AS THE SMA WAS ON THE OTHER FREQ. AS AN ACR JET PASSED OUR 9 O'CLOCK ON FINAL TO RWY 34L, WE WERE CLRED FOR A VISUAL APCH TO FOLLOW THAT JET. AS WE TURNED BASE LEG, THE CAPT WHO WAS THE PF, POINTED OUT AN UNIDENTED ACFT DSNDING OFF OUR RIGHT AND TURNING IN OUR GENERAL DIRECTION. HE INITIATED A RAPID DSNT TO AVOID THE ACFT, WHICH HAD NOT BEEN POINTED OUT BY ATC. WE LEVELED OUT AT 7000', STILL ON BASE LEG, WHEN I (F/O) NOTED AN OBJECT AT OUR 10 O'CLOCK WHICH I FIRST THOUGHT WAS A BALLOON, ABOUT 500' AWAY AND SLIGHTLY BELOW US. I THEN LOOKED FORWARD AND SAW 2 PARACHUTES AT OUR 12 O'CLOCK AND ABOUT 300' AWAY, DIRECTLY IN OUR DSNT PATH. I YELLED SOMETHING ABOUT PARACHUTES AND GRABBED THE YOKE, INITIATING A CLBING LEFT TURN. I RELEASED THE CONTROLS AS SOON AS I SAW THAT THE CAPT WAS AWARE OF AND HANDLING THE SITUATION. WE CONTINUED OUR APCH AND LANDED. CONTRIBUTING FACTORS: SMA PLT DROPPED JUMPERS W/O ATC AUTH, WHILE OPERATING IN RESTRICTED AIRSPACE. I WAS TOLD BY THE TRACON SUPVR THAT THE PLT, WHEN QUESTIONED, ADMITTED SEEING US BELOW HIM BUT THOUGHT THAT THE JUMPERS COULD AVOID US. HE ALSO ALLOWED THOSE JUMPERS OUT W/O ANY LIGHTING, ALTHOUGH LEGAL SUNSET OCCURRED 23 MINS BEFORE. HE ALSO INITIATED A DSNT W/O AUTHORIZATION. ATC--WAY TOO MUCH TFC

FOR A TRNEE TO BE HANDLING 2 FREQS. ALTHOUGH NOT LEGALLY REQUIRED, SINCE THERE WAS AN ASSIGNED ALT DIFFERENCE OF 500', HE DID NOT POINT OUT THE SMA. WE NEEDED A POINTOUT THAT AT LEAST WOULD HAVE MADE US AWARE OF POTENTIAL TFC AND AVOIDED THE FIRST SURPRISE.
POSSIBLE SOLUTIONS: ASIDE FROM THE OBVIOUS BAN ON JUMP ACTIVITIES DURING HVY ATC ACTIVITY, SO THAT THE ACFT WAS NOT EVEN ALLOWED WITHIN 10 MI OF TFC CORRIDORS, THIS PLT'S JUDGEMENT MUST BE SUSPECT. FAA SHOULD ALSO VIOLATE THE OPERATOR IF TRNING IN ATC PROCS IS FOUND TO BE DEFICIENT. THERE IS NOT EXCUSE FOR THIS SORT OF SHODDY OPERATING PRACTICE SO CLOSE TO A MAJOR COMMERCIAL ARPT.

B-2

(REPORT CONTINUED)

THE BIGGEST REASON WE DID NOT HIT THOSE JUMPERS WAS PURE LUCK, GIVEN THE TIME OF DAY.
SYNOPSIS: ACR LTT, ON FINAL APCH COURSE, HAD VERY CLOSE CALL WITH PARACHUTE JUMPERS.
REFERENCE FACILITY ID: SLC
FACILITY STATE: UT
DISTANCE & BEARING FROM REF : 5,,SO
MSL ALTITUDE: 6700,7000

B-3

ACCESSION NUMBER: 102190
DATE OF OCCURRENCE: 8901
REPORTED BY: FLC;
PERSONS FUNCTIONS: FLC,PIC.CAPT;
FLIGHT CONDITIONS: IMC
REFERENCE FACILITY ID:BTR
FACILITY STATE: LA
FACILITY TYPE: ARPT; TWR;
FACILITY IDENTIFIER: BTR; BTR;
AIRCRAFT TYPE: MLG;
ANOMALY DESCRIPTIONS: OTHER;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: NOT RESOLVED/UNABLE;
ANOMALY CONSEQUENCES: FLC/ATC REVIEW;
NARRATIVE: THE LNDG RWY ON THE ATIS WAS A BACK COURSE LOC 4L WITH INCREASED MINIMA DUE TO CONSTRUCTION. APCH CTL ADVISED WE COULD BE USING THE ILS 22R WITH AN 8 KT TAILWIND DUE TO DETERIORATING WX (RAIN/FOG). AN EXPEDITED BELIEVE WE MAY HAVE BEEN THE FIRST COMMERCIAL ACFT TO LAND AFTER THE RWY CHANGE AND THERE WERE 3 TRAILING JETS ON APCH CTL FREQ. WE WERE CONFIGURED WITH FULL t40 DEG) FLAPS, AUTO BRAKING ARMED AND APCH SPD OF 132 KTS. AT APPROX 80 KTS WITH 2500+' REMAINING, THE AUTO BRAKES WERE DISENGAGED DUE TO POOR DECELERATION. BRAKING ACTION WAS NIL AT THIS POINT AND REVERSE THRUST WAS INCREASED BACK UP TO 1.8 EPR AND KEPT THERE UNTIL BELOW 60 KTS WHEN BRAKING ACTION BECAME ACCEPTABLE. WE USED ALMOST ALL THE AVAILABLE RWY AND ADVISED THE TWR THAT BRAKING ACTION WAS POOR AT BEST. THE NEXT ACFT WAS ALERTED FOR A POSSIBLE GAR AND ACKNOWLEDGED OUR BRAKING ACTION RPT. WE CLRED THE RWY IN SUFFICIENT TIME FOR THAT ACFT TO LAND SAFELY AND HEARD THE NEXT ACFT RECEIVE THE ADVISORY BEFORE CHANGING TO GND CTL. THE FOURTH ACFT WENT OFF THE END SOME 200-300' IN THE MUD. MEANWHILE OUR MOMENTUM PRECLUDED THE HARD 180 DEG TURN ONTO TXWY A AND WE HAD TO USE TXWY C, SO UTILIZING WING WALKERS THROUGH THE GA PARKING AREA.
SYNOPSIS: ACR MLG REPORTED BRAKING POOR AFTER LNDG AT BTR. BRAKING ACTION REPORTED TO NEXT 2 ACFT AND REPORT OVERHEARD BY REPORTER VIA PARTYLINE. FOURTH ACFT IN STRING HAD RWY EXCURSION.
SEE ACN 101549 AND 101772.
REFERENCE FACILITY ID: BTR
FACILITY STATE: LA
AGL ALTITUDE: 0,0

B-4

ACCESSION NUMBER: 103715
DATE OF OCCURRENCE: 8902
REPORTED BY: FLC; ; ;
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; TWR,LC;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID: EWR
FACILITY STATE: NJ
FACILITY TYPE: TWR; ARPT;
FACILITY IDENTIFIER: EWR; EWR;
AIRCRAFT TYPE: WDB;
ANOMALY DESCRIPTIONS: OTHER; NO SPECIFIC ANOMALY OCCURRED;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: NOT RESOLVED/ANOMALY ACCEPTED; NOT RESOLVED/DETECTED AFTER-THE-FACT;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: TAXIING OUT TO TKOF AT EWR ATIS CALLING WX CLEAR, GOOD VSBLTY, WINDS 310/18 KTS. TWR CALLING WINDS 310/19 KTS. COMMENCED TKOF ON RWY 22R. ON TKOF ROLL WE OVERHEARD TWR GIVE ANOTHER ACFT THE WINDS OF 300 TO 310 AT 19 KTS GUSTING TO 30-33 KTS. THIS GUST FACTOR WAS NEVER GIVEN TO US. THUS, WE MADE A TKOF WITH RPTED CROSSWINDS THAT WERE MUCH HIGHER THAN WE ANTICIPATED, AND CROSSWINDS THAT WERE CLOSE TO THE LIMITING CROSSWINDS OF THE ACFT. THE TKOF WAS NORMAL AND NO SIGNIFICANT WINDS WERE ENCOUNTERED, BUT IT WOULD HAVE BEEN APPROPRIATED THAT WE BE ADVISED OF THESE SIGNIFICANT GUST FACTORS.
SYNOPSIS: WDB OVERHEARD TWR GIVE WIND GUST INFORMATION TO ANOTHER ACFT WHILE WDB WAS ON TKOF ROLL. REPORTER COMPLAINT THAT HE WAS NOT GIVEN THE GUST INFORMATION.
REFERENCE FACILITY ID: EWR
FACILITY STATE: NJ
AGL ALTITUDE: 0,0

B-5

ACCESSION NUMBER: 105191
DATE OF OCCURRENCE: 8902
REPORTED BY: FLC; ;
PERSONS FUNCTIONS: FLC,PLT; FLC,PIC.CAPT;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:PIB
FACILITY STATE: MS
FACILITY TYPE: ARPT;
FACILITY IDENTIFIER: PIB;
AIRCRAFT TYPE: ; ;
ANOMALY DESCRIPTIONS: UNCTRLED ARPT TRAFFIC PATTERN DEVIATION;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: OTHER;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: I WAS APCHING THE ARPT IN VFR CONDITIONS AND
HAD RECEIVED UNICOM ARPT ADVISORY. APCH WAS FROM THE N AFTER CANCELLING IFR. I WAS ADVISED BY ATC THAT AN ACFT WAS IN TRAIL BY APPROX 2 TOUR MILES AND AT A HIGHER ALT. I THEN ENTERED THE LEFT HAND TFC PATTERN ON THE DOWNWIND AND AS BASE LEG WAS BEING TURNED. A AIRLINER ACFT CALLED FINAL. I OBSERVED WHAT I BELIEVE TO BE THAT ACFT WHICH HAD BEEN BEHIND ME ON AN APPROX 4 MI FINAL. I ANNOUNCED TURNING BASE AND REQUESTED THE OTHER ACFT TO "SAY POS." HE THEN ANNOUNCED THAT HE WOULD BE CROSSING OVER THE FIELD AND ENTERING DOWNWIND (WHICH HE SHOULD HAVE DONE THE FIRST TIME). I REALIZE THAT SCHEDULED CARRIERS HAVE LARGE COSTS INVOLVED BUT SHOULD BE REQUIRED TO COMPLY WITH TFC PATTERNS AT UNCONTROLLED FIELDS.
SYNOPSIS: ACR ACFT MADE IMPROPER TRAFFIC PATTERN ENTRY.
REFERENCE FACILITY ID:PIB
FACILITY STATE: MS
DISTANCE & BEARING FROM REF: 3,,N
AGL ALTITUDE: 1000,1000

B-6

ACCESSION NUMBER: 121920
DATE OF OCCURRENCE: 8909
REPORTED BY: FLC; ;
PERSONS FUNCTIONS: FLC,PLT; FLC,PLT;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:TRK
FACILITY STATE: CA
FACILITY TYPE: ARPT; ARPT;
FACILITY IDENTIFIER: TRK; TRK;
AIRCRAFT TYPE: SMA; SMA;
ANOMALY DESCRIPTIONS: CONFLICT/NMAC; ACFT EQUIPMENT PROBLEM/CRITICAL; UNCTRLED ARPT TRAFFIC PATTERN DEVIATION; NON ADHERENCE LEGAL RQMT/PUBLISHED PROC;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION; NOT RESOLVED/UNABLE;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: CALLED UNICOM AND WAS TOLD THE WINDS WERE SQUIRRELY BUT FAVORING RWY 28. AT THE E END OF DONNER LAKE, I CALLED TRUCKEE TFC TO ANNOUNCE A 45 DEG ENTRY TO LEFT TFC FOR RWY 28. I HEARD THE GLIDER TOWPLANE (ON RIGHT DOWNWIND FOR 19) AND ANOTHER AIRPLANE (ON LEFT DOWNWIND FOR 10) TRYING TO WORK OUT A DANGEROUS CONFLICT IN THEIR PATTERNS. ALSO, AN ACFT REPORTED HIS POSITION NEAR SQUAW VOR WITH INTENTIONS OF FLYING THE LAKESHORE (TAHOE) FOR A LEFT BASE ENTRY INTO RWY 28. I ANNOUNCED DOWNWIND LEFT FOR 28 AND WAS WATCHING THE 10 TFC TURN FINAL. I THEN STARTED LOOKING FOR TFC FROM THE "LAKE" WHEN I NOTICED AN SMA TWIN STARTING TO TAKE OFF ON 28 DIRECTLY OPPOSING THE LNDG ACFT N 10. I ANNOUNCED THE SITUATION ON THE RADIO AND THE SMA TWIN MADE A TURN OFF THE RWY BACK TO THE HOLDING AREA. I TURNED TO FINAL AND ANNOUNCED "TURNING FINAL 28 TRUCKEE." WHILE ON SHORT FINAL, THE ACFT PULLS OUT IN FRONT OF ME AND PROCEEDS TO TAKE OFF. I DIVERTED MY PLANE WELL TO THE RIGHT OF CENTERLINE. AFTER THE ACFT HAD PASSED ME I TURNED TO REENTER THE PATTERN. THERE WAS AN SMA Y ENTERING THE PATTERN AND WE BOTH REPORTED ENTERING DOWNWIND SIMULTANEOUSLY. HE WAS AHEAD OF ME SO I REPORTED BEING #2 FOR 28. AS I PASSED THE 28 NUMBERS, MY ENGINE STOPPED RUNNING. I SWITCHED TANKS AND THE ENGINE STILL WOULD NOT RUN. I INFORMED THE SMA Y I WAS EXPERIENCING ENGINE TROUBLE AND WOULD LAND AHEAD OF HIM. THE TXWY WAS CLEAR SO I ELECTED TO LAND ON THE TXWY. INSPECTION OF MY ACFT REVEALED THAT THE FUEL LINE FROM THE GASCOLATOR TO THE CARBURETOR WAS DEFECTIVE CAUSING A BLOCKAGE OF FUEL TO THE CARBURETOR.
SYNOPSIS: CLOSE PROX GA-SMA GA-SMA TWIN AT NON TWR ARPT.
REFERENCE FACILITY ID:TRK
FACILITY STATE: CA
DISTANCE & BEARING FROM REF.: 2,,SO

MSL ALTITUDE: 5900,5900

B-7

ACCESSION NUMBER: 133393
DATE OF OCCURRENCE: 9001
REPORTED BY: FLC; ; ;
PERSONS FUNCTIONS: FLC,PLT; FLC,PLT; TRACON,AC;
FLIGHT CONDITIONS: MXD
REFERENCE FACILITY ID:CEW
FACILITY STATE: FL
FACILITY TYPE: TRACON; ARPT;
FACILITY IDENTIFIER: VPS; CEW;
AIRCRAFT TYPE: SMA; SMA;
ANOMALY DESCRIPTIONS: CONFLICT/AIRBORNE LESS SEVERE; LESS THAN LEGAL
SEPARATION; OTHER;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: CTLR ISSUED NEW CLNC;
ANOMALY CONSEQUENCES: FLC/ATC REVIEW;
NARRATIVE: I WAS AT 4500' INBND TO CEW VFR ON TOP OF CLOUDS. AS I GOT WITHIN ABOUT 25 MI OF CEW THE CLOUDS WENT FROM SCATTERED TO BROKEN, TO SOLID, WITH TOPS AT ABOUT 2500'. I CALLED CEW FSS AND LEARNED THAT CEW WAS 1000' OVERCAST, VSBLTY 5 MI. I DECIDED THAT THE SAFEST AND BEST COURSE WAS TO REQUEST AN IFR APCH RATHER THAN SEARCH FOR A HOLD TO DSND THROUGH. I CALLED EGLIN APCH AND REQUESTED (I THOUGHT) AN IFR LOCALIZER APCH TO RWY 17 AT CEW. THE EGLIN CTLR CAME RIGHT BACK WITH "SQUAWK...CLEARED TO KOBRA, CLEARED FOR THE LOCALIZER 17 APCH. CRESTVIEW USING RWY 35, MAINTAIN 2200 UNTIL KOBRA OUTBND". I ROGERED THE CLRNC AND REPORTED LEAVING 4500'. UPON REACHING KOBRA I REPORTED "MY ID X, KOBRA OUTBND, LEAVING 2200". ABOUT A MIN LATER, WHILE IN THE APCH AND IN IMC CONDITIONS, I HEARD SMA Y CALL APCH AND REQUEST THE VOR-A APCH TO CRESTVIEW, AND STATE HIS INTENTIONS THAT UPON REACHING VMC HE WOULD CANCEL AND CONTINUE VFR TO DEFUNIAK SPRINGS, A NEARBY VFR ARPT. THIS CAUSED ME TO WONDER IF SMA Y AND I WOULD CONVERGE IN IMC (THE APCHES CONVERGE) SO, THOUGH IT WAS NOT REQUESTED, I REPORTED "PROC TURN INBND". TO MY AMAZEMENT THE CTLR ANSWERED "ROBERT X MAINTAIN VFR!" I THEN SAID "BUT I'M NOT VFR, I'M IN THE CLOUDS". THE CTLR THEN REPLIED "ROGER X, CLIMB TO 2200' HOLD AS PUBLISHED AT KOBRA, YOU'RE #2 FOR APCH!" I THEN SAID "BUT I'M ONLY l MI OUTSIDE THE MARKER AT 1500." AS I TURNED OUTBND IN HOLDING, EGLIN APCH CLEARED ME FOR AN IFR APCH TO CEW. UPON LNDG I CALLED THE EGLIN WATCH SUPVR AND WE AGREED THERE WAS A DISCONNECT BETWEEN ME AND THE CTLR. I THOUGHT I WAS ON AN IFR CLRNC AND THE CTLR THOUGHT I WAS CONDUCTING THE APCH IN VFR CONDITIONS FOR TRAINING/PROFICIENCY. I DON'T THINK I CAME CLOSE TO SMA Y.
SYNOPSIS: LESS THAN STANDARD SEPARATION BETWEEN 2 SMA ACFT MAKING DIFFERENT IFR APCHES TO SAME ARPT. OPERATIONAL ERROR OR PLT DEVIATION.
REFERENCE FACILITY ID:CEW

FACILITY STATE: FL
DISTANCE & BEARING FROM REF.: 5,350
MSL ALTITUDE: 1500,2200

B-8

ACCESSION NUMBER: 141056
DATE OF OCCURRENCE: 9003
REPORTED BY: FLC; ;
PERSONS FUNCTIONS: FLC,PLT; FLC,PLT;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:BLD
FACILITY STATE: NV
FACILITY TYPE: ARPT;
FACILITY IDENTIFIER: BLD;
AIRCRAFT TYPE: SMA; SMA;
ANOMALY DESCRIPTIONS: CONFLICT/NMAC; UNCTRLED ARPT TRAFFIC PATTERN DEVIATION;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;
ANOMALY CONSEQUENCES: OTHER;
NARRATIVE: RETURNING FROM A GRAND CANYON SCENIC FLT, I RPTED TURNING AROUND THE HOOVER DAM AT 3500', SWITCHING TO BLD UNICOM. I SWITCHED FROM 123.05 TO 122.7 (BLD UNICOM) AND DSNDED TO 3200' AND RPTED COMING UP ON GOLD STRIKE CASINO. SHORTLY AFTER, A HELI APPEARED IN FRONT OF ME. I PULLED THE NOSE OF MY ACFT UP TO AVOID THE HELI. I FIRST SAW THE PLANE OF THE ROTOR BLADES PAINTED BLACK AND WHITE. THE FRONT SEAT PAX AND I SAW THE HELI AT THE SAME INSTANT AND MY REACTION WAS INSTANTANEOUS. I SPOKE TO THE HELI PLT RIGHT AWAY AND WE HAD BOTH RPTED THE GOLD STRIKE CASINO BUT ON DIFFERENT FREQS. I HAD HEARD THE HELI RPT AT A DIFFERENT LOCATION EARLIER AND WAS AWARE OF HIS PRESENCE AND WATCHING FOR HIM. HE TURNED OUT TO BE JUST BELOW MY LINE OF SIGHT AND WAS DIFFICULT TO SEE. TO PREVENT A RECURRENCE, WE WILL PLAN ON STAYING AT 3500' UNTIL PAST OUR CHKPOINT. WE WILL GO S OF THE CHKPOINT WHILE HELI WILL GO N. HOPEFULLY THIS WITH INCREASED AWARENESS WILL STOP ANYTHING LIKE THIS HAPPENING AGAIN.
SYNOPSIS: CLOSE PROX CHARTER SMA HELI ENTERING TRAFFIC PATTERN AT NON TWR ARPT.
REFERENCE FACILITY ID:BLD
FACILITY STATE: NV
DISTANCE & BEARING FROM REF.: 5,,NE
MSL ALTITUDE: 3200,3500

B-9

ACCESSION NUMBER: 142110
DATE OF OCCURRENCE: 9004
REPORTED BY: FLC; ; ; ;
PERSONS FUNCTIONS: FLC,FO; FLC,PIC.CAPT; FLC,PLT; TWR,GC;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:LIH
FACILITY STATE: HI
FACILITY TYPE: TWR; ARPT;
FACILITY IDENTIFIER: LIH; LIH;
AIRCRAFT TYPE: MLG; SMT;
ANOMALY DESCRIPTIONS: CONFLICT/GROUND LESS SEVERE; RWY TRANSGRESS/OTHER;
ANOMALY DETECTOR: OTHER; COCKPIT/FLC; ATC/CTLR;
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION; CTLR ISSUED NEW CLNC; FLC EXECUTED GAR OR MAP;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: AS WE TAXIED FOR TKOF AT RWY 3 AT LIH, LIH GND TOLD US TO TAXI INTO POS AND HOLD, MAKE LIH 5 DEP, AND MONITOR THE TWR. AS WE PULLED ONTO RWY 3 (3 AND 35 WERE ACTIVE), WE HEARD AN ACFT ASK TWR IF THE MLG WAS GOING INTO POS. I LOOKED BACK TO MY 5 O'CLOCK POS TO SEE AN SMT ON A CLOSE-IN BASE. WE IMMEDIATELY CLRED THE RWY AS THE TWR TOLD THE SMT TO GO AROUND. WE IMMEDIATELY TOLD THE TWR WE HEARD WE WERE CLRED INTO POS. HIS REPLY WAS, "WELL, I GUESS YOU HEARD WRONG." IT'S COMMON PRACTICE AT THIS TWR TO HAVE THE LCL CTLR WORKING BOTH TWR AND GND FREQS. W/O MAKING ASSUMPTIONS, THERE WERE 3 AIRLINES INBND FOR RWY 35--2 ON THE GND, 1 ABOUT TO BACK-TAXI ON OUR RWY--THAT WE COULD MONITOR VISUALLY. THE LIGHT ACFT WAS ON LEFT BASE FOR RWY 3. WE COULD NEITHER SEE NOR HEAR UNTIL MONITORING TWR. A CONTRIBUTING FACTOR IS CERTAINLY 1 CTLR WORKING 2 FREQS SO THAT WE WERE NOT TOTALLY AWARE OF THE TFC SITUATION. ONE OF OUR COMPANY ACFT WAS ON FINAL APCH AT THIS TIME, HEARING BOTH GND AND TWR, AND STATED HE HEARD US CLRED INTO POS.
SYNOPSIS: ACR MLG TAXIES ONTO ACTIVE RWY INTO PATH OF SMT ON APCH.
REFERENCE FACILITY ID:LIH
FACILITY STATE: HI
AGL ALTITUDE: 0,0

B-10

ACCESSION NUMBER: 142920
DATE OF OCCURRENCE: 9004
REPORTED BY: FLC; ; ;
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,PIC.CAPT; TWR,LC;
FT.TGHT ~ONDITIONS: VMC
REFERENCE FACILITY ID:EWR
FACILITY STATE: NJ
FACILITY TYPE: TWR;
FACILITY IDENTIFIER: EWR;
AIRCRAFT TYPE: LRG; LRG;
ANOMALY DESCRIPTIONS: CONFLICT/AIRBORNE LESS SEVERE;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION; FLC EXECUTED GAR OR MAP;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: ACR X TKOF WAS BEING MADE ON RWY 4R AT EWR. ACR Y HAD PREVIOUSLY BEEN CLRED TO LAND ON RWY 29 AT SAME ARPT. THE 2 DESCRIBED RWYS DO NOT INTERSECT, SO NO PROB WAS ANTICIPATED. ALL MEMBERS OF THE CREW WERE AWARE OF AND MONITORING THE DEVELOPMENT OF THE SITUATION. THE TKOF WAS CONTINUED. JUST AFTER LIFTOFF ACR Y ANNOUNCED HE WAS GOING AROUND. AT 150' OF ALT, BOTH ACFT MADE STEEP LEFT TURN TO AVOID EACH OTHER.
SYNOPSIS: ACR X HAD AIRBORNE CONFLICT LESS SEVERE WITH ACR Y IN ATA.
REFERENCE FACILITY ID:EWR
FACILITY STATE: NJ
DISTANCE & BEARING FROM REF.: 0
MSL ALTITUDE: 150,150

B-11

ACCESSION NUMBER: 149017
DATE OF OCCURRENCE: 9006
REPORTED BY: FLC; ; ;
PERSONS FUNCTIONS: FLC,PLT; TRACON,AC; TWR,LC;
FLIGHT CONDITIONS: MXD
REFERENCE FACILITY ID:HPN
FACILITY STATE: NY
FACILITY TYPE: ARPT; TRACON; TWR;
FACILITY IDENTIFIER: HPN; N90; HPN;
AIRCRAFT TYPE: SMA;
ANOMALY DESCRIPTIONS: IN-FLT ENCOUNTER/WX; OTHER;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: CTLR ISSUED NEW CLNC;
ANOMALY CONSEQUENCES: NONE;
SITUATION REPORT SUBJECTS: PROC OR POLICY/ATC FACILITY;
NARRATIVE: I WAS THE PLT OF AN ACFT WITH PAX, RETURNING TO WESTCHESTER COUNTY ARPT FROM THE PHILADELPHIA AREA. BEFORE DEPARTING, I RECEIVED A WX BRIEFING WHICH INDICATED THAT THE WX AT WESTCHESTER COUNTY ARPT WAS, AMONG OTHER THINGS, SCATTERED CLOUDS AT 4000', VSBLTY 6 MI. WHILE NAVIGATING BTWN THE SOLBERG VOR AND THE SPARTA VOR, I OBSERVED THAT THE WX WAS BEGINNING TO BECOME LESS THAN THAT RPTED FOR WESTCHESTER COUNTY ARPT. CLOUDS WERE LOWERING AND THE VSBLTY WAS APPROX 3 MI. ON REACHING THE SPARTA VOR, I WAS MONITORING NY APCH ON FREQ 126.40. ANOTHER ACFT CONTACTED NY APCH AND REQUESTED VECTORS FOR AN ILS APCH TO RWY 16 AT W. THE CTLR RESPONDED, "WHY WOULD YOU WANT AN ILS APCH?" THE PLT RESPONDED, "VSBLTY IS VERY POOR AND I CAN'T SEE THE ARPT." I WAS ALSO MONITORING THE WESTCHESTER ATIS, WHICH WAS RPTING SCATTERED CLOUDS AT 4000' VSBLTY 6 MI. THE CTLR THEN RESPONDED TO THE PREVIOUS PLT'S REQUEST FOR AN ILS APCH INTO RWY 16 BY SAYING THAT HE WAS PROBABLY IN A LCL SQUALL OR CLOUD BUT WOULD GIVE HIM VECTORS TOWARD THE ARPT. APPROX 15 MI W OF WESTCHESTER COUNTY ARPT, THE CTLR ASSIGNED ME A XPONDER CODE AND TOLD ME TO PROCEED FOR A STRAIGHT IN APCH TO RWY 11. I WAS OVER THE TAPPEN ZEE BRIDGE AND WAS UNABLE TO SEE IT BECAUSE OF LOW CLOUDS AND POOR VSBLTY. I DECLINED RWY 11 AND REQUESTED AN ILS APCH TO RWY 16. HE COMPLIED AND VECTORED ME TO THE N. WHILE MONITORING THE APCH FREQ, I HEARD SEVERAL OTHER PLTS CALL IN AND ASK FOR WX AT WESTCHESTER COUNTY ARPT AND WHETHER IT WAS STILL VFR. THE APCH CTLR REPLIED WITH THE SAME INFO THAT THE ATIS WAS PROVIDING. HE STATED AFFIRMATIVELY THAT WESTCHESTER COUNTY ARPT WAS STILL VFR. THERE WAS NO MENTION TO THESE PLTS CALLING IN THAT OTHER PLTS HAD PREVIOUSLY RPTED THE CONDITIONS TO BE LESS FAVORABLE THAN STATED ON THE ATIS, NOR DID HE RPT THE OTHER PLTS HAD REQUESTED VECTORS FOR THEE ILS APCH BECAUSE OF POOR VSBLTY. THE APCH CTLR FINALLY RETURNED TO ME AND

GAVE ME VECTORS TOWARD AN E DIRECTION, BUT DID NOT VECTOR ME S UNTIL I HAD PASSED THE EXTENDED CENTERLINE OF RWY 16. I RECEIVED VECTORS BACK TO INTERCEPT THE LOC AND G/S. WHILE ON THE LOC AND G/S, WE FLEW THE APCH DOWN TO 800' BEFORE BARELY SEEING THE APCH LIGHTS FOR RWY 16. I WAS SWITCHED OVER TO THE TWR AT THAT POINT AND RPTED THAT THE VSBLTY APPEARED TO BE APPROX 1 MI AND THAT THE ARPT WAS NOT VISIBLE ABOVE 800'. THE TWR CTLR STATED THAT THE ATIS RPT WAS BEING CHANGED. ON THIS PARTICULAR OCCASION, I FEEL THAT

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(REPORT CONTINUED)

THERE WAS A FAILURE ON THE PART OF THE APCH CTLR TO UNDERSTAND AND INTERPRET THE RPTS HE WAS RECEIVING FROM PLTS IN THE AREA AND TO RELAY THESE RPTS TO OTHER PLTS CALLING IN. IN ADDITION, THERE APPEARED TO BE NO COORD BTWN THE TWR AND PACH CTL, INSOFAR AS WX CONDITIONS WERE CONCERNED. PLT CALLING IN TO APCH WERE ADVISED THAT WESTCHESTER WAS STILL VFR WHEN, IN FACT, IT WAS IFR. A PLT WHO WAS NOT INS RATED OR QUALIFIED RELAYING UPON THESE ERRONEOUS RPTS, WOULD QUICKLY FIND HIMSELF IN CONDITIONS ABOVE HIS CAPABILITIES. IF THE PLT OF THE SMA WHICH CRASHED INTO RYE LAKE ON 6/THU/90 WAS NOT INS RATED, AND RELIED UPON THE RPTS GIVEN BY THE APCH CTLR, THEN THE CAUSE OF THE DISASTEROUS RESULTS IS READILY APPARENT. I BELIEVE THAT THE SAFETY FACTOR SOUGHT TO BE ACHIEVED BY THE ATC SYS FALLS FAR SHORT OF ITS MARK WHEN THE APCH CTLR FAILS OR REFUSES TO PASS ON TO PLTS PIREPS WHICH OMPLETELY CONTRADICT PUBLISHED ATIS RPTS OF VFR WX AND IN SO DOING MISLEAD PLTS INTO PROCEEDING TOWARD AN AREA WHERE THYE HAVE NO BUSINESS BEING.

SYNOPSIS: GA SMA PLT THINKS HE AND OTHER GA PLTS WERE LED UP THE GARDEN PATH BY N90 WHEN APCH CTLR FAILED TO FORWARD PLT WX REPORTS AND CONTINUED TO GIVE OUTDATED ATIS WX. HPN TWR SLOW TO UPDATE DETERIORATING WX ON ATIS.

REFERENCE FACILITY ID:HPN
FACILITY STATE: NY
DISTANCE & BEARING FROM REF.: ,,SW
MSL ALTITUDE: 2500,2500

B-13

ACCESSION NUMBER: 151548
DATE OF OCCURRENCE: 9007
REPORTED BY: FLC; ; ;
PERSONS FUNCTIONS: FLC,PLT; FLC,PLT; TWR,LC;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:PRC
FACILITY STATE: AZ
FACILITY TYPE: TWR; ARPT;
FACILITY IDENTIFIER: PRC; PRC;
AIRCRAFT TYPE: SMA; SMA;
ANOMALY DESCRIPTIONS: CONFLICT/NMAC; OTHER;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: I WAS IN A PART 141 PLANE IN R CLOSE TRAFFIC FOR RWY 21. I HEARD ANOTHER PLANE, SMA Y CALLING A 5 MI 45 ENTRY TO DOWNWIND. I LOOKED BUT COULD NOT PICK UP UNTIL HE CALLED A 2 MI 45 DEG. AT THAT POINT I SAW HIS POS WAS NOT MOVING ACROSS A POINT ON MY WINDSCREEN. I ROLLED MY WINGS THEN ATTEMPTED A CALL TO THE TWR TO TELL MY POS. AS I BECAME AWARE THAT THE 45 DEG TFC SMA Y DID NOT SEE ME I CALLED HIS NUMBER AND TOLD MY POS OVER TWR FREQ. AS BEFORE, I GOT STEPPED ON BY OTHER CALLS, AS I FOUND OUT LATER. AT THIS POINT, I DSNDED 200' BELOW TFC PATTERN ALT AS HE PASSED OVER THE TOP OF ME. THEN HE BECAME AWARE OF ME AND WIDENED OUT HIS DOWNWIND. TWR THEN ASKED HIM IF HE HAD ME IN SIGHT. I TALKED TO THE OTHER PLT ON THE GND AND WE AGREED THAT IF I HAD NOT DSNDED WE WOULD HAVE COLLIDED. THIS IS THE STANDARD WAY TO ENTER THE PATTERN. WE BOTH FEEL THAT ATC MIGHT HAVE ADVISED US EACH THAT ANOTHER PLANE WAS IN THE AREA.
SYNOPSIS: NMAC BETWEEN 2 SMA'S IN TRAFFIC PATTERN AT PRC.
REFERENCE FACILITY ID:PRC
FACILITY STATE: AZ
MSL ALTITUDE: 800,1000

ACCESSION NUMBER: 151948
DATE OF OCCURRENCE: 9007
REPORTED BY: FLC; ;
PERSONS FUNCTIONS: FLC,PLT; FLC,PLT;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:FTG
FACILITY STATE: CO
FACILITY TYPE: ARPT;
FACILITY IDENTIFIER: FTG;
AIRCRAFT TYPE: SMA; SMA;
ANOMALY DESCRIPTIONS: OTHER; UNCTRLED ARPT TRAFFIC PATTERN DEVIATION;
CONFLICT/NMAC; NON ADHERENCE LEGAL RQMT/PUBLISHED PROC; NON ADHERENCE LEGAL RQMT/FAR;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;
ANOMALY CONSEQUENCES: OTHER;
NARRATIVE: I ENTERED DOWNWIND ON A 45. I MADE ALL RADIO CALLS, DOWNWIND, BASE AND FINAL.L ON 1/4 MI FINAL, A CIVIL AIR PATROL SMA CALLED FINAL. I LOOKED BEHIND ME AND DID NOT SEE HIM. I THEN SAW HIM JUST ABOVE ME. I TOOK EVASIVE ACTION AND INFORMED HIM I WAS BELOW. HE GOT ABUSIVE ON THE RADIO, THEN TOOK EVASIVE ACTION. THERE WAS A DISCUSSION ON THE GND BTWN MYSELF AND THE OTHER PLT. I TALKED TO THE FAA, AND WAS TOLD ABOUT THE PROCS OF AN INVESTIGATION. THE OTHER PLT HAS SEVERAL ACCIDENTS. THOUGH I'VE NEVER BEEN IN TROUBLE, I CANNOT AFFORD AN INVESTIGATION DUE TO AN UPCOMING CLASS DATE WITH A MAJOR. I DON'T BELIEVE THAT I WAS IN THE WRONG.
SYNOPSIS: CLOSE PROX 2 GA SMA ACFT AT NON TWR ARPT CTAF.
REFERENCE FACILITY ID:FTG
FACILITY STATE: CO
AGL ALTITUDE: 100,250

B-15

ACCESSION NUMBER: 153480
DATE OF OCCURRENCE: 9008
REPORTED BY: FLC; FLC; ; ; ;
PERSONS FUNCTIONS: FLC,ISTR; FLC,ISTR; FLC,TRNEE; FLC, TRNEE; TWR,LC;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID: DRK
FACILITY STATE: AZ
FACILITY TYPE: ARPT; TWR;
FACILITY IDENTIFIER: PRC; PRC;
AIRCRAFT TYPE: SMA; SMA;
ANOMALY DESCRIPTIONS: CONFLICT/NMAC;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;
ANOMALY CONSEQUENCES: NONE;
SITUATION REPORT SUBJECTS: PHYSICAL FACILITY/ATC;
NARRATIVE: 2 FBO SMA WERE EXECUTING THE VOR RWY 11 APCH AT THE SAME TIME. BOTH ACFT WERE EXECUTING THE APCH IN VFR CONDITIONS W/O IFR SEP AND W/O RADAR. BOTH ACFT WOUND UP AT THE DME ARC AT THE SAME TIME, RESULTING IN A NEAR MISS (WITHIN 50' VERT SEP). TWR DID NOT ADVISE ACFT POS TO EITHER ACFT. INCIDENT COULD HAVE BEEN PREVENTED IF TWR HAD RADAR. SUPPLEMENTAL INFO FROM ACN 153814: AS WE TURNED ON 10 DME ARC ANOTHER ACFT RPTED ON THE ARC. I IMMEDIATELY EXECUTED A CLBING RIGHT TURN AND GOT OFF THE ARC. COULD HAVE BEEN AVOIDED IF WE HAD RADAR. VERY BUSY ARPT WITH HIGH INTENSITY FLT TRNING!
SYNOPSIS: CLOSE PROX 2 GA SMA TRAINING ACFT STARTING A DME ARC APCH TO PRC.
REFERENCE FACILITY ID: DRK
FACILITY STATE: AZ
DISTANCE & BEARING FROM REF.: 10,349
MSL ALTITUDE: 9000,9000

B-16

ACCESSION NUMBER: 157890
DATE OF OCCURRENCE: 9009
REPORTED BY: CTLR; CTLR; ; FLC;
PERSONS FUNCTIONS: TWR,LC; TWR,GC; FLC,PLT; FLC,FO;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID: LNS
FACILITY STATE: PA
FACILITY TYPE: TWR; ARPT;
FACILITY IDENTIFIER: LNS; LNS;
AIRCRAFT TYPE: SMA; MDT;
ANOMALY DESCRIPTIONS: CONFLICT/GROUND CRITICAL; LESS THAN LEGAL SEPARATION; NON ADHERENCE LEGAL RQMT/PUBLISHED PROC;
ANOMALY DETECTOR: COCKPIT/FLC; ATC/CTLR;
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;
ANOMALY CONSEQUENCES: FLC/ATC REVIEW;
NARRATIVE: I WAS WORKING LCL CTL ON A W OPERATION, RWY 31 AND 26, TFC WAS MODERATE, NO RESTRICTIONS TO VSBLTY, VFR AND IFR MIX OF TFC. I WAS ON POS FOR JUST OVER ONE HR. GND CTL REQUESTED RWY 31 XING AT BRAVO TXWY, WHICH I APPROVED. AT THS TIME A SINGLE ENG SMA WAS ALREADY FOR TKOF ROLL JUST PASSING THE INTXN AT BRAVO, WHICH IS 1000' DOWN THE RWY, THE NEXT VFR DEP ON RWY 31 WAS TAXIED INTO POS HOLD, FOR THE RWY XING AND FOR THE REQUIRED RWY SEP WITH THE SMA DEP. THE ACFT WAS SMA X, A BI-PLANE. I THEN BEGAN TO MOVE TO OTHER DUTIES THAT NEEDED TO BE RESOLVED, SEQUENCE TFC PATTERN, THERE WERE NUMEROUS ARRS INTO THE PATTERN, AN OPP DIRECTION LOW APCH TO RWY 8, AND TFC ADVISORIES BTWN DEPS AND ARRS. I THEN OBSERVED THE SMA DEP OVER THE DEP END OF RWY 31. I BACK SCANNED THE RWY FROM DEP END TO THE ARR END AND THEN TO THE FINAL, I DIDN'T SEE ANY TFC ON THE RWY, NOR DID I SEE THE ACFT ON BRAVO TXWY. AT THAT POINT, I HAD EITHER FORGOTTEN ABOUT THE RWY XING OR THOUGHT IT WAS COMPLETED. SMA X WAS ISSUED TKOF CLRNC. I STARTED TO PUT THE NEXT ACFT INTO POS HOLD WHEN I OBSERVED ACR Y ENTERING THE RWY ENVIRONMENT AT BRAVO. SMA X LIFTED OFF THE RWY AND OVER FLEW ACR Y BY SOME 10-15'. EVASIVE ACTION WAS REQUIRED OF SMA X. ABOUT AN HR LATER SMA X PLT CAME TO THE CTL TWR, IN TAKING WITH HIM, HE SAW ACR Y ON BRAVO TXWY OFF TO HIS L SIDE, HE THOUGHT ACR Y WAS HOLDING SHORT. SMA X IS A TAIL DRAGGER, AND THE PLT SITS IN AN OPEN COCKPIT IN THE BACK OF THE PLANE, HE COULDN'T SEE IN FRONT OF HIS ACFT, HE REALIZED SOMETHING WAS WRONG WHEN MY NEXT XMISSION TO THE NEXT ACFT FOR DEP WAS INTERRUPTED WITH DESPERATION TO BRING THE SITUATION TO HIS ATTENTION, HE LOOKED L AND SAW ACR Y WAS ENTERING THE RWY AND STARTED HIS CLB OUT. IN LOOKING BACK AT HOW THIS COULD HAVE BEEN AVOIDED, I SHOULD HAVE SCANNED THE RWY WITH MORE CONVICTION ESPECIALLY IF TFC WAS AT A MODERATE LEVEL. WHEN I TAXIED SMA X INTO POS AND HOLD, I SHOULD HAVE TOLD HIM WHY, THIS WOULD HAVE ALERTED HIM THAT AN ACFT WAS XING, AND MAY NOT HAVE STARTED HIS TKOF ROLL. IT ALSO MAY HAVE STUCK IN MY HEAD THAT A XING WAS IN

THE PROCESS, REGARDLESS IF THE RWY WAS CLR. SUPPLEMENTAL INFO FROM ACN 158307. I ADVISED ACR Y TFC HOLDING, CROSS RWY 31. AT THAT TIME ANOTHER ACFT CALLED AND MY ATTENTION WAS

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(REPORT CONTINUED)

DIVERTED. WHEN I CHKED BACK TO SEE HOW ACR Y WAS PROGRESSING, I SAW SMA X IN A STEEP CLB OVER ACR Y. (THE INTXN IS ONLY ABOUT 800' FROM THE BEGINNING OF THE RWY). SUPPLEMENTAL INFO FROM ACN 157275. WE WERE GIVEN CLRNC FROM GND CTL TO TAXI (FROM THE TERMINAL) TO BRAVO HOLD SHORT OF RWY 31. AS WE CAME UPON THE BRAVO HOLD LINE, GND CTL ISSUED US CLRNC TO CROSS RWY 31 AND TAXI TO RWY 26. THERE WAS A TAILWHEEL AIRPLANE (SMA X) HOLDING IN POS ON RWY 31. AS WE BEGAN TO CROSS THE RWY THE CAPT NOTICED THE PROP OF SMA X SPINNING UP. BY THIS TIME SMA X WAS ROLLING TOWARDS US AS WE WERE NOW IN THE MIDDLE OF THE RWY. SMA X ROTATED AND JUST MISSED OUR TAIL. THE CAPT TALKED ON THE PHONE WITH THE SUPVR OF THE TWR TO DISCUSS THE SITUATION. FROM WHAT I UNDERSTAND, SMA X WAS GIVEN TKOF CLRNC RIGHT ABOUT THE TIME WE WERE XING THE RWY. THE CTLR ADMITTED THERE WAS A COMS ERROR IN THE TWR BTWN 2 CTLRS. MY FEELINGS ARE THERE MUST BE AN INCREASED AWARENESS OF BETTER COM SKILLS NEEDED TO PREVENT A SITUATION SUCH AS THIS THAT COULD HAVE BEEN A SERIOUS ACCIDENT.

SYNOPSIS: ACFT WAS CLEARED ACROSS RWY WHILE ANOTHER ACFT WAS CLEARED FOR TKOF. DEP ACFT FLEW OVER CROSSING ACFT.

REFERENCE FACILITY ID: LNS
FACILITY STATE: PA
AGL ALTITUDE: 0,50

B-18

ACCESSION NUMBER: 160210
DATE OF OCCURRENCE: 9010
REPORTED BY: FLC; ;
PERSONS FUNCTIONS: FLC,PLT; FLC,PLT;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:SEZ
FACILITY STATE: AZ
FACILITY TYPE: ARPT;
FACILITY IDENTIFIER: SEZ;
AIRCRAFT TYPE: SMA; SMA;
ANOMALY DESCRIPTIONS: CONFLICT/AIRBORNE LESS SEVERE; UNCTRLED ARPT TRAFFIC PATTERN DEVIATION; OTHER; NON ADHERENCE LEGAL RQMT/FAR;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: NOT RESOLVED/DETECTED AFTER-THE-FACT;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: THE INCIDENT OCCURRED AT SEDONA ARPT. TFC WAS LNDG UPHILL ON RWY 03 AND DEPARTING DOWNHILL ON RWY 21. I WAS DEPARTING SEDONA. I TAXIED FROM PARKING TO RWY 21, COMPLETED MY PREFLT AND WAS READY TO DEPART. I HAD BEEN MONITORING THE CTAF AND DIDN'T HEAR ANY ACFT IN THE PATTERN. I ANNOUNCED MY INTENTION TO DEPART SEZ ON RWY 21 AND TAXIED ONTO THE RWY. I DIDN'T SEE ANY TFC APCHING. AS I TAXIED ONTO THE RWY, I HEARD AN ACFT ANNOUNCE IT WAS TURNING BASE FOR RWY 03. INSTEAD OF HOLDING AT THE END OF THE RWY, I BEGAN MY TKOF ROLL, THINKING I WOULD BE OFF AND CLB OUT OVER THE PATH OF THE LNDG ACFT. THE OTHER ACFT HEARD/SAW ME AND EXECUTED A GO-AROUND, TURNING R OUT OF THE DEP PATH. BECAUSE OF THE OTHER PLT'S EVASIVE ACTION, OUR 2 ACFT REMAINED AT SAFE DISTANCES. BUT I SHOULD HAVE YIELDED THE RIGHT-OF-WAY TO THE LNDG ACFT. (LNDG ACFT WAS A HIGH FIXED WING GA ACFT). CONTRIBUTING FACTORS. I HAD JUST COMPLETED MY AFR AFTER NOT FLYING AT ALL FOR 2 YRS; MY HEAD WORK WAS RUSTY. I WAS TIRED, HAD NOT SLEPT WELL THE NIGHT BEFORE. THE SITUATION OF TFC LNDG AND DEPARTING IN OPP DIRECTIONS IS UNUSUAL. ONCE I TOOK THE RWY, I FELT COMMITTED TO TKOF, A BAD JUDGEMENT. WHAT WOULD HAVE PREVENTED THE CONFLICT. I SHOULD HAVE ASKED UNICOM FOR A TFC ADVISORY BEFORE TAXIING ONTO THE RWY, AND LOOKED MORE CAREFULLY FOR TFC IN THE PATTERN. I ALSO COULD HAVE WAITED A FEW MOMENTS AFTER ANNOUNCING MY INTENTION TO DEPART ON THE CTAF TO SEE IF ANY OTHER ACFT ANNOUNCED THEIR POSITIONS IN THE PATTERN. I COULD HAVE HELD AT THE END OF THE RWY FOR THE ARRIVING TFC TO LAND AND CLR THE RWY. ANOTHER PREVENTION, GIVEN THE UNUSUAL TFC PATTERN, WOULD HAVE BEEN TO ANTICIPATE AND DECIDE AHEAD OF TIME WHAT SAFE/UNSAFE CONDITIONS FOR TAKING OFF (VIS-A-VIS OTHER LCL TFC POSITIONS). FINALLY, NOT FLYING WHEN TIRED, IT DID SEEM TO AFFECT MY JUDGEMENT.
SYNOPSIS: CLOSE PROX GA SMA ON TKOF FROM RWY 21 AND GA SMA IN LNDG PATTERN FOR RWY 03.
REFERENCE FACILITY ID:SEZ
FACILITY STATE: AZ

DISTANCE & BEARING FROM REF.: ,,SW
AGL ALTITUDE: 0,500

B-19

ACCESSION NUMBER: 160654
DATE OF OCCURRENCE: 9010
REPORTED BY: FLC; ; ; ;
PERSONS FUNCTIONS: FLC,TRNEE; FLC,ISTR; FLC,PLT; TWR,LC;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:BVI
FACILITY STATE: PA
FACILITY TYPE: TWR;
FACILITY IDENTIFIER: BVI;
AIRCRAFT TYPE: SMA; SMA;
ANOMALY DESCRIPTIONS: CONFLICT/NMAC; NON ADHERENCE LEGAL RQMT/FAR;
ANOMALY DETECTOR: ATC/CTLR;
ANOMALY RESOLUTION: NOT RESOLVED/ANOMALY ACCEPTED;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: ARPT WAS OPERATING OFF OF RWY 10 IN A RIGHT-HAND TFC PATTERN. THERE WERE APPROX 8 OTHER ACFT IN THE CTL ZONE AREA. WHILE ON DOWNWIND, MY INSTR AND I BEGAN TO HEAR A RATHER URGENT AND PANICKY-SOUNDING CTLR INSTRUCTING AN SMA Y TO "LOOK FOR THE SMA X OFF OF YOUR RIGHT WING." THE CTLR REPEATED THIS OVER AND OVER, EACH TIME SOUNDING MORE PANICKED. THE SMA Y EACH TIME REPLIED THAT HE DID NOT SEE THE SMA X. SUDDENLY, OUT OF THE CORNER OF MY EYE, I SAW THE SMA Y APPROX 50' VERT AND 100' HORIZ TO THE RIGHT OF MY ACFT. I WAS THE SMA X THAT THE CTLR WAS REFERRING TO! THE TWR AT THIS ARPT IS A NON-FEDERAL FAC THAT IS USED PRIMARILY AS A TRNING FAC FOR A LCL COLLEGE. I AM UNCERTAIN IF THE CTLR ON DUTY WAS A STUDENT; HOWEVER, SHE SOUNDED AS IF SHE WAS HAVING TROUBLE HANDLING THIS PRE-EVENING CRUNCH OF TFC BECAUSE JUST BEFORE THE INCIDENT, SHE ANNOUNCED THAT ALL TFC MUST BE FULL STOP AND THAT ALL TOUCH AND GO'S WERE CANCELLED. ADDITIONALLY, HER VOICE SOUNDED VERY FLUSTERED. THE PLT OF THE SMA Y WAS ALSO A STUDENT. I WAS UNABLE TO SEE THE SMA Y COMING TOWARD ME BECAUSE I WAS IN A SLIGHT NOSE HIGH ATTITUDE, CLBING TO PATTERN ALT. THE CTLR KNEW THAT I WAS HEADED TOWARD THIS "LOST" SMA Y. IT HAPPENED AT MID-FIELD, RIGHT IN FRONT OF HER! WHY WASN'T I MADE AWARE OF THE SITUATION SO I COULD'VE TAKEN EVASIVE ACTION IF NECESSARY? INSTEAD, THE CTLR JUST RAISED HER VOICE AND EXPECTED THE SMA Y TO SEE THE SMA X. UNFORTUNATELY, THERE WERE AT LEAST 4 OTHER SMA X'S IN THE PATTERN. IT COULD'VE BEEN ANY ONE OF THEM. SHE KNEW MY CALL SIGN BECAUSE I WAS #4 TO LAND, I FEEL THAT SHE SHOULD'VE TURNED ME LEFT, OUT OF THE PATTERN AS A CORRECTIVE ACTION INSTEAD OF JUST RAISING HER VOICE. SITUATION AWARENESS WOULD HAVE BENEFITTED ALL INVOLVED IN THIS INCIDENT!
SYNOPSIS: CLOSE PROX 2 GA SMA IN TRAFFIC AT BVI.
REFERENCE FACILITY ID:BVI

FACILITY STATE: PA
DISTANCE & BEARING FROM REF.: 1,,SO
MSL ALTITUDE: 1900,2000

B-20

ACCESSION NUMBER: 161078
DATE OF OCCURRENCE: 9010
REPORTED BY: FLC; ; ;
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; FLC,PIC.CAPT;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID: HLF
FACILITY STATE: FO
FACILITY TYPE: ARTCC;
FACILITY IDENTIFIER: OEJD;
AIRCRAFT TYPE: WDB; ;
ANOMALY DESCRIPTIONS: CONFLICT/AIRBORNE LESS SEVERE; LESS THAN LEGAL SEPARATION;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: NOT RESOLVED/DETECTED AFTER-THE-FACT; NOT RESOLVED/INSUFFICIENT TIME;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: AS MY ACFT PASSED OVER HLF VOR AT FL310 AND MADE POS RPT, WE HEARD ANOTHER ACFT RPT THE SAME POS AT THE SAM FLT LEVEL. WE WERE WBND ON 2726 AND OTHER ACFT WAS ON A DIRECT LEG APCHING 45 DEGS FROM LEFT. WE NOTICED OTHER ACFT AT OUR 8 O'CLOCK POS, LESS THAN 1/4 MI. NO EVASIVE ACTION NECESSARY OR TAKEN.
SYNOPSIS: LESS THAN STANDARD SEPARATION AT FL310 IN FOREIGN AIRSPACE.
REFERENCE FACILITY ID: HLF
FACILITY STATE: FO
MSL ALTITUDE: 31000,31000

B-21

ACCESSION NUMBER: 169841
DATE OF OCCURRENCE: 9102
REPORTED BY: FLC;
PERSONS FUNCTIONS: FLC,PLT; TWR,LC;
FLIGHT CONDITIONS: IMC
REFERENCE FACILITY ID: LUK
FACILITY STATE: OH
FACILITY TYPE: ARPT; TWR;
FACILITY IDENTIFIER: LUK; LUK;
AIRCRAFT TYPE: SMA;
ANOMALY DESCRIPTIONS: IN-FLT ENCOUNTER/WX; NON ADHERENCE LEGAL RQMT/CLNC; NON ADHERENCE LEGAL RQMT/PUBLISHED PROC; NON ADHERENCE LEGAL RQMT/FAR;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: NOT RESOLVED/ANOMALY ACCEPTED;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: ON MY FIRST POST-INS CHKRIDE FLT IN IMC, I WAS RETURNING TO LUK FROM MWO (APPROX 1/2 HR FLT). I HAD PICKED UP LIGHT ICE ON THE WAY OUT AND HAD MADE A PIREP. I PICKED UP SOME LIGHT TO MODERATE MIXED ICE ENRTE AT 3000’ MSL. AN ACFT AHEAD OF ME ON THE APCH RPTED HEAVY ICE BUILDUP FROM 2700’ ON DOWN TO 1700'. AS I WAS VECTORED FOR THE APCH, THE ICE STARTED TO BUILD VERY RAPIDLY. BY THE TIME I WAS ESTABLISHED ON THE APCH (OUTSIDE OF THE BEACON), I WAS AT FULL PWR AND BARELY MAINTAINING ALT AT LESS THAN 80 KIAS. I ATTEMPTED TO REMAIN ABOVE THE G/S, BUT COULD NOT. I ADVISED LUK TWR THAT I WOULD DSND TO 1700' (100' ABOVE THE MDA FOR THE LOC APCH), WHICH IS WHERE THE PREVIOUS ACFT HAD RPTED ICE BUILDUP CEASING. HOWEVER I CONTINUED TO BUILD ICE. I ALSO HAD TO KEEP CARB HEAT FULL ON AND PLAY WITH RPM'S TO LOOSEN PROP ICE. I HAD ADVISED TWR AND APCH SEVERAL TIMES OF MY SITUATION (BUT OF COURSE THEY COULD NOT HELP). APPROX 3 MI INSIDE MDE I DOUBLE-CHKED THE BASES AND MADE MY DECISION TO DSND TO 1400' (200’ BELOW THE MDA). I MADE THIS CHOICE BECAUSE~ WITH THE WAY THE ICE WAS BUILDING, I WAS GOING DOWN ANYWAY, AND BECAUSE OF THE FACT THAT I AM VERY FAMILIAR WITH THE AREA. AS I BROKE OUT AT 1400' TWR ASKED MY ALT. I RESPONDED, "1400' OUT OF THE CLOUDS." I HAD VIS CONTACT WITH THE ARPT AND NEW EXACTLY MY POS (I RPTED A LCL SHOPPING CENTER TO MY RIGHT). BY THE TIME I REACHED THE ARPT, SOME ICE HAD SUBLIMATED, BUT VERY LITTLE. IN A FULL STALL LNDG I WAS 3-4 KIAS SLOWER THAN I HAVE BEEN ON THE APCH. I WOULD NOT HAVE MADE THE DECISION TO DSND BELOW THE MDA IF I HAD NOT BEEN VERY FAMILIAR WITH THE ARPT. WHEN I HAD RECEIVED MY BRIEFING FOR THIS FLT, THERE WERE NO PLT RPTS OF ICE IN THE AREA. YET FROM DISCUSSING THE INCIDENT WITH CTLRS AND GND CREW, NUMEROUS ACFT HAD COME IN WITH ICE. 2 THINGS WOULD HAVE MADE ME TAKE THE BUS HOME: GREATER STRESS ON THE HAZARDS OF ICING DURING INS FLYING, AND PIREPS IN THE AREA.
SYNOPSIS: GA SMA ENCOUNTERED ICE ON APCH TO LUK AND DESCENDED BELOW MDA TO GET CLEAR OF CLOUDS.
REFERENCE FACILITY ID: LUK
FACILITY STATE: OH
DISTANCE & BEARING FROM REF.: ,,NE
MSL ALTITUDE: 1400,3000

B-22

ACCESSION NUMBER: 174511
DATE OF OCCURRENCE: 9104
REPORTED BY: FLC; FLC; ; ;
PERSONS FUNCTIONS: FLC,FO; FLC,PIC.CAPT; FLC,PLT; TWR,LC;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:MDW
FACILITY STATE: IL
FACILITY TYPE: TWR; ARPT;
FACILITY IDENTIFIER: MDW; MDW;
AIRCRAFT TYPE: MLG; SMT;
ANOMALY DESCRIPTIONS: ACFT EQUIPMENT PROBLEM/LESS SEVERE; OTHER; RWY TRANSGRESS/OTHER; NON ADHERENCE LEGAL RQMT/CLNC; NON ADHERENCE LEGAL RQMT/FAR;
ANOMALY DETECTOR: COCKPIT/FLC; ATC/CTLR;
ANOMALY RESOLUTION: FLC ABORTED TKOF;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: OUR FLT, MLG X, WAS CLRED FOR TKOF RWY 13C. A LIGHT TWIN, SMT Y, HAD JUST LANDED 1 MIN BEFORE ON RWY 13L. PWR WAS ADVANCED AND TKOF ROLL COMMENCED WITH CAPT SETTING TKOF PWR. AT APPROX 100 KTS, I NOTICED AN ACFT AT DEP END OF RWY AT A FAIRLY GOOD TAXI SPD, APCHING OUR RWY. AT THE SAME TIME I HEARD THE TWR CTLR MAKING SEVERAL ATTEMPTS TO RAISE TXWY SMT Y ON FREQ TO NO AVAIL. I TOLD CAPT THAT I THOUGHT AN ACFT WAS GOING TO CROSS OUR RWY DOWNFIELD. THE CAPT LOOKED OUT AND ALSO OBSERVED INTRUSION AHEAD. CAPT MADE DECISION TO ABORT TKOF AT APPROX 115 KTS (11 KTS BELOW V1). SMT Y NEVER DID STOP AND TWR WAS FINALLY ABLE TO RAISE HIM ONCE HE CROSSED OUR RWY. OUR ACFT CAME TO A STOP ABOUT 2000' PRIOR TO WHERE SMT Y CROSSED IN FRONT OF US. IF TKOF WOULD HAVE BEEN CONTINUED AT OUR FAIRLY LIGHT WT, AND WITH SLIGHTLY MORE AGGRESSIVE ROTATION THAN NORMAL, WE WOULD HAVE CLRED SMT Y BY 100-200'. WORKLOAD OF LCL CTLS AT THE TIME WAS FAIRLY BUSY. WX WAS GOOD IF MVFR OR IFR. OUR NOT BEING AWARE OF A POSSIBLE CONFLICT SITUATION COULD HAVE HAD MUCH MORE SERIOUS CONSEQUENCES. SUPPLEMENTAL INFO FROM ACN 174775: TWR CTLR MADE SEVERAL ATTEMPTS AT REQUESTING THE ACFT TO HOLD SHORT OF 13C WITH NO RESPONSE. THE LIGHT TWIN DID CROSS 13C. RED LIGHTING ALONG THE HOLD LIENS ON TXWYS MAY HELP AVOID SOME OF THESE PROBS.
SYNOPSIS: ACR MLG ABORTS TKOF ABOVE 100 KTS ON RWY 13C AT MDW FOR GA SMT Y CROSSING ACTIVE RWY WITHOUT CLRNC.
REFERENCE FACILITY ID:MDW
FACILITY STATE: IL
AGL ALTITUDE: 0.0

B-23

ACCESSION NUMBER: 177457
DATE OF OCCURRENCE: 9105
REPORTED BY: FLC; ; ; ; ;
PERSONS FUNCTIONS: FLC,FO; FLC,PIC.CAPT; FLC,PIC.CAPT; FLC, FO; TWR,LC;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:SFO
FACILITY STATE: CA
FACILITY TYPE: ARPT; TWR;
FACILITY IDENTIFIER: SFO; SFO;
AIRCRAFT TYPE: MLG; MLG;
ANOMALY DESCRIPTIONS: CONFLICT/NMAC; TRACK OR HDG DEVIATION; NON ADHERENCE LEGAL RQMT/CLNC; NON ADHERENCE LEGAL RQMT/PUBLISHED PROC;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: IN 5/91, WE EXPERIENCED A NEAR MISS BTWN 300 AND 200' AGL WHILE IN THE PROCESS OF LNDG AT SFO. WE WERE ACR X FLT FROM PIT, AN MLG X, AND THE OTHER ACFT WAS ACR Y FLT FROM LAX, ALSO AN MLG Y. WE WERE CLRED FOR THE QUIET BRIDGE APCH. WE CLEARLY HAD THE ARPT IN SIGHT. WE WERE ASSIGNED A SPD OF 170 KTS, WHICH WAS REDUCED TO 160 KTS JUST PRIOR TO BRIDGE. APCH POINTED OUT OUR TFC TO FOLLOW WAS A HEAVY, AND OUR LNDG "PARTNER" AN MLG Y FOR THE LEFT. APCH SAID THAT OUR SPD WAS TO PAIR US UP WITH PARALLEL TFC. I OFFSET SLIGHTLY TO THE E OF THE LOC TO AVOID THE HVT WAKE TURB, AND ALSO TO GIVE US PLENTY OF CLRNC WITH THE PARALLEL TFC. WE WERE ABEAM THE OTHER INSIDE OF BRIJJ. THE WIND WAS 280/23 AT 4000'. AT ABOUT 300', WE WERE STILL SLIGHTLY DISPLACED TO THE RIGHT OF THE LOC, FEELING A LITTLE CROWDED BY THE MLG Y JET, BUT STILL IN A COMFORTABLE PLACE TO LAND. I SAID TO THE CAPT, "HE'S GOING ABOVE G/S." HE THEN MADE A MOVE TO LINE UP WITH THE 28R. I TURNED MORE TO THE RIGHT TO AVOID HIM. THE CAPT THEN SAID ON THE RADIO, "TWR, CONFIRM THE LNDG RWY FOR ACR Y." THE RESPONSE WAS, "FOR 28L." AT ABOUT 200' THE ACR Y ACFT ADDED PWR, PULLED UP, AND BANKED SHARPLY TO THE LEFT. HE MANAGED TO LAND W/O INCIDENT ON THE LEFT. WE WERE ABLE TO MAINTAIN G/S THE WHOLE TIME, BUT WE WERE DISPLACED TO THE RIGHT OF THE LOC. THE CONTRIBUTING FACTORS WERE: 1) THE ACR Y PLTS SOMEHOW MISSED THEIR CLRNC TO THE LEFT RWY WAY BACK AT MENLO. 2) SINCE THE PLTS WERE BASED IN CHICAGO, PERHAPS THEY WEREN'T USED TO THE NORMAL OCCURRENCE OF PARALLEL TFC ON THE TIPTOE/QUIET BRIDGE APCHS. THE LOC FOR 28L (108.5) WAS NOTAMED OUT, SO HE MAY HAVE TALKED HIMSELF INTO A 28R LNDG BY TUNING IN 111.7--INITIALLY JUST FOR G/S, BUT THEN TRACKING THE LOC.
SYNOPSIS: CLOSE PROX 2 ACR MG ACFT ON VISUAL BRIGG APCH TO SFO AT NIGHT.
REFERENCE FACILITY ID:SFO

FACILITY STATE: CA
DISTANCE & BEARING FROM REF.: 1,281
AGL ALTITUDE: 300,300

B-24

ACCESSION NUMBER: 182661
DATE OF OCCURRENCE: 9107
REPORTED BY: FLC; ; ;
PERSONS FUNCTIONS: FLC,FO; FLC,PIC.CAPT; MISC,PAX;
FLIGHT CONDITIONS: IMC
REFERENCE FACILITY ID:DBN
FACILITY STATE: GA
FACILITY TYPE: ARTCC;
FACILITY IDENTIFIER: ZTL;
AIRCRAFT TYPE: MLG;
ANOMALY DESCRIPTIONS: IN-FLT ENCOUNTER/WX;
ANOMALY DETECTOR: OTHER;
ANOMALY RESOLUTION: NOT RESOLVED/DETECTED AFTER-THE-FACT;
ANOMALY CONSEQUENCES: INJURY;
NARRATIVE: WE WERE DSNDING FROM FL370 TO FL330 AND DEVIATING TO THE W TO AVOID A COUPLE OF TSTM CELLS. THE RIDE HAD BEEN SMOOTH. WE WERE IMC IN A CIRRUS DECK AND THERE WAS NO WX ON OUR RADAR EXCEPT FOR THE CELLS WE WERE GOING AROUND. WE WERE AVOIDING THEM BY ABOUT 25-30 MI. OTHER ACFT HAD ALSO DEVIATED W WITH NO RPTS OF TURB. THE VISIBILITY WAS POOR, BUT WE SUDDENLY SPOTTED A SMALL CUMULUS CLOUD ON OUR NOSE. WE TRIED TO TURN TO AVOID IT BUT WERE UNABLE. THERE HAD BEEN NO INDICATION OF THIS WX ON OUR RADAR SCOPE. THE CAPT HAD TURNED ON THE SEAT BELT SIGN PRIOR TO THIS. A PAX WAS IN THE AFT LAVATORY AT THIS TIME. WE ENCOUNTERED MODERATE TURB FOR ABOUT 10 SECONDS. THE PAX APPARENTLY SUFFERED A BROKEN LEG AND WAS MET BY PARAMEDICS AND COMPANY AGENTS IN ATLANTA.
SYNOPSIS: ACR MLG HIT THE TOP OF TSTM BUILD UP. PAX IN AFT

LAVATORY BROKE A LEG.
REFERENCE FACILITY ID:DBN
FACILITY STATE: GA
DISTANCE & BEARING FROM REF.: 25,180
MSL ALTITUDE: 34500,34500

B-25

ACCESSION NUMBER: 184839
DATE OF OCCURRENCE: 9107
REPORTED BY: FLC; ;
PERSONS FUNCTIONS: FLC,PLT; TWR,LC;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:OSH
FACILITY STATE: WI
FACILITY TYPE: TWR; TRACON;
FACILITY IDENTIFIER: OSH; OSH;
AIRCRAFT TYPE: SMA;
ANOMALY DESCRIPTIONS: ACFT EQUIPMENT PROBLEM/LESS SEVERE; OTHER;
ANOMALY DETECTOR: COCKPIT;
ANOMALY RESOLUTION: NOT RESOLVED/OTHER;
ANOMALY CONSEQUENCES: FLC/ATC REVIEW;
NARRATIVE: AFTER BEING HANDED OFF FROM CHICAGO CENTER TO OSHKOSH APCH, APCH SAID OUR TRANSMISSION WAS GARBLED AND ASKED US TO CHANGE FREQS. IN GOING FROM ONE RADIO TO THE OTHER THE RADIO SELECTOR KNOB ON THE AUDIO PANEL BROKE IN THE #3 POS, WHERE NO RADIO EXISTS. WE COULD HEAR APCH AND TWR OK BUT WE COULD NOT XMIT. DURING THE CONVENTION (JUST PRIOR) OSHKOSH AIRSPACE IS PANDEMONIUM - I ELECTED TO FOLLOW IFR RADIO OUT PROCS AND LAND VFR WITHOUT A LNDG CLRNC. NO CONFLICT OCCURRED. I COULD HEAR TWR ADVISING OTHER ACFT OF OUR NORDO SITUATION (BECAUSE WE WERE NOT ANSWERING THEM) AND

THAT THEY HOPED WE WOULD 'LAND SHORT' SO OTHERS COULD LAND LONG. AT THAT TIME I COULD NOT TELL IF TWR EVEN KNEW WE WERE IFR TFC. AFTER LNDG (VERY SHORT) BUT WELL ON THE APPROPRIATE SECTION OF THE RWY, WE IMMEDIATELY EXITED THE RWY ONTO THE GRASS AND I CALLED (AFTER TYING DOWN) GREEN BAY FSS TO CLOSE THE FLT PLAN (SINCE I DIDN'T THINK TWR WOULD DO IT) AND ASKED GREEN BAY TO CALL OSHKOSH TWR AND EXPLAIN WHAT HAPPENED - HE SAID HE WOULD. TENSE MOMENTS!

SYNOPSIS: SMA ON IFR FLT PLAN TO OSH HAS RADIO FAILURE.

CAN RECEIVE BUT NOT XMIT. FOLLOWS IFR RADIO OUT PROCS.

REFERENCE FACILITY ID:OSH

FACILITY STATE: WI

DISTANCE & BEARING FROM REF.: l,,E

AGL ALTITUDE: 0,800

B-26

ACCESSION NUMBER: 185329
DATE OF OCCURRENCE: 9108
REPORTED BY: FLC;
PERSONS FUNCTIONS: FLC,PLT; TWR,LC; FLC,PLT;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID: IPT
FACILITY STATE: PA
FACILITY TYPE: TWR;
AIRCRAFT TYPE: SMA; SMA;
ANOMALY DESCRIPTIONS: CONFLICT/NMAC;
ANOMALY DETECTOR: COCKPIT;
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;
ANOMALY CONSEQUENCES: FLC/ATC REVIEW;
NARRATIVE: AN SMA A FLOATPLANE, WAS INBOUND TO THE IPT VOR AT 3400 MSL, COURSE 010 MAGNETIC. SMA A CALLED THE TWR AT IPT 8.1 DME FROM THE VOR, INDICATING THE INTENTION TO CONTINUE INBOUND TO THE VOR AND DEPART NE TO N27. THE IPT TWR RESPONDED IN THE AFFIRMATIVE, REQUESTING A RPT WHEN N OF THE RWY CENTERLINE IF VISIBLE. IMMEDIATELY THEREAFTER, THE IPT TWR CLRED AN SMA B TO FLY A LOC APCH INTO IPT. THE SMA B RPTED 4000 MSL, DSNDING. UPON HEARING THE SMA B RPTING ITS POS AT 'PICTURE ROCKS', A TOWN MARKED ON THE VFR SECTIONAL, SMA A QUERIED THE SMA B DIRECTLY FOR ALT. THE SMA B REPLIED 3700 DSNDING. SMA A IMMEDIATELY BEGAN CIRCLING TO HOLD A POS S OF THE LOC UNTIL THE SMA B HAD PASSED, NOTIFYING THE TWR OF 'EVASIVE ACTION'. AFTER TURNING APPROX 110 DEG TO THE R, SMA A OBSERVED THE SMA B PASSING ABOUT 100 FT BELOW AND 300 FT N. SMA A THEN RESUMED ITS PROGRESS TOWARD THE VOR AND WAS NOTIFIED BY THE IPT TWR THAT THERE WAS NO TFC TO RPT. THE MAIN CONTRIBUTING FACTOR WAS THE ACTION OF THE IPT TWR CLRING 2 ACFT WITHIN ITS CTL ONTO A COLLISION COURSE. SMA A WAS CLRED TO CROSS THE LOC AT 3400 FT AT THE SAME TIME THE SMA B WAS CLRED TO CONDUCT A LOC APCH STARTING AT 4000 FT. THE RPTR FEELS THAT THE SMA B LOCATION WAS AS MUCH AS A MI S OF THE LOC APCH, NEGATING THE EFFECTIVENESS OF HIS HOLDING ACTION. THE DISCUSSION OF THE 'PICTURE ROCKS' INBOUND LOC WAYPOINT, WHICH WAS ON THE VFR SECTIONAL, ALERTED SMA A TO THE IMMINENT POTENTIAL FOR A COLLISION. EVASIVE ACTION BY SMA A PREVENTED A VERY NEAR MISS OR A POSSIBLE COLLISION. THE HUMAN PERFORMANCE OF THE IPT ATA CTLR FAILED TO ENHANCE THE ACFT SEPARATION WITHIN THE BOUNDS OF THE ATA. THE RPTR FEELS THAT THE TWR CTLR AT IPT DID NOT HAVE A PICTURE OF THE TFC WITHIN THE ATA. THE CTLR'S JUDGEMENT AND SUBSEQUENT INACTION, CREATED A VERY HAZARDOUS CIRCUMSTANCE. I FEEL THAT THE CTLR SHOULD HAVE DIRECTED SOME ACTION TO CREATE POSITIVE VERT OR HORIZ SEPARATION RATHER THAN SIMPLY LEAVING IT UP TO THE AIRCREWS INVOLVES TO PROVIDE SEPARATION VIA SEE-AND- AVOID. I RECOGNIZE THAT SEE--AND--AVOID IS A CONTINUING AIRCREW RESPONSIBILITY, BUT WHEN UNDER POSITIVE CTL IN AN ATA, THE CTLR IS EXPECTED TO HELP BY POSITIVE ACTIONS ENHANCING SEPARATION.
SYNOPSIS: SMA CLRED TO VOR AS SECOND ACFT CLRED FOR ILS APCH. NMAC.
REFERENCE FACILITY ID: IPT
FACILITY STATE: PA
DISTANCE & BEARING FROM REF.: 8,,SO
MSL ALTITUDE: 3300,3400

B-27

ACCESSION NUMBER: 188555
DATE OF OCCURRENCE: 9109
REPORTED BY: FLC;
PERSONS FUNCTIONS: FLC,PLT; FLC,PIC.CAPT; TWR,LC;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID: PDX
FACILITY STATE: OR
FACILITY TYPE: TWR; ARPT;
FACILITY IDENTIFIER: PDX; PDX;
AIRCRAFT TYPE: LRG; SMA;
ANOMALY DESCRIPTIONS: CONFLICT/AIRBORNE LESS SEVERE; OTHER; NON ADHERENCE LEGAL RQMT/PUBLISHED PROC;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: CTLR ISSUED NEW CLNC;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: I WAS WAITING FOR IFR DEP. WAS TOLD TO TAXI INTO POS AND HOLD RWY 28R. RIGHT AFTER THIS ACR X CHKED ON AND RPTED THAT HE WAS ON THE VISUAL FOR THE R. AFTER MORE THAN 1 MIN OF WAITING I TURNED MY ACFT (SMA Y) APPROX 40 DEG TO THE L. THIS ALLOWED ME BOTH TO SEE THE ARRIVING ACFT AND ALSO POS THE ACFT TOWARDS THE TURNOFF. AFTER I DID THIS I NOTICED ACR X WAS GETTING VERY CLOSE. I CONTACTED TWR, SAYING THAT I WAS STILL IN POS AND HOLD ON THE R. TWR CAME BACK WITH A VERY REAL SENSE OF URGENCY AND TOLD ME TO TURN L AND EXIT THE RWY IMMEDIATELY. FORTUNATELY I WAS ALREADY FACING TOWARDS THAT DIRECTION AND QUICKLY GOT OFF THE RWY. I ESTIMATE THAT LESS THAN 1 1/2 SECONDS PASSED BTWN ME XING THE HOLD LINE EXITING THE RWY AND ACR X XING THE THRESHOLD. SHADES OF LAX CROSSED MY MIND. AFTER THIS I WAS AGAIN TOLD TO TAXI INTO POS AND HOLD, AND DEP WAS UNEVENTFUL. I FEEL THAT POS AND HOLD GAINS CTLRS VERY LITTLE WITH SMALL PLANES AND THAT IT SHOULD NEVER BE USED UNLESS DEP IS ENSURED IN A VERY TIMELY FASHION (LESS THAN 30 SECS). I HATE TO THINK WHAT WOULD HAVE HAPPENED IF I HAD NOT BEEN LISTENING TO THE RADIO AND NOTICED THE OTHER PLANE COMING IN. I MIGHT ADD THAT THE TWR FREQ WAS NOT VERY BUSY AT THE TIME. I THINK THE CTLR JUST FORGOT ABOUT ME.
SYNOPSIS: SMA TOLD TO TAXI INTO POS AND HOLD. CTLR CLRED AN ACR TO LAND ON THE RWY AND FORGOT ABOUT THE SMA. SMA ADVISED THE TWR BEFORE AN INCIDENT OCCURRED.
REFERENCE FACILITY ID:PDX
FACILITY STATE: OR
AGL ALTITUDE: 0,0

ACCESSION NUMBER: 190783
DATE OF OCCURRENCE: 9110
REPORTED BY: FLC; ; ; ;
PERSONS FUNCTIONS: FLC,FO; FLC,PIC.CAPT; TRACON,DC; FLC, PIC.CAPT;
FLIGHT CONDITIONS: IMC
REFERENCE FACILITY ID:MCI
FACILITY STATE: MO
FACILITY TYPE: TRACON; ARPT;
FACILITY IDENTIFIER: MCI; MCI;
AIRCRAFT TYPE: MLG; ;
ANOMALY DESCRIPTIONS: LESS THAN LEGAL SEPARATION; OTHER; ALT DEV/OVERSHOOT ON CLB OR DES; NON ADHERENCE LEGAL RQMT/PUBLISHED PROC;
ANOMALY DETECTOR: COCKPIT/FLC; COCKPIT/EQUIPMENT;
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: DEPARTED RWOl. SWITCHED AS ASSIGNED TO WORK DEP ON 126.6, ASSIGNED HDG AND CLB TO 7000 FT, ALSO, GIVEN TFC AT 7000 OPPOSITE DIRECTION XYZ AIRLINER. AT ABOUT THE SAME TIME THE CTLR CALLED THE TFC AT 2 O'CLOCK DSNDING TO 7000. WE SPOTTED SUSPECT ACFT ON TCASII AT 10 O'CLOCK. XYZ TFC WAS ALSO ISSUED 2 O'CLOCK TFC (SUPPOSEDLY OUR ACFT) CLBING TO 6000. WELL, WE WOULD HAVE BEEN AT XZY'S 10 O'CLOCK AS WELL AND HAD JUST BEEN ASSIGNED 7000. A TFC ALERT WAS RECEIVED, THE CTLR SAID 'MLG MAINTAIN 6000' AS WE VERBALLY QUESTIONED OUR ASSIGNED ALT TO 6000, AS WOULD HAVE BEEN EXPECTED IF THE CTLR KNEW WHERE WE WERE. WHEN THE CTLR REALIZED THERE MAY BE AN ERROR/CONFLICT, HE ISSUED US A L TURN, WHICH WOULD HAVE AGGRAVATED THE SITUATION, AS TARGET ACFT WAS ON TCASII TA AT 10 O'CLOCK AND CLOSING. CAPT RAISED FLT SPOILERS, TURNED ABOUT 30 DEG R, AND WENT DOWN TO 6000. NO RA WAS PRESENT, BUT THANK GOD WE HAD TCASII, BECAUSE WITHOUT IT WE WOULD HAVE TURNED DIRECTLY INTO THE PATH OF THAT INBOUND, OPPOSITE DIRECTION AIRLINER.
SYNOPSIS: ACR ISSUED CLB TO 7000 FT WHEN CHANGED TO DEP FREQ. TAKES EVASIVE ACTION WHEN TCASII TA INDICATES TFC AND CTLR CALLS TFC AT SAME ALT.
REFERENCE FACILITY ID:MCI
FACILITY STATE: MO
DISTANCE & BEARING FROM REF.: 10,,N
MSL ALTITUDE: 6000,7000

ACCESSION NUMBER: 193844
DATE OF OCCURRENCE: 9111
REPORTED BY: FLC;
PERSONS FUNCTIONS: FLC,FO; FLC,PIC.CAPT; FLC,PLT; MISC,FSS;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID: BTM
FACILITY STATE: MT
FACILITY TYPE: ARPT; FSS;
FACILITY IDENTIFIER: BTM; BTM;
AIRCRAFT TYPE: LTT; SMA;
ANOMALY DESCRIPTIONS: CONFLICT/GROUND CRITICAL; UNCTRLED ARPT TRAFFIC PATTERN DEVIATION; NON ADHERENCE LEGAL RQMT/FAR;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: WE WERE LNDG AT BTM. WE WERE ADVISED THAT THE ACTIVE RWY WAS 33 BUT THERE WAS AN ACFT DOING TOUCH AND GOES ON 15 WHO WAS COMMUNICATING BUT COULD NOT HEAR. HE ANNOUNCED HE WAS DOWNWIND FOR 15 WHEN WE WERE ON FINAL FOR 33 THAT WAS THE LAST WE HEARD FROM HIM. WE DID NOT SEE HIM UNTIL WE WERE BOTH ON THE GND HDG AT EACH OTHER. WE BRAKED HARD AND WERE STOPPED WITHIN 1500 FT OF HIM.
SYNOPSIS: GND CONFLICT BTWN COMMUTER LTT AND A GA SMA LNDG OPPOSITE DIRECTION.
REFERENCE FACILITY ID:BTM
FACILITY STATE: MT
AGL ALTITUDE: 0,0

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ADVISORY PLI ELEMENTS: Correct Transmission, Incorrect Action

ACCESSION NUMBER:129866
DATE OF OCCURRENCE: 8911
REPORTED BY: FLC;
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; MISC,GNDCREW;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:BWI
FACILITY STATE: MD
FACILITY TYPE: ARPT; TWR;
FACILITY IDENTIFIER: BWI; BWI;
AIRCRAFT TYPE: MLG;
ANOMALY DESCRIPTIONS: IN-FLT ENCOUNTER/OTHER; ACFT EQUIPMENT PROBLEM/CRITICAL;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: NOT RESOLVED/UNABLE;
ANOMALY CONSEQUENCES: ACFT DAMAGED;
NARRATIVE: RIGHT AFTER LIFTOFF ON RWY 28, I ENCOUNTERED A LARGE FLOCK OF SEA GULLS. I HEARD ONE STRIKE THE ACFT AND CONTINUED THE TKOF, MONITORING THE ENG INSTRUMENTS CLOSELY. I HAD THE F/O TELL THE TWR ABOUT THE LARGE FLOCK OF BIRDS. AFTER SWITCHING TO DEP CTL, WE CLBED EXPEDITIOUSLY THROUGH HIS AIRSPACE, WAS HANDED OFF TO ZDC AND CLRED TO FL250. ONLY THEN WAS CLB PWR REDUCED, AT WHICH TIME THE #2 ENG VIBRATION INDICATOR WENT FROM LESS THAN 1 TO 3-4. I ELECTED TO STAY AT FL250 AND CALLED COMPANY MAINT CTL. WE AGREED I SHOULD DIVERT, SO I LANDED AT GSO W/O FURTHER INCIDENT. POSTFLT INSPECTION REVEALED NUMEROUS BIRD STRIKES, INCLUDING SEVERAL #2 ENG FIRST STAGE FAN BLADES DAMAGED AND A LARGE DENT IN THE #2 ENG COWL. THIS INCIDENT COULD HAVE HAD DISASTROUS CONSEQUENCES.THE BIRDS MUST HAVE FLOWN JUST AT ROTATION, AND ONLY BY ROTATING HIGHER THAN NORMAL WAS I ABLE TO MISS THE MAJORITY OF THEM (I THOUGHT I HAD HIT ONLY 1). A PLT WHO HAD JUST LANDED RPTED THE FLOCK OF BIRDS AS I WAS IN THE TKOF ROLL, BUT EITHER HE DIDN'T SPECIFY THEIR EXACT LOCATION OR DIDN'T HEAR IT. MORE TIMELY AND SPECIFIC INFO MIGHT HAVE LED TO DIFFERENT ACTIONS ON MY PART.
SYNOPSIS: ACR MLG BIRD STRIKE ON TKOF FROM BWI. NOT INDICATED ENGINE PROBLEM UNTIL POWER REDUCED TO CLIMB, THEN ENGINE VIBRATION CAUSED FLT CREW TO CALL COMPANY MAINTENANCE AND SUBSEQUENTLY DIVERT TO ALTERNATE.
REFERENCE FACILITY ID:BWI
FACILITY STATE: MD
AGL ALTITUDE: 50,100

ACCESSION NUMBER:160210
DATE OF OCCURRENCE: 9010
REPORTED BY: FLC;
PERSONS FUNCTIONS: FLC,PLT; FLC,PLT;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:SEZ
FACILITY STATE: AZ
FACILITY TYPE: ARPT;
FACILITY IDENTIFIER: SEZ;
AIRCRAFT TYPE: SMA; SMA;
ANOMALY DESCRIPTIONS: CONFLICT/AIRBORNE LESS SEVERE; UNCTRLED ARPT TRAFFIC PATTERN DEVIATION; OTHER; NON ADHERENCE LEGAL RQMT/FAR;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: NOT RESOLVED/DETECTED AFTER-THE-FACT;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: THE INCIDENT OCCURRED AT SEDONA ARPT. TFC WAS LNDG UPHILL ON RWY 03 AND DEPARTING DOWNHILL ON RWY 21. I WAS DEPARTING SEDONA. I TAXIED FROM PARKING TO RWY 21, COMPLETED MY PREFLT AND WAS READY TO DEPART. I HAD BEEN MONITORING THE CTAF AND DIDN'T HEAR ANY ACFT IN THE PATTERN. I ANNOUNCED MY INTENTION TO DEPART SEZ ON RWY 21 AND TAXIED ONTO THE RWY. I DIDN'T SEE ANY TFC APCHING. AS I TAXIED ONTO THE RWY, I HEARD AN ACFT ANNOUNCE IT WAS TURNING BASE FOR RWY 03. INSTEAD OF HOLDING AT THE END OF THE RWY, I BEGAN MY TKOF ROLL, THINKING I WOULD BE OFF AND CLB OUT OVER THE PATH OF THE LNDG ACFT. THE OTHER ACFT HEARD/SAW ME AND EXECUTED A GO-AROUND, TURNING R OUT OF THE DEP PATH. BECAUSE OF THE OTHER PLT'S EVASIVE ACTION, OUR 2 ACFT REMAINED AT SAFE DISTANCES. BUT I SHOULD HAVE YIELDED THE RIGHT-OF-WAY TO THE LNDG ACFT. (LNDG ACFT WAS A HIGH FIXED WING GA ACFT). CONTRIBUTING FACTORS. I HAD JUST COMPLETED MY AFR AFTER NOT FLYING AT ALL FOR 2 YRS; MY HEAD WORK WAS RUSTY. I WAS TIRED, HAD NOT SLEPT WELL THE NIGHT BEFORE. THE SITUATION OF TFC LNDG AND DEPARTING IN OPP DIRECTIONS IS UNUSUAL. ONCE I TOOK THE RWY, I FELT COMMITTED TO TKOF, A BAD JUDGEMENT. WHAT WOULD HAVE PREVENTED THE CONFLICT. I SHOULD HAVE ASKED UNICOM FOR A TFC ADVISORY BEFORE TAXIING ONTO THE RWY, AND LOOKED MORE CAREFULLY FOR TFC IN THE PATTERN. I ALSO COULD HAVE WAITED A FEW MOMENTS AFTER ANNOUNCING MY INTENTION TO DEPART ON THE CTAF TO SEE IF ANY OTHER ACFT ANNOUNCED THEIR POSITIONS IN THE PATTERN. I COULD HAVE HELD AT THE END OF THE RWY FOR THE ARRIVING TFC TO LAND AND CLR THE RWY. ANOTHER PREVENTION, GIVEN THE UNUSUAL TFC PATTERN, WOULD HAVE BEEN TO ANTICIPATE AND DECIDE AHEAD OF TIME WHAT SAFE/UNSAFE CONDITIONS FOR TAKING OFF (VIS-A-VIS OTHER LCL TFC POSITIONS). FINALLY, NOT FLYING WHEN TIRED, IT DID SEEM TO AFFECT MY JUDGEMENT.
SYNOPSIS: CLOSE PROX GA SMA ON TKOF FROM RWY 21 AND GA SMA IN LNDG PATTERN FOR RWY 03.
REFERENCE FACILITY ID:SEZ
FACILITY STATE: AZ
DISTANCE & BEARING FROM REF.: ,,SW
AGL ALTITUDE: 0,500

ACCESSION NUMBER:181915
DATE OF OCCURRENCE: 9106
REPORTED BY: FLC;
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; FLC,PLT; TWR,LC;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:HPN
FACILITY STATE: NY
FACILITY TYPE: TWR;
FACILITY IDENTIFIER: HPN;
AIRCRAFT TYPE: SMA;
ANOMALY DESCRIPTIONS: CONFLICT/NMAC; NON ADHERENCE LEGAL RQMT/PUBLISHED PROC;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: NOT RESOLVED/UNABLE;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: DEPARTED 6N4 ENRTE HPN. RECEIVED THE ATIS AT ABOUT 12 NM FROM HPN (THEY WERE LNDG 34 AND 29). I CALLED HPN TWR AT 10 NM SW OF HPN AND REQUESTED THE SIERRA RTE, LNDG AT THE MAIN TERMINAL. HPN GAVE US A TRANSPONDER CODE AND CLRED US TO PROCEED INBOUND ON THE SIERRA RTE. RADIO TFC WAS VERY HVY, SO WE HAD NO FURTHER CONTACT WITH HPN TWR UNTIL I RPTED CPR X APCHING S BOUNDARY. WE WERE AT 1400 MSL PER ESTABLISHED PROC. (AN SMA WAS MOVING FROM OUR L TO R.) THE SMA WAS NOT A FACTOR, BUT I THOUGHT IT MAY HAVE LOOKED LIKE A PROBLEM FROM THE TWR. IT IS COMMON PRACTICE CALL POS AT THE ARPT BOUNDARY. TWR RESPONDED TO OUR POS RPT, 'DO YOU HAVE THE SMA ON GAR?' I DID NOT HEAR ANY REF TO RWY FROM WHICH THE GAR WAS BEING EXECUTED. I HESITATED MOMENTARILY IN REPLYING IN ORDER TO SCAN FOR THE GAR TFC. I DID NOT SEE IT. BEFORE I COULD ANSWER, OTHER RADIO TFC MADE MY REPLY IMPOSSIBLE. DURING MY VISUAL SEARCH, I SAW A LIGHT AIRPLANE MOVING ALONG, OR SLIGHTLY ABOVE, RWY 34 JUST SHORT OF 29. WE WERE NOW ABOUT OVER THE DEP END OF 29. I THOUGHT THIS LIGHT AIRPLANE MIGHT BE THE GAR TFC, BUT WAS UNSURE. STILL CONCERNED AND UNCERTAIN, I HAD RECEIVED NO FURTHER COM FROM THE TWR. I ANNOUNCED 'CPR X OVERHEAD AT 1 POINT 4.' ALMOST IMMEDIATELY THEREAFTER WE SAW THE BELLY OF SMA Y, CLBING THROUGH OUR ALT (1400 MSL) IN WHAT APPEARED TO BE A L BANK IN EXCESS OF 60 DEG IN HIS SUCCESSFUL EFFORT TO AVOID US. WE WERE, AT THAT TIME, ABOUT 1/4 MI NW OF THE INTXN OF 34 AND 29. I MAKE THE FOLLOWING OBSERVATIONS. IT SEEMS THE TWR WAS HAVING SOME DIFFICULTY IN COPING WITH THE HVY TFC, AS WE HAD NO COM WITH TWR FOLLOWING OUR INITIAL CONTACT/CLRNC UNTIL WE CALLED THEM AT THE ARPT BOUNDARY. NO TA'S WERE ISSUED UNTIL THE QUESTION 'DO YOU HAVE SMA Y ON GAR?' NO FURTHER TA'S WERE ISSUED AT ANY TIME THEREAFTER -- TO US THAT IS. I WAS NOT AWARE OF THE GAR IN PROGRESS, ALTHOUGH I PROBABLY SHOULD HAVE BEEN, AS THE OTHER PLT WITH ME SAID HE HEARD EARLIER REF TO A GAR, BUT DID NOT HEAR ANY REF TO WHICH RWY WAS INVOLVED. IMPROVED COM IN THE COCKPIT MAY HAVE HELPED. AFTER LEARNING OF THE GAR, I TOOK NO EVASIVE ACTION, AS I DID NOT KNOW WHERE THE ACFT WAS THAT I WANTED TO AVOID. I CONTINUED STRAIGHT AHEAD AND ANNOUNCED MY POS SO AS TO BE SURE MY LOCATION WAS KNOWN, WHICH SEEMED ESPECIALLY IMPORTANT

SINCE I DIDN'T KNOW WHERE THE OTHER GUY WAS. I THINK IT MAY HAVE BEEN APPROPRIATE TO HAVE ISSUED US INSTRUCTIONS TO CLR THE AIRSPACE CONFLICTING WITH THE GAR. I WOULD RESTATE, HOWEVER, THAT I AM

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(REPORT CONTINUED)

WELL AWARE THAT THE TWR WAS VERY BUSY, WITH A HIGH VOLUME OF TFC, AND COMS WERE A PROBLEM, GIVEN THE RADIO CONGESTION. ALTHOUGH IT MAY HAVE HAD NO IMPACT ON THIS PARTICULAR SITUATION, I SEE SOMEWHAT OF A PROBLEM WITH HAVING HELIS ENTERING ON FLT PATHS WHICH CROSS FIXED WING TFC PATTERNS WITH ONLY 100 FT VERT SEPARATION IN THE INTEREST OF NOISE ABATEMENT. IN SUMMARY, WE COULD, I THINK, HAVE BENEFITTED FROM MORE POSITIVE CTL OF THE AIRSPACE, MORE TA'S, AND PERHAPS LESS CONFLICTING TFC FLOWS. ALSO, MORE SITUATIONAL AWARENESS ON MY PART, WHICH COULD HAVE RESULTED FROM A MORE DILIGENT MONITORING OF THE RADIO AND MORE EFFECTIVE CREW COM WOULD HAVE BEEN MOST HELPFUL.

SYNOPSIS: CPR X HAD NMAC IN TFC PATTERN WITH SMA Y. SEE AND AVOID CONCEPT.

REFERENCE FACILITY ID:HPN

FACILITY STATE: NY

DISTANCE & BEARING FROM REF.: 0

MSL ALTITUDE: 1400,1400

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ACCESSION NUMBER:199428
DATE OF OCCURRENCE: 9201
REPORTED BY: LC;
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; FLC,PIC.CAPT; MISC,UNICOM;
FLIGHT CONDITIONS: IMC
REFERENCE FACILITY ID:ILN
FACILITY STATE: OH
FACILITY TYPE: ARPT; TRACON;
FACILITY IDENTIFIER: ILN; DAY;
AIRCRAFT TYPE: MLG; HVT;
ANOMALY DESCRIPTIONS: CONFLICT/GROUND LESS SEVERE; RWY TRANSGRESS/OTHER; NON ADHERENCE LEGAL RQMT/FAR;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: NOT RESOLVED/DETECTED AFTER-THE-FACT;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: FLT WAS CLRED FOR APCH ILS TO RWY 22 AT ILN BY DAYTON APCH CTL AND TOLD TO 'CONTACT ADVISORY'. MY FLT ROGERED THE CLRNC AND CALLED AIRBORNE UNICOM AND RPTED 'AIRBO INBOUND RWY 22 WILMINGTON.' THE FLT WAS GIVEN LCL ALTIMETER AND WIND FROM AIRBORNE TWR. WHEN MY FLT LANDED MY FO AND I NOTICED AN HVT TURNING OFF AT THE FAR END OF THE 10700 FT RWY. NEITHER OF US SAW THE AIRPLANE ON THE RWY DURING LNDG, DUE TO THE TAIL LIGHT OF THE HVT BLENDING IN WITH THE CENTERLINE LIGHTS, UNTIL THE HVT TURNED SIDEWAYS TO US AND HE WAS TURNING OFF THE FAR END OF THE RWY. THE 'ADVISORY TWR' DID NOT MENTION THE HVT WAS STILL ON THE RWY WHEN WE MADE CONTACT WITH THEM AT THE AIRBO OM. PRIOR TO REACHING AIRBO WE DID HEAR THE HVT CANCEL HIS IFR FLT PLAN WITH DAYTON APCH. WHEN I QUESTIONED THE ADVISORY ABOUT THE HVT BEING ON THE RWY AND TELLING ADVISORY I DIDN'T KNOW THE HVT WAS STILL ON THE RWY OR SEE IT UNTIL IT TURNED OFF, I WAS TOLD 'THEY WERE ONLY AN 'ADVISORY' AND THEY DIDN'T SEE THE HVT ON THE RWY EITHER.' CONTRIBUTING FACTORS WERE: I HEARD THE HVT CANCEL HIS IFR WITH DAYTON APCH WHEN I WAS MORE THAN 7 MI FROM TOUCHDOWN. IN THE TIME FRAME OF BEING CLRED FOR THE ILS APCH BY DAYTON APCH AND CONTACTING AIRBORNE ADVISORY AT AIRBO INBOUND I FIGURED THE HVT WOULD HAVE BEEN OFF THE RWY. NOTHING WAS SAID TO MAKE ME THINK OTHERWISE. FROM NOW ON I WILL ASK ADVISORY IF THE RWY IS CLRED.
SYNOPSIS: ACR MLG FRT ACFT LANDED ON AN OCCUPIED RWY AT NIGHT AT A NON TWR ARPT.
REFERENCE FACILITY ID:ILN
FACILITY STATE: OH
AGL ALTITUDE: 0,1077

ADVISORY PLI ELEMENTS: Incorrect Transmission, Correct Action

ACCESSION NUMBER:163786
DATE OF OCCURRENCE: 9011
REPORTED BY: FLC;
PERSONS FUNCTIONS: FLC,PLT; FLC,PLT;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:TIW
FACILITY STATE: WA
FACILITY TYPE: ARPT;
FACILITY IDENTIFIER: TIW;
AIRCRAFT TYPE: SMA; SMA;
ANOMALY DESCRIPTIONS: CONFLICT/NMAC; UNCTRLED ARPT TRAFFIC PATTERN DEVIATION;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: SOME LOW STRATUS AND GND FOG WAS BEGINNING TO FORM IN THE AREA, BUT IT WASN'T A DIRECT FACTOR IN THE INCIDENT. THE TWR WAS CLOSED, SO I CALLED ON THE CTAF 8 MI OUT THAT I WAS INBND FOR STRAIGHT IN TO RWY 17. ON APPROX 4 MI FINAL ANOTHER ACFT CALLED OVER THE OM INBND ON LOW APCH. I COULD SEE ANOTHER ACFT (OR SO I THOUGHT) APPROX 3/4 MI AHEAD OF ME ON A SOMEWHAT ERRATIC APCH, BUT I COULDN'T SEE THE ACFT I ASSUMED WAS BEHIND ME THAT HAD CALLED THE OM. I KEPT UP CRUISE SPD TO PUT DISTANCE BTWN ME AND THE ACFT DOING THE ILS. I DID A COUPLE OF S-TURNS TO MAKE MYSELF MORE VISIBLE AND TO TRY TO SPOT THE PHANTOM ACFT BEHIND ME. I THEN REALIZED WHAT WAS HAPPENING. I HAD FIXED ON THE THOUGHT THAT I COULD BE RUN DOWN FROM BEHIND, WHEN ALL THE TIME THE ACFT I WAS LOOKING FOR WAS THE ONE IN FRONT OF ME. THIS REALIZATION TOOK THE FORM OF AN ACFT SILHOUETTE APPROX 50' ABOVE AND 100' AHEAD OF ME. I HAD ALMOST CAUGHT UP WITH HIM. I DID A 360 DEG TURN TO THE LEFT, AND WHEN I ROLLED OUT ON FINAL AGAIN, THE OTHER ACFT WAS JUST BEGINNING HIS MISSED APCH, COMPLETING UNAWARE OF HOW CLOSE HE CAME TO BECOMING A BIPLANE. CONTRIBUTING FACTORS TO THIS WERE FATIGUE ON MY PART, A CONCERN FOR THE GROWING AREAS OF STRATUS AND GND FOG THAT WERE FORMING, AND A FAILURE ON MY PART TO USE A STANDARD PATTERN ENTRY INSTEAD OF DOING A STRAIGHT-IN. A THOUGHT, FOR FUTURE REF, WOULD BE THAT WHEN DOING IFR PRACTICE APCHS, THE PLT OR INSTR SHOULD CALL ACTUAL POS WHEN ON CTAF, RATHER THAN WHERE THEY WERE 30 SECS OR MIN AGO.
SYNOPSIS: CLOSE PROX 2 GA SMA'S IN TRAFFIC TO TIW.
REFERENCE FACILITY ID:TIW
FACILITY STATE: WA
DISTANCE & BEARING FROM REF.: l,,N
MSL ALTITUDE: 700,700

ACCESSION NUMBER:166711
DATE OF OCCURRENCE: 9012
REPORTED BY: FLC;
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; FLC,SO; TWR,LC; MISC,DRIVER;
FLIGHT CONDITIONS: IMC
REFERENCE FACILITY ID:LGA
FACILITY STATE: NY
FACILITY TYPE: TWR; TRACON; ARPT;
FACILITY IDENTIFIER: LGA; N90; LGA;
AIRCRAFT TYPE: LRG;
ANOMALY DESCRIPTIONS: CONFLICT/GROUND CRITICAL; RWY TRANSGRESS/OTHER; NON ADHERENCE LEGAL RQMT/CLNC; NON ADHERENCE LEGAL RQMT/PUBLISHED PROC;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION; FLC EXECUTED GAR OR MAP;
ANOMALY CONSEQUENCES: FLC/ATC REVIEW;
NARRATIVE: ON SHORT FINAL, CLRED TO LAND, ILS 4 AT LGA, HAD TO GO AROUND AT LESS THAN 100' AGL BECAUSE OF SNOW REMOVAL EQUIP -IN THE T/D ZONE. RETURNED FOR ANOTHER APCH AND LANDED W/O INCIDENT. WX FOR THE APCH WAS AT MINIMUMS WITH BLOWING SNOW, FOG, WINDSHEAR ALERT. PARTIALLY SNOW COVERED RWY, AND NO PREVIOUS BRAKING ACTION RPTS. DURING THE APCH WE HEARD SEVERAL CONVERSATIONS BTWN APCH/TWR AND THE LEADER OF THE SNOW REMOVAL TEAM. TWR ADVISED THE SNOW TEAM OF OUR POS AND REQUESTED THEY GET OFF THE RWY FOR OUR LNDG. APPROX 4 MI FROM T/D THE SNOW TEAM LEADER RPTED TO TWR THAT INDEED HE WAS IN RADIO CONTACT WITH ALL THE VEHS AND THAT ALL THE VEHS WERE CLR OF RWY 4. TWR THEN CLRED US TO LAND. APPROX 2 MI FROM T/D WE THOUGHT WE SAW A STROBE LIGHT IN THE R EDGE LIGHTS ADJACENT TO THE T/D ZONE. AT LESS THAN 100' AGL WITH BLOWING SNOW OBSCURRING MOST GND FEATURES WE SPOTTED A YELLOW STATION WAGON WITH STROBE LIGHT IN THE MIDDLE OF THE T/D ZONE. GO AROUND INITIATED WITH THE ACFT DSNDING TO APPROX 50' OVER SAID FLEEING STATION WAGON. I DID NOT HAVE A CHANCE TO DISCUSS THIS WITH THE CTLR AFTER LNDG. RECOMMENDATIONS: FOR CTLR/ATC, NONE, HE DID EVERYTHING HE COULD TO ENSURE THE RWY WAS CLR. FOR SNOW REMOVAL EQUIP, ENSURE STROBES ON (IT WAS THE ONLY THING THAT KEPT US FROM LNDG ON TOP OF THE VEH) AND ALL VEHS EQUIPPED WITH RADIOS TUNED TO TWR AND TEAM LEADER (IE, TWO RADIOS). OUR COMPANY FLT SAFETY OFFICE DISCUSSED THIS EVENT WITH THE LGA TWR AND ARPT MGRS. IT WAS RECOMMENDED THAT PROCS BE PUT IN PLACE AT LGA TO HAVE TWR SOLICIT EARLIER ETA OF KNOW INBNDS DURING SNOW REMOVAL OPS TO PREPARE SNOW REMOVAL TEAM TO CLR RWY AND THAT ALL VEHS ON TEAM IS ACCOUNTED FOR WHEN CLRING; ALSO THAT TEAM LEADER NOT NORMALLY LEAVE THE RADIO POST W/O POSITIVE XFER TO ANOTHER LEADER.
SYNOPSIS: CARGO LGT SPOTTED VEHICLE ON RWY AND MADE A GO AROUND. TWR NOTIFIED AND SUBSEQUENT MEETINGS HELD BETWEEN TWR ACR ARPT MGR.
REFERENCE FACILITY ID:LGA
FACILITY STATE: NY
AGL ALTITUDE: 50,100

ADVISORY PLI ELEMENTS: Incorrect Transmission, Incorrect Action

None Reported

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INSTRUCTIONAL PLI ELEMENTS: Correct Transmission, Correct Action

ACCESSION NUMBER:76961
DATE OF OCCURRENCE: 8710
REPORTED BY: FLC;
PERSONS FUNCTIONS: FLC,PIC.CAPT; TRACON,AC;
FLIGHT CONDITIONS: IMC
REFERENCE FACILITY ID:IAD
FACILITY STATE: VA
FACILITY TYPE: ARPT; TRACON;
FACILITY IDENTIFIER: IAD; IAD;
AIRCRAFT TYPE: WDB;
ANOMALY DESCRIPTIONS: OTHER;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: NOT RESOLVED/UNABLE;
ANOMALY CONSEQUENCES: FLC/ATC REVIEW;
SITUATION REPORT SUBJECTS: PROC OR POLICY/ATC FACILITY;
NARRATIVE: LETDOWN IN IMC CONSISTING OF SOLID STRATO-CUMULUS CLOUDS TOGETHER WITH RAINSHOWERS, EXTENSIVE RADAR VECTORS WERE RECEIVED. INBND TFC CONSISTED OF A VARIETY OF ACFT INCLUDING GA, COMMUTER AND AIRLINE TRANSPORTS. ALL WERE BEING CTLED FOR APCHS TO RWY lR AT IAD. WX WAS RPTED AS 300-400 OVERCAST 1 1/2 MI VIS IN FOG AND RAIN. APCHING FROM THE W SOME CONCERN WAS VOICED BY OUR CREW REGARDING THE EXTENSIVE VECTORS WHICH WE WERE RECEIVING AND CONSISTED OF HDGS OF 110, 120, 180 AND 070 DEGS THROUGH THE LOCALIZER FOLLOWED BY A 90 DEG TURN TO 340 DEGS TO INTERCEPT THE 010 DEG LOCALIZER COURSE, ALL WITHIN ABOUT 17 NM OF THE ARPT. ON APCH AT ABOUT 800' WE WERE ADVISED THAT THERE WAS AN ACFT STILL ON THE RWY AND TO GAR. A LONG EXTENDED DOWNWIND VECTOR WAS GIVEN E OF THE AIRFIELD HDG S. WE WERE ASKED TO MAINTAIN A VERY SLOW 190 KTS AND LATER 170 KTS, WHICH CAUSED A MUCH GREATER FUEL BURN. APPROX ABEAM THE OM, WE WERE ADVISED THAT WE WERE #6 FOR APCH. THE VECTOR TOOK US SOME 17 NM S OF THE ARPT AND CONSUMED ABOUT 15-20 MINS TIME. OUR TURN TO FINAL WAS BEHIND AN SMT WITH A RPTED GND SPD OF 90 KTS. AS WE APCHED THE OM THE CTLR BEGAN TO BECOME CONCERNED AND ADVISED US THAT OUR AIRSPD WAS 60 KTS, FASTER THAN THE PRECEEDING ACFT. THEN WITHIN A FEW MI OF THE OM, WE WERE ASKED IN A SOMEWHAT FRENZIED MANNER, IF WE COULD TAKE RWY lL! THIS CAME AS AN UNEXPECTED SHOCK. WE HAD BRIEFED AND PLANNED FOR RWY lR APCH AND WITH THE HIGH WORKLOAD IN IMC TOGETHER WITH SOME ACFT IRREGULARITIES, A SUDDEN SHIFT TO ANOTHER RWY WAS VERY PERPLEXING AND DIFFICULT TO HANDLE. WE WERE ABLE TO ADEQUATELY ACCOMMODATE THE REQUEST, BUT IT WAS VERY DISTRACTING AND DEGRADED THE OPERATION FROM BEING AS SAFETY EFFICIENT AS IT COULD HAVE BEEN. A DIVERSION TO OUR ALTERNATE WOULD HAVE BEEN REQUIRED HAD WE BEEN UNABLE TO ADJUST TO THE SITUATION. LATER THE OPERATION WAS DISCUSSED WITH THE APCH CTL SUPVR AND WE WERE NOT SATISFIED WITH THE PROBABLE REASONS FOR THE PROBLEMS, SUCH AS WIND SHEARS AT DIFFERENT LEVELS CAUSING DIFFICULTY IN SPACING ACFT, ETC. THERE SEEMS TO BE A MUCH BROADER PROBLEM THAT MAY NOT BE APPARENT TO THOSE VERY NEAR THE ISSUES, SUCH AS THE SUPVR. THESE ISSUES MAY VERY WELL INVOLVE THE SUDDEN GROWING UP OR COMING OF AGE OF DULLES INT'L ARPT AND THE DRAGGING

(REPORT CONTINUED)

BEHIND OF MANY IMPORTANT ASPECTS OF TOP NOTCH, CRISP AND HIGHLY PROFESSIONAL SVCS THAT SHOULD BE SUPPORTING THIS ARPT TODAY, INCLUDING LCL ATC RADAR SVCS AND THE WAY THEY DO BUSINESS. I HAD ADDED 4000# OVER AND BEYOND COMPANY/DISPATCH PLANNING. THIS PROVED TO BE THE MARGIN NECESSARY TO AVOID AN ALTERNATE OPERATION IN THIS INSTANCE. WHY WAS IT NECESSARY TO INITIALLY BE VECTORED BY SUCH LARGE HDG CHGES (1 TOTAL REVERSAL OVERALL WAS 200 DEGS AND INCLUDING A PERPENDICULAR VECTOR THROUGH THE LOCALIZER SO CLOSE TO THE ARPT? AFTER OUR ORIGINAL MISSED APCH, WHY DID THE NEW CTLR THAT VECTORED US BACK FOR ANOTHER APCH NOT HAVE INFO THAT WE WERE A MISSED APCH ACFT? THIS FACTOR WAS REVEALED BY THE APCH CTL SUPVR AND WOULD HAVE BEEN A VITAL CONSIDERATION TO THE NEW CTLR REGARDING POSSIBLE LOW FUEL CONSIDERATIONS AND SPACING ON PRECEEDING ACFT, SO AS TO INSURE AS MUCH AS POSSIBLE A COMPLETED LNDG ON THE SECOND ATTEMPT. OUR FUEL USED DURING THIS MISSED APCH, VECTOR AND NEW APCH WAS ABOUT 4000-4500#. WHAT HUMAN FACTOR ISSUES CAME INTO PLAY THAT CAUSED THE FINAL CTLR TO POS OUR ACFT IN SUCH A MANNER THAT A SECOND GAR WOULD HAVE BEEN NECESSARY NEAR THE lR OM, DUE TO OUR RAPIDLY OVERTAKING VERY SLOW PRECEEDING ACFT? WAS THERE ADDITIONAL AIRSPACE TO MANEWER THAT OUR FLT COULD HAVE USED? COULD LOW CTLR EXPERIENCE LEVELS IN THE CTL OF A MIX OF ACFT REQUIRING RELATIVELY SLOW TO HIGH MANEUVER AND APCH SPDS HAVE BEEN A FACTOR? MORE ADVANCE NOTICE FOR RWY CHGES UNDER SUCH CIRCUMSTANCES IS ESSENTIAL FOR THE HIGHEST SAFETY AND OPERATIONAL EFFICIENCIES. WHAT GUIDLINES ARE NORMAL, PRACTICAL AND IN THE BEST INTEREST OF SAFETY, WHEN DECIDING TO SUDDENLY SWITCH RWYS UNDER SUCH CIRCUMSTANCES. FINALLY, IF TFC AT DULLES IS INCREASING TO SUCH AN EXTENT THAT EXTENSIVE VECTORING IS BECOMING NECESSARY, WOULD IT NOT BE REASONABLE THAT THE N/S APCHS BE UPGRADED TO ACCOMMODATE SIMULTANEOUS INSTRUMENT APCHS? IN THIS REGARD, WOULD IT NOT BE FURTHER BENEFICIAL TO PREDOMINANTLY ASSIGN GA AND SLOW COMMUTER AND AIR TAXI ACFT TO 1 RWY WHILE THE OTHER RWY HANDLES BUSINESS JETS AND AIR TRANSPORT ACFT?

SYNOPSIS: COMPLAINT ABOUT APCH CTLR HANDLING AT IAD. WX WAS IMC AND GO AROUND ISSUED AT 800' DUE ACFT STILL ON RWY.

REFERENCE FACILITY ID:IAD
FACILITY STATE: VA
DISTANCE & BEARING FROM REF.: 3,,SO
MSL ALTITUDE: 800,3000

ACCESSION NUMBER:85529
DATE OF OCCURRENCE: 8804
REPORTED BY: FLC;
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; FLC,PIC.CAPT; TWR, GC; TWR,LC;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:BOS
FACILITY STATE: MA
FACILITY TYPE: TWR; ARPT;
FACILITY IDENTIFIER: BOS; BOS;
AIRCRAFT TYPE: LRG; SMT;
ANOMALY DESCRIPTIONS: OTHER; CONFLICT/GROUND LESS SEVERE; LESS THAN LEGAL SEPARATION;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: OTHER;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: GND CTL CLRED US TO CROSS 4L AND CONTACT TWR ON OTHER SIDE. WE ACKNOWLEDGED THE CLRNC AND INITIATED THE TAXI. WE DID NOT OBSERVE A LNDG ACFT WHICH WAS ON L TURN TO FINAL UNTIL OUR ACFT WAS ON THE RWY. POSSIBLY DUE TO THE ANGLE OF THE APCHING ACFT AND OUR VANTAGE POINT. F/O CALLED ATTENTION TO APCHING ACFT, AT SAME TIME AS CAPT OBSERVED SAME. AS THE ACFT COMPLETED ITS TURN TO FINAL, CAPT APPLIED ADDITIONAL PWR TO FURTHER EXPEDITE CROSSING. CALLBACK CONVERSATION WITH RPTR REVEALED THE FOLLOWING INFO: OTHER ACFT WAS AN SMT ON APCH TO RWY 4L AND WAS ON A CLOSE PATTERN. RPTR THINKS THE SMT FLEW A MUCH TIGHTER BASE AND FINAL THAN GND CTLR HAD EXPECTED. AT A LATER DATE HE WAS ON A HARBOR CRUISE AND SAW AN SMT DO THE SAME THING WITH A VERY TIGHT PATTERN. THE SMT DID NOT GO AROUND, IN FACT, LGT GOT ON TWR FREQ IN TIME TO HEAR LCL CTLR TELL SMT OK TO LAND THAT THE RWY WAS CLR SO SMT AND TWR WERE ALL AWARE OF SITUATION AND READY TO TAKE ALTERNATE ACTION.
SYNOPSIS: ACR LGT CLEARED ACROSS ACTIVE WITH ACR SMT ON CLOSE IN CIRCLING APCH WITH LESS THAN GOOD SEPARATION.
REFERENCE FACILITY ID:BOS
FACILITY STATE: MA
AGL ALTITUDE: 0,0

ACCESSION NUMBER:100348
DATE OF OCCURRENCE: 8812
REPORTED BY: FLC;
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; TWR,LC;
FLIGHT CONDITIONS: IMC
REFERENCE FACILITY ID:TPA
FACILITY STATE: FL
FACILITY TYPE: TRACON; TWR; ARPT;
FACILITY IDENTIFIER: TPA; TPA; TPA;
AIRCRAFT TYPE: MLG;
ANOMALY DESCRIPTIONS: OTHER;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: NOT RESOLVED/ANOMALY ACCEPTED;
ANOMALY CONSEQUENCES: FLC/ATC REVIEW;
NARRATIVE: APCH CTL TURNED US OVER TO TWR. WE CALLED WITH NO RESPONSE FROM TWR. WE WERE ON INSTRUMENTS INSIDE THE OM. WE CALLED AGAIN; NO LUCK. WE CALLED GND CTL; NO LUCK. WE CALLED APCH CTL AGAIN; NO LUCK. WE THEN CALLED THE TWR AGAIN; NO LUCK. I THEN CALLED THE TWR AND SAID, "IF YOU READ ME, GIVE ME A LIGHT." STILL NO LUCK. AT THIS TIME AN ACR FLT ANSWERED MY CALL AND SAID THEY READ US AND THAT TWR WAS OFF THE AIR. WE NOW HAD RWY 36 IN SIGHT AND I LANDED W/O CLRNC. ALL THE ABOVE OCCURRED IN LESS THAN A MINUTE. I ELECTED TO LAND AS I HAD RWY 36 IN SIGHT. NO ACFT WERE ON THE RWY AND A GAR WOULD HAVE PUT ALL MISSED APCH ACFT AT THE SAME MISSED APCH FIX AND AT THE SAME ALT WITH NO ATC CTL, AS IT WAS THEIR RADIOS THAT WERE CUT. AFTER LNDG, CONTACT WAS MADE WITH GND CTL WHO TOLD ME THAT A MASTER SWITCH WAS SHUT OFF, TURNING OFF TWR, APCH AND GND CTL.
SYNOPSIS: UNABLE TO CONTACT TWR FOR LNDG CLRNC.
REFERENCE FACILITY ID:TPA
FACILITY STATE: FL
DISTANCE & BEARING FROM REF.: 5,,SO
MSL ALTITUDE: 2000,2000

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ACCESSION NUMBER: 102921
DATE OF OCCURRENCE: 8901
REPORTED BY: FLC; ; ;
PERSONS FUNCTIONS: FLC,FO; FLC,PLT; TWR,LC;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:SJC
FACILITY STATE: CA
FACILITY TYPE: ARPT; TWR; TWR;
FACILITY IDENTIFIER: SJC; SJC; SJC;
AIRCRAFT TYPE: LTT; SMA;
ANOMALY DESCRIPTIONS: CONFLICT/NMAC; NON ADHERENCE LEGAL RQMT/CLNC;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: OUR ACFT POS AND HOLD RWY 30L SJC. AN SMA WAS CLRED FOR TKOF RWY 30R AND TOLD TO TURN LEFT BEHIND DEPARTING LTT. WE WERE CLRED TO DEPART AND WERE TOLD BY TWR THAT THE DEPARTING SMA WOULD TURN BEHIND US. THE OTHER ACFT WAS AIRBORNE BEFORE WE STARTED OUR TKOF ROLL. THE SMA WAS AGAIN TOLD TO TURN BEHIND US, "THE LTT." THE PLT APPARENTLY BECAME CONFUSED AND TURNED INTO US. I ADVISED THE CAPT LOUDLY OF THE CLOSING TFC. ADVISED A RIGHT TURN AND APPLIED PRESSURE TO THE FLT CONTROLS TO AVOID COLLISION. THE OTHER PLT MAY HAVE MISTAKEN THE LIGHTS OF A MUCH LARGER JET A FEW MI OFF THE DEP END FOR OUR AIRPLANE. THE AVERAGE PLT SHOULD NOT BE EXPECTED TO IDENT SPECIFIC ACFT TYPES IN THE DARK! ALSO, IT WAS A BUSY NIGHT AT SJC. TFC WAS CONSTANTLY ARRIVING AND DEPARTING OFF THE LEFT RWY. IN MY OPINION, TFC REQUESTING A LEFT TURN OFF THE RIGHT RWY UNDER THESE CONDITIONS SHOULD BE ISSUED A CLRNC FOR A RIGHT 270 DEG CLBING TURN OVERHEAD. A MORE TIMELY DEP FOR EITHER ACFT WOULD HAVE SOLVED THE PROB. MORE SPECIFIC PHRASEOLOGY BY THE TWR DIRECTED TO THE SMA MAY HAVE HELPED ALSO. I AM THANKFUL THE TWR INFORMED US BOTH DIRECTLY AND INDIRECTLY (WE COULD HEAR THE TWR CALL THE SMA) OF THE SMA'S INTENTIONS. AFTER BEING SO ALERTED, I WATCHED THE TFC CLOSELY THROUGHOUT THE TKOF. HAD I NOT BEEN CONCENTRATING ON THE SMA LIGHTS, THE SMA SLOW TURN MIGHT HAVE BEEN IMPERCEPTIBLE WITH PERIPHERAL VISION. THE PIC DID NOT SEE THE TFC BEFORE I CALLED IT. I BELIEVE WE WOULD HAVE HIT THE AIRPLANE W/O EVASIVE ACTION.
SYNOPSIS: CLOSE PROX CPR-LTT GA-SMA DURING ICB FROM PARALLEL RWYS.
REFERENCE FACILITY ID:SJC
FACILITY STATE: CA
AGL ALTITUDE: 0 500

ACCESSION NUMBER: 104390
DATE OF OCCURRENCE: 8902
REPORTED BY: FLC; DISP;
PERSONS FUNCTIONS: FLC,PIC.CAPT; MISC,DISP;
FLIGHT CONDITIONS: IMC
REFERENCE FACILITY ID:PIT
FACILITY STATE: PA
FACILITY TYPE: ARPT; TWR;
FACILITY IDENTIFIER: PIT; PIT;
AIRCRAFT TYPE: MLG; LTT;
ANOMALY DESCRIPTIONS: CONFLICT/NMAC; LESS THAN LEGAL SEPARATION;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;
ANOMALY CONSEQUENCES: OTHER;
NARRATIVE: 28C TKOF WITH CLRNC, "TURN LEFT TO HDG 200 DEGS." CAME IN CONFLICT WITH TWIN ENG PROP WHO HAD MISSED APCH ON 28L. ROLLED OUT OF TURN BACK TOWARD RWY HDG AND INFORMED TWR. WE HEARD THE OTHER ACFT CALL MISSED APCH AND RECEIVE INSTRUCTIONS TO CLB TO 3000'/RWY HDG. WE SAW THE ACFT CONFLICTING WITH OUR COURSE AND TOOK APPROPRIATE ACTION. WE PASSED WITHIN 200'. SUPPLEMENTAL INFO FROM ACN 104402: OUR CREW UNDERSTOOD THE TWR TO HAVE GIVEN THE LIGHT ACFT A MISSED APCH PROC OF MAINTAIN RWY HDG TO 3000'. OUR CREW DID TELL THE TWR, HOWEVER, THEY DIDN'T SEEM TO THINK THERE WAS A PROB.
SYNOPSIS: CLOSE PROX ACR-MLG GA-LTT IN PIT ATA.
REFERENCE FACILITY ID:PIT
FACILITY STATE: PA
DISTANCE & BEARING FROM REF.: l,,W
AGL ALTITUDE: 450,500

ACCESSION NUMBER:109866
DATE OF OCCURRENCE: 8904
REPORTED BY: FLC;
PERSONS FUNCTIONS: FLC,ISTR; FLC,PLT; TWR,LC;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:BMI
FACILITY STATE: IL
FACILITY TYPE: ARPT; TWR;
FACILITY IDENTIFIER: BMI; BMI;
AIRCRAFT TYPE: SMA; SMA;
ANOMALY DESCRIPTIONS: CONFLICT/NMAC;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: FLC EXECUTED GAR OR MAP;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: ON AN INSTRUMENT FLT PLAN WAS HANDED OFF FROM PEORIA, IL, APCH TO BMI TWR, AND TOLD RPT MISIE INBND TO BMI TWR. WE WERE CLRED TO LAND UPON RPTING MISIE. I HEARD THE CTLR (BMI TWR) CLR AN SMA X TO LAND AND AN SMA Y TO DEPART. I HAD A VIS ON THE DEPARTING TFC, BUT NO VIS ON THE SMA X. MY STUDENT WAS CENTERED ON THE ILS AND WAS TRACKING IT WELL SO I COULD SCAN FOR TFC. ABOUT 1700' MSL THE SMA X APPEARED AT 2 O'CLOCK AND APPROX 1/8 OF A MI. THE SMA X APPEARED TO HAVE SEEN US AND WAS RUSHING TO GET IN FRONT OF US. THE SMA X THEN TURNED IN FRONT OF US AND CONFIGURED FOR A LNDG AT WHICH TIME I CALLED A GO AROUND AND TOOK THE ACFT FROM THE STUDENT. IT SEEMS TO ME THAT THE SMA PLT WAS IN A HURRY TO GET IN FRONT OF OUR ACFT WHICH WAS SLOWED UP IN AN IFR APCH CONFIGN (STABILIZED AT 90 KTS). THE SMA X PLT'S PERFORMANCE INDICATED A LACK OF PLANNING OR SAFETY.
SYNOPSIS: CLOSE PROX GA-SMA ON PRACTICE ILS APCH AND GA-SMA ENTERING TRAFFIC PATTERN.
REFERENCE FACILITY ID:BMI
FACILITY STATE: IL
DISTANCE & BEARING FROM REF.: l,,E
MSL ALTITUDE: 1700,1700

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ACCESSION NUMBER:112175
DATE OF OCCURRENCE: 8905
REPORTED BY: FLC;
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; TWR,LC;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:OMA
FACILITY STATE: NE
FACILITY TYPE: ARPT; TWR;
FACILITY IDENTIFIER: OMA; OMA;
AIRCRAFT TYPE: SMT; SMT;
ANOMALY DESCRIPTIONS: CONFLICT/NMAC;
ANOMALY DETECTOR: COCKPIT/FLC; ATC/CTLR;
ANOMALY RESOLUTION: FLC EXECUTED GAR OR MAP; CTLR ISSUED NEW CLNC;
ANOMALY CONSEQUENCES: NONE;
SITUATION REPORT SUBJECTS: PROC OR POLICY/ATC FACILITY;
NARRATIVE: THE F/O WAS CONDUCTING A VIS APCH TO RWY. "FLAPS FULL" WERE CALLED FOR AT THE APPROPRIATE TIME--LNDG A-SYRED. THE LCL CTLR THEN CLRED ANOTHER SCHEDULED ACR (COMMUTER) FOR TKOF W/O DELAY ON RWY 35. THE DEP ACFT WAS NOT YET AT THE RWY ENTRANCE AND STILL HAD AN ESTIMATED 50' TO THE RWY. THE OTHER PLT ACKNOWLEDGED HIS DEP CLRNC. I COMMENTED TO MY F/O THAT THIS WAS NOT GOING TO WORK AND ADVISED HIM TO BE PREPARED FOR A GAR. OUR APCH WAS CONTINUED UNTIL WE WERE OVER THE APCH END OF THE RWY 100'. I ANTICIPATED THE LCL CTLR TO CANCEL TKOF CLRNC OF THE OTHER ACFT. INSTEAD WE WERE INSTRUCTED TO GO AROUND WITH NO SPECIFIC INSTRUCTIONS. THE F/O INITIATED THE PROC, I INDICATED FOR HIM TO TURN RIGHT TO 350 DEGS SO THAT I COULD KEEP IN VIEW THE OTHER ACFT. THE OTHER ACFT WAS AIRBORNE BEAM THE TWR AS WERE WE. WE WERE LIMITED TO TURNING FURTHER RIGHT BECAUSE OF THE ELEVATED TERRAIN. THIS HAS NOT BEEN THE FIRST TIME AT OMA--JUST THE CLOSEST!! IT HAS TO STOP, REGARDLESS OF TRNING (ATC) OR OTHERWISE.
SYNOPSIS: CLOSE PROX COMMUTER SMT ON SHORT FINAL AND COMMUTER SMT ON TKOF ROLL.
REFERENCE FACILITY ID:OMA
FACILITY STATE: NE
AGL ALTITUDE: 100,400

ACCESSION NUMBER 115635
DATE OF OCCURRENCE: 8907
REPORTED BY: FLC; ; ; ;
PERSONS FUNCTIONS: FLC,FO; FLC,PIC.CAPT; FLC,PLT; TWR,LC; VMC
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:GEB
FACILITY STATE: WA
FACILITY TYPE: ARPT; TWR;
FACILITY IDENTIFIER: GEG; GEG;
AIRCRAFT TYPE: MLG; SMA;
ANOMALY DESCRIPTIONS: CONFLICT/GROUND CRITICAL;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: FLC EXECUTED GAR OR MAP;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: WE WERE CONDUCTING A VISUAL APCH TO RWY 3, CLEARED TO LAND. A LIGHT ACFT WAS CLEARED TO LAND ON INTERSECTING RWY 7 "HOLD SHORT OF RWY 3". THE SMA DOVE FOR THE THRESHOLD AND WAS IN MARGINAL CONTROL OF ACFT AND IT APPEARED VERY DOUBTFUL THAT HE COULD, IN FACT, HOLD SHORT OF RWY 3. WE EXECUTED A MISSED APCH TO AVOID PROBABLE COLLISION.
SYNOPSIS: ACR MLG MADE GO AROUND TO AVOID SMA THEY THOUGHT WOULD NOT BE ABLE TO HOLD SHORT OF INTERSECTING RWY.
REFERENCE FACILITY ID:GEB
FACILITY STATE: WA
DISTANCE & BEARING FROM REF.: l,,SW
AGL ALTITUDE: 400,400

ACCESSION NUMBER:121909
DATE OF OCCURRENCE: 8909
REPORTED BY: FLC;
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; TWR,LC;
FLIGHT CONDITIONS: MXD
REFERENCE FACILITY ID:CLE
FACILITY STATE: OH
FACILITY TYPE: ARPT; TWR;
FACILITY IDENTIFIER: CLE; CLE;
AIRCRAFT TYPE: ; ;
ANOMALY DESCRIPTIONS: CONFLICT/GROUND LESS SEVERE; OTHER; LESS THAN LEGAL SEPARATION;
ANOMALY DETECTOR: ATC/CTLR; COCKPIT/FLC;
ANOMALY RESOLUTION: FLC EXECUTED GAR OR MAP; CTLR ISSUED NEW CLNC;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: WE WERE MAKING AN INSTRUMENT APCH TO CLEVELAND 23L AND WERE ASKED TO SIDESTEP TO THE 23R. THE WX ON THE APCH DID NOT ALLOW US TO SIDESTEP BECAUSE OF A HEAVY RAIN STORM. WE COULD NOT SEE EITHER RWY. THE TWR HAD TAXIED ACR Y ONTO 23L FOR TKOF, THEY THEN DECIDED THAT I WOULD NOT BE ABLE TO SIDESTEP SO THEY ASKED ACR Y TO TAXI OF 23L. I HEARD ON THE RADIO WHAT WAS GOING ON AND AS I CAME INTO THE CLEAR I SAW ACR Y WAS TURNING TO CLEAR THE RWY. AT THIS TIME I LEVELED OFF ABOVE DECISION HEIGHT AND STARTED TO MAKE A GO AROUND. I WAS WAITING FOR THE TWR TO ORDER A GO AROUND, BUT THEY NEVER DID. AS I CONTINUED ON THE GO AROUND AND FLEW OVER ACR Y, THE TWR THEN SAW I WAS CLEAR, SO THEY THEN GAVE ME ORDERS TO LAND ON 23L. WX DID NOT PERMIT ME TO SIDESTEP. ACFT WAS TAXIED INTO POSITION FOR TKOF BEFORE THEY KNEW I COULD SIDESTEP. TWR CTLR WAS A TRAINEE.
SYNOPSIS: COMMUTER ACFT MADE GO AROUND WHEN THEY WERE UNABLE TO SIDESTEP TO PARALLEL RWY AS CLEARED.
REFERENCE FACILITY ID:CLE
FACILITY STATE: OH
DISTANCE & BEARING FROM REF.: 2,,NE

ACCESSION NUMBER:142265
DATE OF OCCURRENCE: 9004
REPORTED BY: FLC;
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; FLC,PLT; TWR,LC;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:BTV
FACILITY STATE: VT
FACILITY TYPE: TWR; ARPT;
FACILITY IDENTIFIER: BTV; BTV;
AIRCRAFT TYPE: MLG; SMA;
ANOMALY DESCRIPTIONS: CONFLICT/NMAC; NON ADHERENCE LEGAL RQMT/CLNC;
ANOMALY DETECTOR: COCKPIT/FLC; ATC/CTLR;
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION; CTLR INTERVENED;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: WAS IN POS AND HOLDING FOR TKOF ON RWY 33 AT BTV. LIGHT ACFT WAS IN THE PATTERN ON RWY 01 DOING LEFT PATTERNS. AFTER LIGHT ACFT COMPLETED HIS TOUCH AND GO ON RWY 01, HE WAS GIVEN CLRNC FOR ANOTHER PATTERN WITH A RIGHT TURN TO A RIGHT BASE, AND WE WERE CLRED FOR TKOF WITH THE COPLT MAKING THE TKOF. AS WE WERE PASSING 100 KTS I NOTICED THE LIGHT ACFT MAKING A LEFT TURN TOWARD THE DEP END OF OUR RWY AT AN ALT OF 400-500' AGL. AS WE WERE MOVING RAPIDLY AND I HAD CLR VIS CONTACT, I NOTIFIED THE F/O OF THE PROB, TOLD HIM TO CONTINUE AND MAKE A VERY SHALLOW CLBOUT. AS WE LIFTED OFF TWR NOTIFIED THE LIGHT ACFT OF THIS WRONG TURNAND VERIFIED THAT WE HAD VIS SEP. WE PASSED DIRECTLY UNDERNEATH THE OTHER ACFT BY ABOUT 200'. IF VIS CONTACT HAD NOT BEEN ESTABLISHED, A MIDAIR WOULD HAVE BEEN A HIGH PROBABILITY. FROM MY OBSERVATION POINT, ALL PARTIES WERE COMPLYING WITH STANDARD PROCS, UP TILL THE TIME THAT THE LIGHT ACFT TURNED TO A LEFT INSTEAD OF RIGHT BASE. I SUSPECT TRNING WAS GOING ON AND BEING A QUIET SUNDAY MORNING THE OTHER ACFT WAS USED TO LEFT TURNOUTS AND UNCONSCIOUSLY CONTINUED IN ITS ESTABLISHED ROUTINE. FORTUNATELY FOR US, IT WAS A CLEAR DAY AND WE SAW THE OTHER ACFT WITH PLENTY OF TIME TO SPARE. THERE IS ALSO A STRONG POSSIBILITY THAT TWR'S CALL WOULD ALSO HAVE HELPED US IF WE HAD NOT NOTICED THE OTHER ACFT A FEW SECS EARLIER. THE KEY HERE WAS SITUATIONAL AWARENESS. WE WERE VERY MUCH AWARE OF THE OTHER ACFT WITH TWR, HOWEVER THE OTHER PARTY NOT ONLY MADE A WRONG TURN, BUT ALSO THE CLR FOR TKOF CALLS ON RWY 33 WHICH SHOULD HAVE WARNED HIM THAT TURNING THAT WAY AT 500' AGL WOULD BE A PROB.
SYNOPSIS: SMA PLT DID NOT COMPLY WITH INSTRUCTIONS FROM TWR LCL CTLR. HE TURNED LEFT DOWNWIND INSTEAD OF A RIGHT DOWNWIND PATTERN. PREVIOUS PATTERN WAS LEFT DOWNWIND--HOWEVER, TWR CHANGED TO RIGHT PATTERN TO ALLOW THE MLG TO DEPART TO THE NORTHWEST. RIGHT DOWNWIND WOULD HAVE TAKEN THE SMA BEHIND THE DEP.
REFERENCE FACILITY ID:BTV
FACILITY STATE: VT
DISTANCE & BEARING FROM REF.: l,,NW
MSL ALTITUDE: 200,200

B--49

ACCESSION NUMBER:142920
DATE OF OCCURRENCE: 9004
REPORTED BY: FLC;
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,PIC.CAPT; TWR,LC;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:EWR
FACILITY STATE: NJ
FACILITY TYPE: TWR;
FACILITY IDENTIFIER: EWR;
AIRCRAFT TYPE: LRG; LRG;
ANOMALY DESCRIPTIONS: CONFLICT/AIRBORNE LESS SEVERE;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION; FLC EXECUTED GAR OR MAP;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: ACR X TKOF WAS BEING MADE ON RWY 4R AT EWR. ACR Y HAD PREVIOUSLY BEEN CLRED TO LAND ON RWY 29 AT SAME ARPT. THE 2 DESCRIBED RWYS DO NOT INTERSECT, SO NO PROB WAS ANTICIPATED. ALL MEMBERS OF THE CREW WERE AWARE OF AND MONITORING THE DEVELOPMENT OF THE SITUATION. THE TKOF WAS CONTINUED. JUST AFTER LIFTOFF ACR Y ANNOUNCED HE WAS GOING AROUND. AT 150' OF ALT, BOTH ACFT MADE STEEP LEFT TURN TO AVOID EACH OTHER.
SYNOPSIS: ACR X HAD AIRBORNE CONFLICT LESS SEVERE WITH ACR Y IN ATA.
REFERENCE FACILITY ID:EWR
FACILITY STATE: NJ
DISTANCE & BEARING FROM REF.: 0
MSL ALTITUDE: 150,150

B-50

ACCESSION NUMBER: 190584
DATE OF OCCURRENCE: 9110
REPORTED BY: FLC; FLC; ; ; ;
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; FLC,SO; FLC, PIC.CAPT; TRACON, DC;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:LAX
FACILITY STATE: CA
FACILITY TYPE: ARPT; TRACON;
FACILITY IDENTIFIER: LAX; LAX;
AIRCRAFT TYPE: WDB;
ANOMALY DESCRIPTIONS: TRACK OR HDG DEVIATION; NON ADHERENCE LEGAL RQMT/CLNC;
ANOMALY DETECTOR:OTHER; COCKPIT/FLC;
ANOMALY RESOLUTION: FLC RETURNED ACFT TO ORIGINAL CLNC OR INTENDED COURSE;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: CLRED TO TURN TO HDG 235 DEG AT SHORELINE MAINTAIN 2000 FT ON A LOOP 8 DEP. AT ABOUT 900 FT TCASII ALARM -- TFC, TFC SOUNDED TWICE, NO ACFT IN SIGHT. TURNED TO HDG 235 DEG AND WAS CHANGED TO DEP CTL AND AS SOON AS THE FREQ WAS SET CTLR GAVE HDG OF 160 DEG CLB TO 13000. FO ACKNOWLEDGED, READ BACK CLRNC. L TURN WAS BEGUN AND THE FLT, WHO WE WERE FOLLOWING, ASKED WHO THE CLRNC WAS FOR AND DEP RESPONDED THAT IT WAS FOR THEM. WE STOPPED THE TURN AT 210 DEG AND RETURNED TO THE ASSIGNED HDG AND CONTINUED THE DEP. ALTHOUGH IT IS NOT USUAL TO GET A CLRNC FOR A TURN THAT EARLY, I THOUGHT THAT THEY MAY BE TURNING US TO CLR THE TFC ON TCASII.
SYNOPSIS: ACR WDB TRACK HDG DEV ON SID OUT OF LAX.
REFERENCE FACILITY ID:LAX
FACILITY STATE: CA
DISTANCE & BEARING FROM REF.: 2,,W
MSL ALTITUDE: 900,2000

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ACCESSION NUMBER: 196903
DATE OF OCCURRENCE: 9112
REPORTED BY: FLC; ; ;
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; ARTCC,RDR;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:LMN
FACILITY STATE: IA
FACILITY TYPE: ARTCC;
FACILITY IDENTIFIER: ZMP;
AIRCRAFT TYPE: LTT;
ANOMALY DESCRIPTIONS: ALT DEV/EXCURSION FROM ASSIGNED; NON ADHERENCE LEGAL RQMT/CLNC;
ANOMALY DETECTOR: ATC/CTLR;
ANOMALY RESOLUTION: CTLR INTERVENED;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: I UNDERSTOOD CTLR ISSUE US A DSCNT FROM 15000 TO 11000. INSTRUCTED FO (PNF) TO REQUEST 7000 FT. ATC TOLD US TO STANDBY. I THEN BEGAN DSCNT TO 11000 FT. APPROX 13000 FT ATC ASKED US IF WE HAD BEGUN DSCNT. FO RESPONDED WE WERE DSNDING TO 11000 AS PREVIOUSLY INSTRUCTED. ATC INFORMED US THAT DSCNT INSTRUCTION WAS FOR ANOTHER COMPANY FLT, WHOSE FLT NUMBER WAS THE NUMBER WE HAD USED ON OUR IMMEDIATELY PRECEDING FLT. SINCE THAT FLT WAS ON ANOTHER FREQ, WE DID NOT HEAR A RESPONSE THAT WOULD HAVE CLUED US THAT IT WAS NOT OUR INSTRUCTION. I SHOULD HAVE EITHER WAITED FOR ATC TO REINSTRUCT US, OR ASKED IF THE TRANSMISSION WAS FOR US OR NOT.
SYNOPSIS: TOOK DSCNT CLRNC MEANT FOR ANOTHER ACFT.
REFERENCE FACILITY ID:LMN
FACILITY STATE: IA
MSL ALTITUDE: 13000,15000

B-78

ACCESSION NUMBER: 204663
DATE OF OCCURRENCE: 9203
REPORTED BY: FLC; ; ;
PERSONS FUNCTIONS: FLC,FO; FLC,PIC.CAPT; TWR,LC;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:DEN
FACILITY STATE: CO
FACILITY TYPE: ARPT; TWR;
FACILITY IDENTIFIER: DEN; DEN;
AIRCRAFT TYPE: MLG;
ANOMALY DESCRIPTIONS: TRACK OR HDG DEVIATION; NON ADHERENCE LEGAL RQMT/CLNC;
ANOMALY DETECTOR: ATC/CTLR;
ANOMALY RESOLUTION: FLC RETURNED ACFT TO ORIGINAL CLNC OR INTENDED COURSE; CTLR INTERVENED; CTLR ISSUED NEW CLNC;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: DEN TWR CLRED US ON TO HOLD 35L. WE WAITED APPROX 5 MINS FOR TKOF CLRNC. OUR INITIAL CLRNC WAS DENVER-l SID (RWY HDG 10000 FT). TWR GAVE INSTRUCTIONS TO AT LEAST 4 OTHER ACFT (DEPARTING 35L AND R) TO MAINTAIN 7500 FT AND 010 DEG HDG. WHEN WE WERE CLRED FOR TKOF, I THOUGHT I HEARD TWR SAY 010 DEG 7500 FT AFTER TKOF, TURNED 20 DEG R TO 010 DEGS. TWR THEN QUERIED AND TOLD US TO TURN BACK TO 350 DEG 7500 FT. NO CONFLICTS. THINK TWR SHOULD CLR US RWY HDG 7500 FT IN THIS SITUATION DUE TO THE LARGE NUMBER OF PREVIOUS ACFT BEING ISSUED 010 DEG HDG. THIS WOULD HELP TREMENDOUSLY, BECAUSE I WAS PROBABLY UNDER THE PRECONCEIVED MINDSET OF A 010 DEG HDG.
SYNOPSIS: HDG TRACK DEV IN NON ADHERENCE TO AN ATC CLRNC INSTRUCTION.
REFERENCE FACILITY ID:DEN
FACILITY STATE: CO
DISTANCE & BEARING FROM REF.: l,,N
AGL ALTITUDE: 1000,1000

B-79

ACCESSION NUMBER: 210241
DATE OF OCCURRENCE: 9205
REPORTED BY: FLC; ; ;
PERSONS FUNCTIONS: FLC,PLT; FLC,PLT; TRACON,AC;
FLIGHT CONDITIONS: MXD
REFERENCE FACILITY ID:SLI
FACILITY STATE: CA
FACILITY TYPE: TRACON; ARPT;
FACILITY IDENTIFIER: SNA; FUL;
AIRCRAFT TYPE: SMT; SMA;
ANOMALY DESCRIPTIONS: RWY OR TXWY EXCURSION; RWY TRANSGRESS/OTHER;
ANOMALY DETECTOR: COCKPIT/FLC; ATC/CTLR;
ANOMALY RESOLUTION: CTLR INTERVENED;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: I WAS MAKING THE VOR APCH TO FULLERTON AND WAS BEING VECTORED TO FINAL BY COAST APCH. I WAS AT 3000 ASSIGNED ND HAD JUST BEEN GIVEN APCH CLRNC AND A TURN TO FINAL. I BEGAN THE TURN AS NORMAL AT WHICH TIME THE CTLR REQUESTED A GOOD RATE OF TURN. I IMMEDIATELY DISENGAGED THE AUTOPLT AND ROLLED INTO A 45 DEG TURN. DURING THIS APCH PERIOD I HEARD ANOTHER ACFT ALSO ON FREQ. THE SMA Y WAS ALSO AT 3000 AND BEING VECTORED FOR THE APCH. I BELIEVED HIM TO BE TO THE NW OF MY POS ALTHOUGH HE WAS NEVER GIVEN AS TFC. I WAS BTWN LAYERS, BUT DID NOT SEE ANY TFC. I COMPLETED THE APCH AND LNDG WITHOUT INCIDENT. WHILE ON THE RAMP I WAS APCHED BY THE PLT OF THE SMA Y, HE APPEARED VERY SHAKEN. HE INDICATED THAT WE HAD MISSED COLLIDING BY ABOUT 200-500 FT WHILE I WAS TURNING TO FINAL. HE THOUGHT THAT I HAD SEEN HIM AND TURNED SHARPLY TO AVOID HIM. I WAS NOT AWARE HE WAS THERE. HE DID NOT SEE ME UNTIL HE SAW THE BELLY OF THE SMT X IN THE TURN. WE WERE BOTH IFR AND NEITHER OF US HAD BEEN GIVEN THE OTHER AS TFC.
SYNOPSIS: SMA PLT ALLEGES THAT HE HAD AN NMAC WITH SMT WHILE ON APCH TO FUL ARPT, BOTH ACFT ON IFR FLT PLANS.
REFERENCE FACILITY ID:SLI
FACILITY STATE: CA
DISTANCE & BEARING FROM REF.: 3,20
MSL ALTITUDE: 3000,3000

B-80

ACCESSION NUMBER: 217637
DATE OF OCCURRENCE: 9208
REPORTED BY: FLC; ; ; ;
PERSONS FUNCTIONS: FLC,FO; FLC,PIC.CAPT; FLC,PIC.CAPT; TWR, LC;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:ORD
FACILITY STATE: IL
FACILITY TYPE: ARPT; TWR; TWR;
FACILITY IDENTIFIER: ORD; ORD; ORD;
AIRCRAFT TYPE: MLG; WDB;
ANOMALY DESCRIPTIONS: OTHER; ERRONEOUS PENETRATION OR EXIT AIRSPACE; NON ADHERENCE LEGAL RQMT/CLNC;
ANOMALY DETECTOR: ATC/CTLR;
ANOMALY RESOLUTION: NOT RESOLVED/DETECTED AFTER-THE-FACT;
ANOMALY CONSEQUENCES: FAA INVESTIGATORY FOLLOW-UP; FLC/ATC REVIEW;
SITUATION REPORT SUBJECTS: PHYSICAL FACILITY/ATC; PHYSICAL FACILITY/ARPT; PROC OR POLICY/ATC FACILITY;
NARRATIVE: WE WERE AN XX00 PM DEP FROM ORD AND THE ARPT WAS EXTREMELY BUSY. THE TWR CTLR WAS WORKING TKOFS USING FREQ 132.7 WHICH WAS NOT PUBLISHED ON THE ARPT PLATE. THERE WAS QUITE A BIT OF STATIC ON THE RADIOS. THE PLANE AHEAD OF US WAS CLRED FOR TKOF AND IT CAME IN STATICLY AND WHEN THE CREW ASKED FOR A CLARIFICATION, THE CTLR CAME BACK IN A VERY SHARP TONE TO LISTEN UP AND CLRED FOR TKOF. NEXT WE WERE CLRED INTO POS AND HOLD. OUR CALL SIGN WAS ACR X, DXY. WE SAT ON THE RWY FOR ABOUT 2 MINS AND THEN THOUGHT WE HEARD ACR X, DXY CLRED FOR TKOF. ONCE AGAIN, LIKE THE PREVIOUS ACFT, THERE WAS STATIC ON THE RADIOS. I QUESTIONED THE TKOF CLRNC DUE TO THE STATIC ON THE FIRST RECEPTION AND THE CTLR REPLIED AFFIRMATIVE CLRED FOR AN IMMEDIATE TKOF, I WILL GIVE YOU A TURN IN THE AIR. I THEN REPLIED ACR X, DXY ROLLING. AS SOON AS WE WERE AIRBORNE, TWR CALLED US AND SAID ACR X, DXY WHAT ARE YOU DOING? I NEVER CLRED YOU FOR TKOF, I CLRED ACR Y, FXY FOR TKOF, YOU NEVER HAD A TKOF CLRNC. HE THEN LEFT US ON RWY HDG AND SENT US TO DEP CTL. I NEVER THOUGHT SOMETHING LIKE THIS COULD EVER HAPPEN TO ME. I HAVE READ ABOUT THIS HAPPENING AND HAVE ALWAYS THOUGHT THAT IT WAS DUE TO INATTN BY THE PLTS AND A LACK OF PROFESSIONALISM. BUT NOW I BELIEVE THAT, DUE TO THE INTENSE SITUATION AND SOME SHORTCUTS IN RADIO TRANSMISSIONS, THAT THIS IS A VERY EASY OCCURRENCE. SOME OF THE FACTORS INVOLVED IN THIS SITUATION WAS FIRST, THE TWR CTLR WAS WORKING A SPLIT FREQ AND WAS WORKING 2 RWYS -- 32L AND 32R. THE 2 FREQS WERE 132.7 FOR 32L AND 126.9 FOR 32R. WE DID NOT KNOW HE WAS WORKING 2 RWYS AND COULD NOT HEAR ANY REPLIES ON 126.9. WE DISCOVERED THIS WHEN THE CAPT TALKED TO MR X, THE TWR SUPVR. WE BELIEVE THAT, DUE TO THE RUSHED SITUATION IN TRYING TO GET ACR Y TO TKOF, THE CTLR DROPPED THE PREFIX (ACR Y) AND THE SUFFIX (HVY) AND JUST XMITTED FXY. WHEN I QUESTIONED THE TKOF CLRNC, MR X SAID BOTH US AND ACR Y QUESTIONED IT AT THE SAME TIME WITH THE SAME VERBIAGE. THE CTLR HEARD WHAT HE NEEDED TO HEAR AND THEN CLRED FXY FOR AN IMMEDIATE TKOF. SOME OF THE PROBLEMS WE THE l)STATIC ON THE RADIOS, 2) THEY WERE CLOSE TO PUTTING ANOTHER CTLR ON TO HANDLE THE OTHER RWY, BUT DELAYED WAITING UNTIL IT GOT A LITTLE BUSIER. 3) WE DID NOT KNOW ANOTHER SIMILAR SOUNDING CALL SIGN WAS BEING

USED ON THE ARPT OR THAT THE TWR CTLR WAS WORKING 2 RWYS. 4) NEXT, THE

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(REPORT CONTINUED)

STRESSFUL TONE OF THE CTLR AND THE PROBLEM WITH THE PREVIOUS ACFT THAT TOOK OFF FROM 32L PUT US IN A HURRY STATE OF MIND. 5) NEXT, THE CTLR, EITHER DUE TO THE STATIC OR BEING UNDER A LOT OF PRESSURE, STARTED TO TAKE SHORTCUTS IN THE CALL SIGN BECAUSE WE NEVER HEARD HIM USE ACR Y FXY HVY CLRED FOR TKOF, EITHER THE ACR Y OR HVY WOULD HAVE FLAGGED US THAT HE HAD NOT CLRED US FOR TKOF. ANOTHER ACR X ACFT BEHIND US FOR TKOF ON 32L. AFTER WE WERE AIRBORNE AND THE TWR SAID HE DID NOT CLR US FOR TKOF, THE OTHER ACR ACFT SAID THAT, YES, HE DID CLR US, ACR X, DXY, FOR TKOF. THEREFORE, HE HAD HEARD THE SAME CLRNC WE HEARD. I ACCEPT 1/2 THE RESPONSIBILITY FOR THIS OCCURRENCE BECAUSE I NORMALLY AM VERY SPECIFIC IN ACKNOWLEDGING CLRNCS USING OUR FULL CALL SIGN AND CLRNC. IN THIS OCCURRENCE, I THOUGHT A CONFLICT WAS ABOUT TO OCCUR DUE TO THE TRANSMISSION OF 'CLRED FOR AN IMMEDIATE' TKOF THAT TO EXPEDITE, I SHORTENED MY REPLY TO X, DXY ROLLING INSTEAD OF ACR X DXY CLRED FOR TKOF FROM 32L. THE BEST LESSON LEARNED IS NEVER GET CAUGHT UP IN GO, GO STATE OF MIND AND ALWAYS SIT BACK AND TAKE YOUR TIME TO BE SURE YOU HEAR WHAT YOU ARE SUPPOSED TO HEAR.

SYNOPSIS: UNAUTHORIZED TKOF RWY OP RESULTS IN UNAUTHORIZED UNCOORD PENETRATION OF AIRSPACE. PROX OF ATA TCA.
REFERENCE FACILITY ID: ORD
FACILITY STATE: IL
AGL ALTITUDE: 0,0

B-82

ACCESSION NUMBER: 241011
DATE OF OCCURRENCE: 9305
REPORTED BY: FLC; ; ; ;
PERSONS FUNCTIONS: FLC,FO; FLC,PIC.CAPT; ARTCC,RDR; FLC, PIC.CAPT;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:LAX
FACILITY STATE: CA
FACILITY TYPE: ARTCC; ARPT;
FACILITY IDENTIFIER: ZLA; LAX;
AIRCRAFT TYPE: SMT; WDB;
ANOMALY DESCRIPTIONS: CONFLICT/AIRBORNE LESS SEVERE; LESS THAN LEGAL SEPARATION; ALT DEV/OVERSHOOT ON CLB OR DES; NON ADHERENCE LEGAL RQMT/CLNC;
ANOMALY DETECTOR: ATC/CTLR;
ANOMALY RESOLUTION: NOT RESOLVED/DETECTED AFTER-THE-FACT;
ANOMALY CONSEQUENCES: FLC/ATC REVIEW;
NARRATIVE: DURING CRUISE I HEARD ZLA TELL ACR X (DSNDING) TO LGB 'PLAN ON 35 DME N OF SXC (SANTA CATALINA VOR) AT 11000 FT.' I MADE NOTE. AND SINCE WE WERE ON THE SAME ROUTING, I FIGURED THEY WOULD GIVE US THE SAME ALT RESTRICTION. 3 MINS LATER THEY SAID 'SMT PLAN ON 35 N OF SXC AT 11000 FT.' BOTH THE CAPT AND I HAD REMOVED OUR HEAD SETS FOR THE 1.5 HR FLT. WE ALSO TURNED OFF THE 'SIDE TONE' TO AVOID LOUD SQUEALS WHEN XMITTING. WE HAD APPROX 75 KTS TAILWIND DURING OUR DSCNT. REALIZING I'D BETTER START DOWN TO MEET THE RESTRICTION, WE ASKED CTR FOR LOWER. THE CTLR SAID 'SMT DSND AND MAINTAIN 11000 FT.' AT THIS POINT I BEGAN CALCULATING WHAT RATE OF DSCNT WOULD BE REQUIRED TO MEET THE 35 N AT 11000 FT RESTRICTION. (IN HINDSIGHT, THE CTLR NEVER GAVE US THE RESTRICTION, JUST PLAN ON IT.) SINCE THE CTLR SAID PLAN ON THE RESTRICTION, I WAS BUSY PLANNING THE DSCNT. AFTER WE HAD STARTED DOWN I FAILED TO HEAR A CALL FROM CTR AND FAILED TO HEAR THE CAPT READ BACK THE CLRNC 'SMT DSND AND MAINTAIN 13000 FT FOR TFC AT 12000 FT.' AGAIN WE HAD OUR SIDE TONE TURNED OFF. SINCE THE ALT ALERTER IS CLOSER TO THE FO SIDE OF THE COCKPIT, I USUALLY SET THE CLRNC ALT. BUT THE LAST CLRNC I HEARD WAS 11000 FT, THAT REMAINED IN THE ALERT BOX. AS WE CONTINUED THE DSCNT, CTR CALLED OUT TFC AS AN ACR WDB AT 12 O'CLOCK, 'DO WE HAVE HIM IN SIGHT?' WE RESPONDED 'AFFIRMATIVE, WDB IN SIGHT.' DSNDING THROUGH 11800 FT THE CTLR ASKED 'SMT, WHAT IS YOUR ALT?' WE RESPONDED 11800 FT FOR 11000 FT.' SHE RESPONDED 'NEGATIVE, YOU WERE ASSIGNED 13000 FT.' 'SMT YOU WERE INVOLVED IN A POTENTIAL PLT ALT VIOLATION. CONTACT CTR [WITH THE TELEPHONE NUMBER] ON THE GND.' (ON THE TAPE, THE CAPT READ BACK 13000 FT, BUT WE BOTH FAILED TO ADJUST THE ALT ALERTER.)
SYNOPSIS: COMMUTER ACFT DSNDS BELOW ASSIGNED ALT.
REFERENCE FACILITY ID:LAX
FACILITY STATE: CA
DISTANCE & BEARING FROM REF.: 30,,W
MSL ALTITUDE: 11800,13000

INSTRUCTIONAL PLI ELEMENTS: Incorrect Transmission. Correct Action

ACCESSION NUMBER: 100800
DATE OF OCCURRENCE: 8812
REPORTED BY: FLC; ;
PERSONS FUNCTIONS: FLC,PLT; FLC,PIC.CAPT;
FLIGHT CONDTTIONS: VMC
REFERENCE FACILITY ID:LRD
FACILITY STATE: TX
FACILITY TYPE: ARPT; TWR;
FACILITY IDENTIFIER: LRD; LRD;
AIRCRAFT TYPE: SMA; SMT;
ANOMALY DESCRIPTIONS: CONFLICT/GROUND CRITICAL; LESS THAN LEGAL SEPARATION;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: WHEN APPROX 15 MI SE OF LRD FOR THE PURPOSE OF LNDG, I ANNOUNCED MY POS TO LRD TWR AND RECEIVED LNDG INFO AND WAS INSTRUCTED TO ENTER LEFT DOWNWIND FOR RWY 17R. I RPTED ENTERING LEFT DOWNWIND AND RECEIVED LNDG CLRNC AT THAT TIME. WHILE TURNING BASE, ANOTHER ACFT (TWIN TURBO PROP) WAS TAXIING FOR TKOF AND REPORTED READY AT THE END. AT THAT TIME THE TWR ISSUED TKOF CLRNC TO THE ACFT. WHILE TURNING FINAL, I SHINED MY LNDG LIGHT DIRECTLY AT THE ACFT SO I COULD BE EASILY SEEN. I HAD PLANNED MY APCH TO CROSS THE THRESHOLD AT APPROX 200' TO MINIMIZE MY TIME ON THE RWY. WHILE ON SHORT FINAL THE ACFT TAXIED EBND UNDER MY ACFT AND I PASSED OVER HIM AND LANDED. DURING MY FLAIR, THE TWR INSTRUCTED ME TO BREAK IT OFF DUE TO TFC CONFLICT. I TOLD THE TWR THAT THE OTHER ACFT HAD PASSED UNDER ME AND WAS OFF TO THE E OF RWY 17R AND VERIFIED CLRED TO LAND. DURING THIS TIME I WAS PREPARED TO EXECUTE A GO AROUND IN THE EVENT THE OTHER ACFT TAXIED ONTO THE RWY, BUT NO FURTHER EVASIVE ACTION WAS NECESSARY. AFTER I LANDED THE TWR COMMUNICATED TO THE OTHER ACFT THAT HE HAD TAXIED PAST THE ACTIVE RWY. AT THIS TIME THE OTHER ACFT STATED THAT HE HAD GONE BEYOND THE RWY AS EVASIVE ACTION TO AVOID CONFLICT AND STATED, "I GUESS HE JUST WANTED TO CUT US OUT." UPON HEARING THIS ATTITUDE, I STATED THAT I HAD NOT INTENDED TO CUT ANYONE OUT, BUT ONLY CONTINUED MY NORMAL APCH FOR WHICH I HAD BEEN CLRED TO LAND. I APOLOGIZED FOR ANY MISUNDERSTANDING AND STATED THAT I HAD SHINED MY LNDG LIGHT DIRECTLY AT HIM TO ENSURE THAT I WAS SEEN SINCE IT WAS OBVIOUS TO ME THAT WE WOULD BOTH NEED THE SAME PORTION OF THE RWY AT THE SAME TIME. DUE TO LIGHTS AROUND THE ARPTS, I CAN UNDERSTAND THAT THE TWR CTLR MAY NOT HAVE BEEN ABLE TO SEE THAT THE LNDG AND DEPARTING ACFT WERE ARRIVING AT THE END OF THE RWY AT THE SAME TIME. I FELT THAT THE DEPARTING ACFT WOULD HOLD FOR MY LNDG AND I WOULD TAXI CLR ASAP. EITHER THE DEPARTING ACFT DID NOT SEE ME OR FELT THAT THE DEPARTING ACFT HAD THE RIGHT OF WAY. IN MY OPINION, THE TWR OPERATOR SHOULD HAVE INSTRUCTED THE OTHER ACFT TO HOLD FOR LNDG TFC OR

INSTRUCTED ME TO EXTEND MY PATTERN. NEITHER WAS DONE. IF I HAD QUERIED THE TWR REF MY LNDG CLRNC WHEN I SAW THE CONFLICT, I COULD HAVE CAUSED THE TWR TO CLARIFY LNDG OR TKOF CLRNCS. IN THE FUTURE, I WILL NOT

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(REPORT CONTINUED)

ASSUME THE OTHER ACFT HAS VIS CONTACT WITH ME AND WILL COMMUNICATE ANY POSSIBLE CONFLICTS TO ATC. IF THE OTHER ACFT WAS READY FOR DEP WHEN HE CALLED INSTEAD OF SOME DISTANCE FROM THE RWY, HE WOULD HAVE BEEN OUT OF MY WAY BEFORE MY ARR. THE TWR COULD HAVE AVOIDED THE SITUATION BY BEING MORE AWARE OF TFC LOCATION. IN SUMMARY, ANY OF THE 3 PLAYERS COULD HAVE AVOIDED THE POTENTIALLY DANGEROUS SITUATION. FROM TWR COMS, IT WAS APPARENT THE TWR CTLR DID NOT KNOW THE POS OF HIS TFC WHILE ISSUING CLRNCS.

SYNOPSIS: LESS THAN STANDARD SEPARATION AND GND CRITICAL NMAC BETWEEN ATX AND TWIN GA ACFT. OPERATIONAL ERROR.

REFERENCE FACILITY ID:LRD
FACILITY STATE: TX
DISTANCE & BEARING FROM REF.: l,,N
AGL ALTITUDE: 0,200

B-85

ACCESSION NUMBER: 115584
DATE OF OCCURRENCE: 8907
REPORTED BY: FLC; ; ; ;
PERSONS FUNCTIONS: FLC,SO; FLC,PIC.CAPT; FLC,PIC.CAPT; TWR, LC;
FLIGHT CONDITIONS: MXD
REFERENCE FACILITY ID:DFW
FACILITY STATE: TX
FACILITY TYPE: ARPT; TWR;
FACILITY IDENTIFIER: DFW; DFW;
AIRCRAFT TYPE: LRG; WDB;
ANOMALY DESCRIPTIONS: IN-FLT ENCOUNTER/WX; OTHER;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: FLC ABORTED TKOF;
ANOMALY CONSEQUENCES: NONE;
SITUATION REPORT SUBJECTS: PROC OR POLICY/ATC FACILITY;
NARRATIVE: WE WERE #3 FOR TKOF ON 17R FACING N ON THE OUTER TXWY. AN ACR B WDB WAS IN POSITION ON 17R. DEP HAD BEEN STOPPED BY CENTER, UNKNOWN CAUSE. WE WERE LOOKING AT TSTMS TO THE N OF DFW APCHING. NO TSTM PRESENT TO THE S. AN ACR C WDB DEPARTED 17L WITH ACR B STILL HOLDING. THE TSTM WAS APCHING WITH WIND AND RAIN STARTING. ACR B WAS CLEARED FOR TKOF. THERE SEEMED TO BE SOME CONFUSION IN TWR. WE WERE CONCERNED THAT ACR B DID NOT KNOW WHAT WAS BEHIND THEM. MY CAPT THOUGHT THE ACR B CAPT WAS CRAZY FOR ATTEMPTING THE TKOF SO HE ASKED FOR A WIND CHECK FROM TWR TO TRY AND CLUE THE ACR B CAPT (THE TWR WAS BEHIND THE CURVE). THE TWR SAID SOMETHING LIKE 15 KTS CENTER FIELD AND 35 KTS NORTH BOUNDARY. THE ACR B CAPT GOT THE HINT AND REFUSED THE TKOF CLRNC. WE SAT ON THE TXWY FOR THE NEXT 2 HRS. THE TSTM WAS LARGE, IRREGULAR IN SHAPE, AND SEVERE. A MICROBURST COULD HAVE OCCURRED CAUSING THE ACR B TO CRASH ON RWY 17 AT DFW. THE TWR OPERATORS WERE UNDER PRESSURE TO GET AS MANY ACFT AIRBORNE BEFORE THE TSTMS HIT. THIS INCIDENT WAS JUST TOO CLOSE. THE TWR OPERATORS DID NOT HAVE A GOOD IDEA WHAT THE WX WAS DOING.
SYNOPSIS: ACR WDB REFUSED TKOF CLRNC WHEN PARTY LINE CONVERSATION REVEALED POSSIBILITY OF WIND SHEAR DURING TKOF ROLL.
REFERENCE FACILITY ID:DFW
FACILITY STATE: TX
AGL ALTITUDE: 0,0

ACCESSION NUMBER: 134748
DATE OF OCCURRENCE: 9001
REPORTED BY: FLC; ; ; ;
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; TRACON,DC; ARTCC, RDR;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:SYR
FACILITY STATE: NY
FACILITY TYPE: ARPT; TRACON; ARTCC;
FACILITY IDENTIFIER: SYR; SYR; ZNY;
AIRCRAFT TYPE: MLG;
ANOMALY DESCRIPTIONS: TRACK OR HDG DEVIATION; ALT DEV/EXCURSION FROM ASSIGNED; NON ADHERENCE LEGAL RQMTtCLNC;
ANOMALY DETECTOR: OTHER; COCKPIT/FLC;
ANOMALY RESOLUTION: CTLR ISSUED NEW CLNC;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: WE TOOK OFF E, WITH A DEP CLRNC OF RWY HDG AND UP TO 4000'. DEP CTL TURNED US TO 290 DEGS AND SWITCHED US TO CENTER FREQ. WE WERE CLRED TO 15000'. WE CHKED IN WITH CENTER AND ACKNOWLEDGED ALL CLRNCS USING OUR FLT ADDB CALL SIGN. AS WE CLBED THROUGH 6000', I WONDERED ABOUT THE FACT THAT 15000' WAS THE WRONG ALT. FOR OUR DIRECTION OF FLT AND ASKED THE F/O TO CONFIRM THE CLRNC. HE DID, USING OUR ADDB CALL SIGN, AND CENTER CONFIRMED THE 15000' ALT CLRNC, ACKNOWLEDGING OUR USE OF AND IN RETURN ADDRESSING US BY OUR ADDB CALL SIGN. AT THIS TIME ANOTHER FLT, EBND FLT XXDB, BROKE IN AND WONDERED IF MAYBE WE, FLT ADDB, HADN'T BEEN GETTING THEIR CLRNC. CENTER SUDDENLY REALIZED THEY HAD THE 2 FLT'S CONFUSED AND TOLD US, ADDB, TO LEVEL AT OUR PRESENT ALT (8500') AND RETURN TO DEP CTL FREQ. WE DID AND DEP APOLOGIZED FOR THE CONFUSION AND GAVE US ANOTHER CENTER FREQ. WE CONTACTED ANOTHER CENTER ON ANOTHER FREQ AND WERE CLRED TO 10000', AND THEN TO 14000' AS FILED. SAFETY WAS NEVER COMPROMISED, THERE WERE NO CLOSE CALLS, AND NO ABRUPT OR EVASIVE ACTIONS WERE TAKEN, BUT THIS NARRATIVE AGAIN POINTS OUT THE PROBS INHERENT TO SIMILAR FLT #'S OPERATING IN THE SAME AREA AT THE SAME TIME. FLT XXDB HAD TAKEN OFF AHEAD OF US, AND WHILE IT IS POSSIBLE WE RESPONDED TO A FREQ SWITCH GIVEN BY DEP CTL TO XXDB, I BELIEVE DEP SWITCHED US ADDB, INSTEAD OF XXDB, TO CENTER FREQ AND CREATED THE CONFUSION. AT ANY RATE, WE CHKED IN ON FREQ USING OUR ADDB CALL SIGN, WERE ADDRESSED BY CENTER AS ADDB, AND RESPONDED AS ADDB. WE EVEN QUESTIONED AND ASKED FOR CONFIRMATION, AND RECEIVED IT AS ADDB. SUGGESTIONS AND SOLUTIONS: CENTER AND PROBABLY DEP CTL NEED TO PAY CLOSER ATTN TO FLT #'S. A CORRECT CLRNC GIVEN TO THE WRONG FLT IS ALMOST WORSE THAN NO CLRNC AT ALL. FLT CREWS MAYBE NEED TO BE A LITTLE QUICKER AND A LITTLE MORE FORCEFUL IN QUESTIONING THINGS WHEN THEY JUST DON'T SOUND RIGHT. THE FIRST PARTY AWARE OF PROX OF SIMILAR FLT #'S NEEDS TO BE SURE ALL INTERESTED PARTIES ARE EQUALLY AWARE OF THE FACT.
SYNOPSIS: ACR MLG CLRNC RESPONSE TO WRONG CALL SIGN. CLRNC READBACK HEARBACK.
REFERENCE FACILITY ID:SYR
FACILITY STATE: NY
DISTANCE & BEARING FROM REF.: ,,NW
MSL ALTITUDE: 7000,7000

ACCESSION NUMBER: 160299
DATE OF OCCURRENCE: 9010
REPORTED BY: FLC; ; ; ; ;
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; FLC,SO; FLC, PIC.CAPT; TWR,LC;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:SFO
FACILITY STATE: CA
FACILITY TYPE: ARPT; TWR;
FACILITY IDENTIFIER: SFO; SFO;
AIRCRAFT TYPE: WDB; ;
ANOMALY DESCRIPTIONS: CONFLICT/GROUND LESS SEVERE; NON ADHERENCE LEGAL RQMT/FAR; NON ADHERENCE LEGAL RQMT/PUBLISHED PROC;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: OTHER;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: WE WERE CLRED FOR TKOF ON SFO RWY 28L AND HAD REACHED ABOUT 15 KTS GNDSPD WHEN AN ACFT W OF US WAS CLRED TO CROSS RWY 28L. THE PLT OF THIS ACFT IMMEDIATELY CHALLENGED THIS CLRNC AND WAS TOLD TO HOLD SHORT OF RWY 28L. THIS SOLVED OUR PROB AND WE CONTINUED OUR TKOF. THIS IS RPTED AS AN EXAMPLE OF THE ALERTNESS AND SITUATIONAL AWARENESS ON THE PART OF THE PLT OF THE OTHER ACFT AND OF THE NEED FOR CAUTION AT ALL TIMES, ESPECIALLY AT TIMES OF HIGH CTLR WORKLOAD.
SYNOPSIS: WITH AN ACR WDB ON TKOF ROLL ATCT LCL CTLR CLEARED ANOTHER ACFT TO CROSS THE ACTIVE DOWNFIELD. FLT CREW OF TAXIING ACFT QUESTIONED THE CLRNC AND ATCT LCL CTLR ADVISED THEM TO HOLD SHORT.
REFERENCE FACILITY ID:SFO
FACILITY STATE: CA
AGL ALTITUDE: 0,0

ACCESSION NUMBER: 184688
DATE OF OCCURRENCE: 9107
REPORTED BY: FLC; ; ; ;
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; FLC,PIC.CAPT; TRACON,AC;
FLIGHT CONDITIONS: MXD
REFERENCE FACILITY ID:SMO
FACILITY STATE: CA
FACILITY TYPE: ARPT; TRACON;
FACILITY IDENTIFIER: LAX; LAX;
AIRCRAFT TYPE: MLG; MLG;
ANOMALY DESCRIPTIONS: NO SPECIFIC ANOMALY OCCURRED;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: CTLR INTERVENED; NOT RESOLVED/UNABLE;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: DURING VERY BUSY PERIOD OF IFR ARRS APCH CTL ISSUED A CLRNC TO AN ACFT (UNKNOWN CALL SIGN~ TO 'DSND TO 2500 FT'. THE OTHER AIRPLANE READ BACK 'CLRED TO 1500 FT'. APCH CTLR MISSED THE ERROR AS HE WAS OVERLOADED. I ATTEMPTED TO TELL APCH CTLR BUT TRANSMISSION WAS BLOCKED BY OTHER TRANSMISSIONS. I WAS NOT SURE WHO THE WRONG CLRNC WAS FOR AND WRONGFULLY ASSUMED THAT MODE C READOUTS WOULD KEEP EVERYONE OK. I KNEW THERE WAS CEILING OF AROUND 1000 FT, AND RATIONALIZED THAT A TRAGEDY WOULD NOT OCCUR. HOWEVER, THE CTLR DID NOT NOTICE THE ALT ERROR UNTIL 1500 FT, WHEN THE OFFENDING ACR WAS TOLD TO GO BACK TO 2500 FT. I LEARNED 2 THINGS. I SHOULD HAVE INSISTED ON RELAYING THE ERROR TO APCH, EVEN IF IT WAS ME WHO MISUNDERSTOOD. ALSO THE ACR DIDN'T READ BACK CORRECTLY, TERMINOLOGY WISE. ('1500' APCH WOULD'VE PROBABLY NOTICED.)
SYNOPSIS: ATTEMPTED TO ADVISE CTLR ACFT HAD COPIED CLRED ALT WRONG.
REFERENCE FACILITY ID:SMO
FACILITY STATE: CA
MSL ALTITUDE: 7000,7000

ACCESSION NUMBER: 184723
DATE OF OCCURRENCE: 9107
REPORTED BY: FLC; FLC; ; ; ;
PERSONS FUNCTIONS: FLC,SO; FLC,PIC.CAPT; FLC,PIC.CAPT; FLC, FO; ARTCC, RDR;
FLIGHT CONDITIONS: IMC
REFERENCE FACILITY ID:SAX
FACILITY STATE: NJ
FACILITY TYPE: ARTCC;
FACILITY IDENTIFIER: ZBW;
AIRCRAFT TYPE: WDB; WDB;
ANOMALY DESCRIPTIONS: CONFLICT/AIRBORNE LESS SEVERE; LESS THAN LEGAL SEPARATION; NON ADHERENCE LEGAL RQMT/PUBLISHED PROC;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: CTLR ISSUED NEW CLNC;
ANOMALY CONSEQUENCES: FAA INVESTIGATORY FOLLOW-UP;
NARRATIVE: RADAR WAS OTS AT EWR BACKING UP TFC AT EWR. BOSTON CENTER PLACED ACR X IN HOLDING PATTERN. ACR X WAS CLRED TO HOLD AT SHAFF INTXN AT 8000 FT. ACR Y SIMILAR NUMBER WAS ON FREQ. WE WERE ABOUT 20 MI FROM SHAFF WHEN BOSTON CENTER (128.67) CLRED US TO 7000 FT. THE FO READ IT BACK WITH NO RESPONSE. THE FO RPTED OUT OF 8000 FT FOR 7000 FT. NO RESPONSE FROM ATC. (THIS SECTOR WAS VERY BUSY AT THIS TIME). AS WE PASSED THROUGH 7600 FT, ACR Y QUESTIONED OUR ALT DIRECTLY TO US. WE SAID WE WERE OUT OF 8000 FT FOR 7000 FT. HIS RESPONSE WAS HE WAS AT 7000 FT AT SHAFF. ATC THEN PICKED UP ON THE PROBLEM AND REASSIGNED 8000 FT TO US. WE CLBED TO 8000 FT. APPROX 1 MIN LATER WE SAW ACR Y IN HIS HOLD OVER SHAFF. WHEN WE WERE FIRST ASSIGNED 7000 FT WE WERE IMC.
SYNOPSIS: ACR X HAD LTSS FROM ACR Y. SAME ALT ASSIGNED IN HOLDING PATTERN. SYS ERROR.
REFERENCE FACILITY ID:SAX
FACILITY STATE: NJ
DISTANCE & BEARING FROM REF.: 14,29
MSL ALTITUDE: 7000,8000

ACCESSION NUMBER: 191230
DATE OF OCCURRENCE: 9110
REPORTED BY: FLC; ; ; ; ;
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; FLC,SO; ARTCC,RDR; ARTCC,SUPVR;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:CCE
FACILITY STATE: FL
FACILITY TYPE: ARPT; ARTCC;
FACILITY IDENTIFIER: MIA; ZMA;
AIRCRAFT TYPE: LRG;
ANOMALY DESCRIPTIONS: LESS THAN LEGAL SEPARATION; NON ADHERENCE LEGAL RQMT/PUBLISHED PROC; NON ADHERENCE LEGAL RQMT/FAR;
ANOMALY DETECTOR: ATC/CTLR; COCKPIT/FLC;
ANOMALY RESOLUTION: CTLR ISSUED NEW CLNC;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: I WAS THE CAPT ON ACR X, BOS TO MIA. WE WERE HOLDING AT THE PUBLISHED PATTERN AT CCE ON THE COLLIER 2 ARR INTO MIA AT FL260. THE INCIDENT TOOK PLACE AT XX00Z. WE HAD ENTERED HOLDING AT FL240, THEN GIVEN A CLB TO FL250, THEN LATER, TO FL260. DURING THIS TIME THE CTLR WAS GIVING AN EFC TO ALL ACFT IN THE PATTERN OF XX05Z. I THOUGHT THIS WAS RATHER STRANGE AS I HAD ALWAYS OBSERVED EACH ACFT RECEIVING AN INDIVIDUAL TIME. AS WE WERE INBOUND ON HOLDING (10 MI LEGS OVER THE VOR) THE CTLR ISSUED A DSCNT CLRNC TO AN ACR Y FLT TO FL250. I THOUGHT THIS STRANGE AS WE SHOULD HAVE BEEN NEXT TO FL250. I ASKED THE CTLR IF HE WAS HANDLING ANY OTHER HOLDING PATTERNS. HE SAID NO. NOW, AS WE WERE HDG OUTBOUND (W) I TOLD HIM WE WERE AT FL260 AND WOULDN'T WE BE NEXT TO FL250. AFTER A BRIEF PAUSE, ANOTHER VOICE CAME OVER THE RADIO TELLING US TO TURN IMMEDIATELY TO A HDG OF 180 (S AND AWAY FROM THE HOLDING PATTERN). WE HELD THIS HDG FOR ABOUT 1 MIN, THEN WERE GIVEN A HDG OF 270, PARALLEL TO THE OUTBOUND LEG OF THE PATTERN FOR ABOUT 2 MINS, THEN WERE GIVEN A TURN TO 360, THEN A TURN TO JOIN THE INBOUND LEG OF THE PATTERN OF THE VOR. IN MY OPINION, THE CTLR DSNDED THE ACR Y THROUGH OUR ALT BLOCK. AS THEY WERE ONLY 10 MI LEGS, WE MOST LIKELY WERE VERY CLOSE AS THE VECTOR AWAY FROM THE PATTERN. THE CTLR NEVER MADE MENTION OF THE POSSIBILITY OF A NEAR MISS, HOWEVER, ANOTHER CTLR'S VOICE INDICATED SOMETHING WAS AMISS. EVEN THOUGH YOU CAN'T SEE ACFT, IT'S GOOD TO LISTEN UP ON THE RADIO AND MAKE A MENTAL PICTURE OF THE ACFT AROUND YOU, I.E., HOLDING, ON APCH, ETC.
SYNOPSIS: ACR CAPT RPTS ARTCC CONFUSION AS ACFT ARE HOLDING AT CCE FOR ARR INTO MIA. HE SUSPECTS LTSS WITH OTHER ACFT THOUGHT TO BE IN THE PATTERN. SEE ACN #191235.
REFERENCE FACILITY ID:CCE
FACILITY STATE: FL
DISTANCE & BEARING FROM REF.: 8,,W
MSL ALTITUDE: 26000,26000

ACCESSION NUMBER: 217638
DATE OF OCCURRENCE: 9208
REPORTED BY: FLC; ; ; ;
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; FLC,PIC.CAPT; TWR, LC;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:SFO
FACILITY STATE: CA
FACILITY TYPE: ARPT; TWR; TWR;
FACILITY IDENTIFIER: SFO; SFO; SFO;
AIRCRAFT TYPE: LTT; MLG;
ANOMALY DESCRIPTIONS: CONFLICTlGROUND LESS SEVERE; LESS THAN LEGAL SEPARATION; NON ADHERENCE LEGAL RQMT/CLNC;
ANOMALY DETECTOR: COCKPIT/FLC; ATC/CTLR;
ANOMALY RESOLUTION: NOT RESOLVED/UNABLE;
ANOMALY CONSEQUENCES: FLC/ATC REVIEW;
SITUATION REPORT SUBJECTS: PROC OR POLICY/ATC FACILITY; PROC OR POLICY/COMPANY;
NARRATIVE: ON AUG/SUN/92, FLT FROM SMF TO SFO WAS CLRED TO LAND ON RWY 28R. DURING DECELERATION, TWR CLRED US TO CROSS RWY 28L AND CONTACT GND CTL AFTER XING. WE EXITED RWY 28R ON TAXIWAY 'E' AND BEFORE ENTERING RWY 28L WHILE STILL INBTWN OF RWYS I HEARD TWR CLR AN ACFT FOR TKOF ON RWY 28L. MY REACTION WAS TO STOP MY ACFT BEFORE ENTERING THE RWY 28L BOUNDARY WHICH WE MANAGED TO DO SO. I LOOKED TO MY L AND SAW AN ACFT AT THE APCH END OF RWY 28L AND AT THAT POINT I DECIDED TO POSTPONE MY RWY XING UNTIL AFTER DEP OF THAT ACFT AND FURTHER CLRNC BY TWR. A FEW SECONDS LATER TWR CTLR ONCE AGAIN CLRED US FOR AN IMMEDIATE XING OF RWY 28L AND WITHOUT DELAY RETURNED TO DEPARTING ACFT AND ORDERED HIM TO ABORT HIS TKOF. AT THIS POINT, BASED ON MY JUDGEMENT OF HIS ROLLING SPD AND ESTIMATED OVER 6000 FT OF DISTANCE BTWN US, AND ASSUMING HE IS ON THE TKOF ABORTION STAGE, I EXECUTED AN EXPEDITIOUS XING OF RWY 28L. DURING XING I MAINTAINED A VISUAL CONTACT WITH THE TFC AND ENSURING THE SAFETY OF MY ACFT FROM THE TAKING OFF TFC WHO FAILED TO RESPOND TO REPEATED TKOF CANCELLATION FROM TWR. AT NO TIME DURING THIS ORDEAL WAS SAFETY OF MY ACFT OR PAX COMPROMISED. MY SUGGESTION WOULD BE MORE CAREFUL CTLRS AND MORE SITUATION AWARENESS IN TWR. ALSO, ON THE PART OF THE OTHER INVOLVED ACFT. TO LISTEN CLOSER TO ATC.
SYNOPSIS: ACR LTT PIC INDUCES A DEPARTING ACFT INTO AN ABORT SITUATION WHEN HE FAILS TO COMPLY WITH TWR'S CLRNC TO CROSS RWY 28L.
REFERENCE FACILITY ID:SFO
FACILITY STATE: CA
AGL ALTITUDE: 0,0

INSTRUCTIONAL PLI ELEMENTS: Incorrect Transmission, Incorrect Action

ACCESSION NUMBER: 109535
DATE OF OCCURRENCE: 8904
REPORTED BY: CTLR; ; ;
PERSONS FUNCTIONS: TWR,LC; FLC,PLT; FLC,PLT;
FLIGHT CONDITIONS: IMC
REFERENCE FACILITY ID:SBA
FACILITY STATE: CA
FACILITY TYPE: TWR;
FACILITY IDENTIFIER: SBA;
AIRCRAFT TYPE: SMA; SMA;
ANOMALY DESCRIPTIONS: CONFLICT/AIRBORNE LESS SEVERE; LESS THAN LEGAL SEPARATION; NON ADHERENCE LEGAL RQMT/PUBLISHED PROC;
ANOMALY DETECTOR: ATC/CTLR;
ANOMALY RESOLUTION: CTLR INTERVENED; NOT RESOLVED/INSUFFICIENT TIME;
ANOMALY CONSEQUENCES: FAA INVESTIGATORY FOLLOW-UP;
NARRATIVE: IFR WX, RWYS 7 AND 15L/R IN USE. SMA X WAS ON ILS APCH/MISSED APCH RWY 7. MISSED APCH INSTRUCTIONS WERE NONSTANDARD AND COORDINATED BY RADAR CTLR. RWY HDG UNTIL 700', THEN TURN RIGHT HDG 200 DEGS, CLB AND MAINTAIN 2000'. SMA Y CALLED FOR DEP IFR TO VFR ON TOP RWY 15L. RELEASE WAS OBTAINED FORM RADAR. SMA Y WAS GIVEN TFC (SMA X) 2 MI FINAL RWY 7 AND CLRED FOR TKOF RWY 15L RWY HDG CLB TO VFR ON TOP 2000'. SMA X EXECUTED MISSED APCH 1/2 MI FINAL, WAS INSTRUCTED TO FLY RWY HDG UNTIL DEP END THEN TURN TO 200 DEGS. SMA Y WAS NOW 2 MI S AT 1300' TALKING TO DEP. SMA X BEGAN TURN TO 200 DEGS APPROX 1/2 MI BEYOND DEP END. SMA X TARGET WENT NO BEACON ON RADAR. RADAR CTLR GAVE SMA X RIGHT TURN TO 100 DEGS WHILE ACFT WAS STILL ON LCL FREQ. SMA Y HEARD THE HDG ISSUED THE SMA X AND TURNED LEFT TO 100 DEGS. TARGETS PASSED WITHIN 1 1/2 MI OF EACH OTHER, ALT OF THE SMA X WAS UNKNOWN. LCL WAS UNABLE TO PROVIDE VIS BECAUSE OF THE WX. THE RADAR CTLRS RPTED THE LOSS OF SEP. THE ACFT NEVER SAW EACH OTHER. LCL CTLR WAS DECERTIFIED FOR THE OPERROR, NOT PROVIDING INITIAL SEP OF SUCCESSIVE DPTRS. LCL CTLR WAS AWARE OF THE SITUATION BUT JUDGEMENT WAS POOR IN ASSUMING SEP WOULD EXIST WHEN SMA X TURNED. POSITIVE SEP WAS NOT ENSURED.
SYNOPSIS: ACFT TOOK HEADING INTENDED FOR ANOTHER ACFT AFTER DEPARTURE RESULTING IN LESS THAN STANDARD SEPARATION.
REFERENCE FACILITY ID:SBA
FACILITY STATE: CA
DISTANCE & BEARING FROM REF.: 2,,SO
MSL ALTITUDE: 0,2000

ACCESSION NUMBER: 187752
DATE OF OCCURRENCE: 9108
REPORTED BY: FLC; ; ;
PERSONS FUNCTIONS: FLC,ISTR; FLC,PLT; TWR,LC; FLC,PLT;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:UGN
FACILITY STATE: IL
FACILITY TYPE: TWR;
FACILITY IDENTIFIER: UGN;
AIRCRAFT TYPE: SMA; SMA;
ANOMALY DESCRIPTIONS: CONFLICT/NMAC; NON ADHERENCE LEGAL RQMT/FAR;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;
ANOMALY CONSEQUENCES: FLC/ATC REVIEW;
NARRATIVE: I WAS ACTING AS FLT INSTRUCTOR IN AN SMA A. STUDENT RECENT PRIVATE PLT TRANSITIONING FROM SMA B INVOLVED IN SHORT FIELD TKOF PROCS. COMPLETED SEVERAL TKOFS AND LNDGS, RWY 5, L TFC. LITTLE TFC IN PATTERN. MY ACFT INSTRUCTED POS AND HOLD RWY 5, DEPARTING TFC ON 14, L CLOSED TFC. TAXIED INTO POS, OTHER ACFT WAS CLRED TO TKOF AFTER SOME DELAY, ADDITIONAL DELAY WHILE TWR DEALT WITH TFC TRANSITIONING THE ATA. I WAS THEN CLRED TO TKOF. AT SOME POINT, TWR CALLED MY POS TO ANOTHER ACFT AS DEPARTING RWY 5, L CLOSED TFC. WAS UNCLR TO ME WHERE THIS OTHER ACFT WAS, POSSIBLY AN INBOUND TO THE ARPT. DISCOVERED AFTER THE INCIDENT, OTHER TFC WAS AN SMA B WHO DEPARTED 14 AND WAS TURNING ONTO DOWNWIND. I WAS UNAWARE OF THE PRESENCE OF THIS TFC. NO TA WAS ISSUED TO ME AFTER MY TKOF CLRNC. MY STUDENT FLEW A NORMAL PATTERN, TURNING XWIND, CONTINUING TO CLB TO PATTERN ALT (1500 FT), UNDERNEATH THE SMA B ON ITS DOWNWIND LEG. SMA B WAS NOT SEEN BY MYSELF OR MY STUDENT. HIGH WINGS BLOCKED VISION WHERE SMA B PROBABLY WAS PRIOR TO OUR TURN TO XWIND. WE WERE THE ONLY 2 AIRPLANES IN THE PATTERN. AS WE REACHED 1500 FT MSL, STUDENT LOWERED NOSE, RAISED L WING TO CLR TFC, AND DISCOVERED THE SMA B AT OUR ALT WITHIN 100 FT HORIZ, ABEAM OUR L WING IN STRAIGHT AND LEVEL FLT, SAME DIRECTION. I QUERIED TWR AS TO THE INTENTIONS OF THE TFC. REPLY WAS 'I CALLED OUT THAT TFC FOR YOU', REFERRING TO THE ADVISORY GIVEN WHILE I WAS STILL ON THE TAXIWAY PRIOR TO TKOF. LACKING INFO ON THE INTENTIONS OF THE SMA B I EVADED WITH A R 270 WITH TWR APPROVAL. I VISITED TWR CAB, TO GET IMPRESSION OF THE CTLR INVOLVED. HIS STATEMENTS: 1) THE ADVISORY HE GAVE ME ON THE TAXIWAY MET LEGAL REQUIREMENTS AND 'HIS ASS WAS COVEREDI. 2) A PREVIOUS COMPLAINT LODGED BY ME ABOUT THE TWR WAS THE REASON FOR PROVIDING MIN ADVISORIES. 3) I WAS SUPPOSED TO BE LISTENING TO TRANSMISSIONS FROM THE TWR TO OTHERS, AND KNOW WHERE THEY WERE. 4) HE KNEW THAT I WAS ABOARD, AS AN INSTRUCTOR, AND AS THE CONFLICT DEVELOPED THOUGH MY FLT PATH WAS UNUSUAL WITH RESPECT TO THAT OF THE _____. HIS ATTITUDE WAS HOSTILE, AND THE ABOVE STATEMENTS ARE NOT INTENDED AS DIRECT QUOTES BUT ARE PARAPHRASED TO BEST OF MY RECOLLECTION. TWR CTLR WATCHED A LIFE THREATENING CONVERSION OF 2 ACFT DEVELOP, AND CHOSE NOT TO PROVIDE SEPARATION OR ADVISORIES TO ONE OF THE ACFT. THE HUMAN FACTOR INVOLVED INCLUDED THE CTLR ALLOWING A PREVIOUS COMPLAINT TO INTERFERE WITH COMMON SENSE, GOOD JUDGEMENT, CONCERN FOR

SAFETY AND STANDARD PRACTICE IN THIS UNSAFE CTLING SITUATION.
UNDER OTHER CONDITIONS
B-94

(REPORT CONTINUED)

AN ADVISORY WOULD HAVE BEEN ISSUED TO THE DEPARTING SMA AFTER THIS TKOF.

SYNOPSIS: SMA IN PATTERN HAS NMAC WITH SECOND SMA.
REFERENCE FACILITY ID:UGN
FACILITY STATE: IL
DISTANCE & BEARING FROM REF.:
MSL ALTITUDE: 1500,1500

B-95

Non-Specific Party Line Incidents

ACCESSION NUMBER: 98555
DATE OF OCCURRENCE: 8810
REPORTED BY: FLC; ; ;
PERSONS FUNCTIONS: FLC,PLT; ARTCC,RDR; TRACON,AC;
FLIGHT CONDITIONS: VMC
FACILITY STATE: NY
FACILITY TYPE: TRACON; ARTCC; ARPT;
FACILITY IDENTIFIER: BUF; ZOB; IAG;
AIRCRAFT TYPE: FGT;
ANOMALY DESCRIPTIONS: ALT DEV/EXCURSION FROM ASSIGNED;
ANOMALY DETECTOR: ATC/CTLR;
ANOMALY RESOLUTION: CTLR INTERVENED; NOT RESOLVED/ANOMALY ACCEPTED;
ANOMALY CONSEQUENCES: FLC/ATC REVIEW;
NARRATIVE: DURING A NIGHT DESCENT INTO NIAGARA FALLS IAP, NY, MY AIRPLANE EXPERIENCED COMPLETE UTILITY HYDRAULIC FAILURE. I WAS CLEARED FROM 17000' TO 10000' AT THE TIME OF THE FAILURE, AND WAS TALKING TO CLEVELAND CENTER. I DECLARED AN EMERGENCY WITH CLEVELAND AND WAS HANDED OFF TO BUFFALO APPROACH. AFTER TALKING TO BUFFALO, I WAS CLEARED OFF THE FREQUENCY TO CONTACT OPERATION FOR ASSISTANCE. AFTER RETURNING TO APPROACH FREQUENCY, I BEGAN RUNNING CHECKLISTS, (THERE ARE AT LEAST THREE FOR THIS EMERGENCY). AT THIS POINT, I BECAME CONCERNED ABOUT FLYING IMC WITH DEGRADED FLT CONTROLS THROUGH A 5000' DECK IN THE VICINITY OF IAG, SO I ELECTED TO START A VMC DESCENT. I WAS UNABLE TO TALK TO BUFFALO APPROACH ABOUT THIS DEVIATION FROM ATC CLEARANCE BECAUSE OF CONGESTION ON THE FREQUENCY. JUST AFTER LEAVING 10000', I VISUALLY ACQUIRED AN AIRPLANE AT ABOUT 1 O'CLOCK AND SLIGHTLY LOW. I BEGAN A CLIMB BACK TO 10000', AND RECEIVED A QUERY FROM BUFFALO AND A TRAFFIC CALL ON THE 9000' TRAFFIC. HAD WE BEEN ON THE SAME FREQUENCY (UHF VS VHF), WE WOULD HAVE KNOWN ABOUT THE TRAFFIC. I THEN INFORMED BUFFALO THAT WE NEEDED AN IMMEDIATE DESCENT TO 5000', OR CLEAR OF CLOUDS. THIS WAS ACCOMPLISHED, AND AFTER BLOWING DOWN GEAR AND FLAPS, WE MADE AN UNEVENTFUL ARRESTED LANDING. AFTER FLIGHT, WE RECEIVED A CALL FROM BUFFALO APPROACH ADVISING US THAT ALTHOUGH NO TRAFFIC SEPARATION PROBLEMS OCCURRED, A REPORT WOULD BE FILED BECAUSE OF CONVERSATION ON A RECORDED LINE BETWEEN BUFFALO AND CLEVELAND. CALLBACK CONVERSATION WITH REPORTER REVEALED THE FOLLOWING: REPORTER WAS OPERATING ON UHF AND DID NOT HAVE VHF ON THE FGT. CONTROL PROBLEMS RESULTING FROM THE LOSS OF HYD WAS NO POWERED RUDDER, ONE-HALF AILERON AND SPOILER MOVEMENT. HAS RECEIVED NO FURTHER INQUIRY FROM THE FAA AND WAS ASSURED BY THE CTLR THAT NO LOSS OF SEPARATION OCCURRED. WITH THE CONTROL SITUATION HE WAS IN AND THE FACT HE COULD DESCEND IN VFR CONDITIONS, FELT THAT WAS THE BEST PROC. DID SQUAWK 7700 BUT HAD DECLARED AN EMERGENCY AND LANDED AT IAG THAT HAD AN ARRESTING GEAR.
SYNOPSIS: FGT LOST UTILITY HYDRAULIC SYSTEM RESULTING IN PARTIAL LOSS OF FLT CONTROLS AND EMERGENCY LNDG.
REFERENCE FACILITY ID:IAG
FACILITY STATE: NY
MSL ALTITUDE: 10000,17000

ACCESSION NUMBER: 100007
DATE OF OCCURRENCE: 8812
REPORTED BY: FLC; ; ;
PERSONS FUNCTIONS: FLC,PLT; FLC,PIC.CAPT; TWR,LC;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:SBD
FACILITY STATE: CA
FACILITY TYPE: TWR; ARPT;
FACILITY IDENTIFIER: SBD; LIZ;
AIRCRAFT TYPE: SMA; MLT;
ANOMALY DESCRIPTIONS: CONFLICT/NMAC; LESS THAN LEGAL SEPARATION;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: MY WIFE AND I WERE DEPARTING REDLANDS MUNICIPAL ARPT ON A VFR FLT TO CATALINA. PRIOR TO TKOF I CONTACTED NORTON GND ON 121.8 AND STATED MY INTENTIONS. I WAS CLRED THROUGH NORTON'S ATA AND TOLD TO CONTACT NORTON TWR. I CALLED THE TWR ON 119.45 AND WAS TOLD TO RPT WHEN AIRBORNE. WE DEPARTED AND BEGAN FLYING A HDG OF 240 DEGS, CLBING TO 4500' MSL. I CONTACTED NORTON TWR ABOUT 30 SECS AFTER TKOF. I WAS GIVEN A SQUAWK ISSUED BY ONTARIO APCH THROUGH NORTON TWR AND WAS TOLD TO RPT PASSING THROUGH 2700' MSL. ABOUT 2 MINS LATER NORTON TWR INFORMED ME THAT A HEAVY MLT WAS GOING TO DEPART RWY 6 FOR CLOSED RIGHT TFC. I RESPONDED THAT I HAD MLT Y IN SIGHT ON THE RWY. MLT Y BEGAN ITS TKOF AND AS SOON AS IT HAD ENOUGH ALT IT BEGAN A CLBING RIGHT TURN. I HAD NOT EXPECTED HIM TO TURN SO SOON AND IT BECAME APPARENT TO ME AT THIS TIME THAT Y AND I WERE IN IMMEDIATE CONFLICT. I CALLED NORTON TWR AND TOLD HIM THAT I WAS AT Y'S 1 'CLOCK POS. I DID NOT WAIT FOR A REPLY AND IMMEDIATELY BEGAN A STEEP DIVE FROM ABOUT 2500' TO AROUND 2300. ABOUT 15 SECS LATER MLT Y PASSED DIRECTLY OVER MY ACFT. AT NO TIME THAT I WAS ON NORTON'S FREQ DID I HEAR THE TWR ADVISE THE MIL PLT OF MY POS OR DIRECTION OF FLT. THE MLT WAS USING UHF FREQS AND I WAS ON VHF. THE TWR WAS USING UHF/VHF SIMULTANEOUSLY. I FEEL THIS INCIDENT OCCURRED BECAUSE THE TWR DID NOT ADVISE MLT Y OF MY POS AND ALSO BECAUSE 2 DIFFERENT FREQ BANDS WERE BEING USED. HAD Y BEEN ON VHF, THEY WOULD HAVE HEARD MY XMISSIONS. I FEEL THAT IN THE INTEREST OF SAFETY, ALL ACFT OPERATING IN CLOSE PROX UNDER ATC CTL BE ON THE SAME RADIO BAND AND FREQ. MANY TIMES WHILE TALKING TO NORTON OR ONT APCH I HAVE HEARD MIL ACFT USING VHF FREQS. IT MAKES IT MUCH EASIER TO UNDERSTAND THEIR INTENTIONS WHEN YOU CAN HEAR BOTH SIDES OF THE CONVERSATION.
SYNOPSIS: NMAC BETWEEN SMA AND MLT. OPERATIONAL ERROR BY MIL TWR FAC.
REFERENCE FACILITY ID:SBD
FACILITY STATE: CA
DISTANCE & BEARING FROM REF.: 2,,SE
MSL ALTITUDE: 2300,2500

ACCESSION NUMBER: 123431
DATE OF OCCURRENCE: 8909
REPORTED BY: FLC; ;
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,PIC;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:UGN
FACILITY STATE: IL
FACILITY TYPE: TWR;
FACILITY IDENTIFIER: UGN;
AIRCRAFT TYPE: SMT; LTT;
ANOMALY DESCRIPTIONS: CONFLICT/NMAC;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;
ANOMALY CONSEQUENCES: NONE;
NARRATIVE: FLYING OFF SHORE OVER LAKE MICHIGAN ENRTE FROM MKE TO CHICAGO CGX. VFR IN HAZY CONDITIONS (+/- 4 NM). KNOWING OUR FLT PATH WOULD TAKE US ACROSS THE UGN LOC, I ELECTED TO FLY ABOVE THE G/S ALT TO AVOID ANY INBND ACFT. AT 2700' MSL, 6 NM (REF LORAN) FROM THE ARPT, WE HAD TO MAKE A SUDDEN DEVIATION TO AVOID AN LTT INBND ON THE LOC. HE SAW US AT THE SAME TIME, AND ALSO TURNED TO AVOID A COLLISION. WE WERE MONITORING BOTH APCH AND THE CTL TWR, BUT WERE NOT TALKING TO EITHER. WE KNEW FROM MONITORING RADIOS THAT THE LTT WAS INBND, BUT ASSUMED HE WOULD BE BELOW US ON THE G/S (BELOW 2200' MSL AT THAT POINT OF THE APCH). HE WAS APPARENTLY FLYING THE LOC INBND AND MAINTAINING ALT TO CIRCLE FOR LNDG. WE MISSED THAT PART OF THE RADIO CONVERSATION, IF IT WAS INDEED WHAT TRANSPIRED. BY ASSUMING THAT HE WAS ON THE G/S, WE SET OURSELVES AND HIM UP FOR A MIDAIR. REDUCED VSBLTY MADE IT DIFFICULT TO SEE ANY ACFT THAT DAY. WE OFTEN FLY THE LAKESHORE VFR W/O COMMUNICATING WITH APCH BECAUSE OF HVY TFC AND RADIO CONGESTION IN THE CHICAGO AREA. THE SITUATION DISCOURAGES VFR ACFT FROM USING ATC FOR TFC AVOIDANCE.
SYNOPSIS: SMA HELICOPTER, IN CRUISE, CROSSES A LOCALIZER ABOVE GLIDE SLOPE, BUT HAS NMAC WITH ACR LTT INBOUND ON CIRCLE-TO-LAND.
REFERENCE FACILITY ID:UGN
FACILITY STATE: IL
DISTANCE & BEARING FROM REF.: 6,,N
MSL ALTITUDE: 2700,2700

ACCESSION NUMBER: 128730
DATE OF OCCURRENCE: 8911
REPORTED BY: FLC; ; ; ; ;
PERSONS FUNCTIONS: FLC,TRNEE; FLC,ISTR; FLC,PLT; TRACON,AC;TWR,LC;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:RNO
FACILITY STATE: NV
FACILITY TYPE: ARPT; TRACON; TWR;
FACILITY IDENTIFIER: RNO; RNO; RNO;
AIRCRAFT TYPE: SMA; ;
ANOMALY DESCRIPTIONS: CONFLICT/NMAC; OTHER;
ANOMALY DETECTOR: COCKPIT/FLC;
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION;
ANOMALY CONSEQUENCES: NONE;
SITUATION REPORT SUBJECTS: PROC OR POLICY/ATC FACILITY;
NARRATIVE: I WAS IN RADAR CONTACT WITH RNO ARSA AND HAD JUST BEEN GIVEN A 090 DEG HDG TO ENTER THE RIGHT TFC PATTERN FOR 16R AT RNO. MY INSTR AND I OBSERVED TFC AT 12 O'CLOCK LESS THAN A MILE CLBING TOWARD US. I CONTINUED MY TURN AND DSNT. APCH CALLED THE TFC TO US AND WE ACKNOWLEDGED AND CONTINUED TURNING TO AVOID HIM. HE PASSED VERY CLOSE TO US AT CO-ALT BANKING TO HIS RIGHT. THE OTHER ACFT ASKED APCH WHAT WAS GOING ON, HE THOUGHT HE WAS IN RADAR CONTACT, WHY WASN'T HE AWARE OF THE CONFLICTING TFC. APCH ANSWERED HIM WITH THE RESPONSE THAT THE OTHER ACFT (ME) HAD HIM SIGHT, SO NO PROB. AFTER SPEAKING WITH TRACON AFTER LNDG, IT SEEMS TO ME THAT THE PROB WAS WITH THE HDOF FROM TWR TO APCH/DEP. WHEN WE FIRST SIGHTED THE OTHER ACFT, HE WAS STILL ON TWR FREQ, SO NEITHER ONE OF US HAD THE ADVANTAGE OF HEARING THE RADIO XMISSIONS TO EACH OTHER. THE OTHER ACFT WAS ALSO CLBING INTO THE SUN. RNO IS ALSO A TRNING FAC AND I GET THE IMPRESSION THAT THE SUPVRS AREN'T PAYING ENOUGH ATTN. THAT SAME DAY, I WITNESSED 2 OTHER INCIDENTS INVOLVING THE TWR. ONE INVOLVED AN ACFT LINED UP TO LAND ON THE TXWY. THE TWR DID NOT CATCH THE OBVIOUS UNTIL THE LNDG ACFT FLEW OVER AN ACR MLG ON THE TXWY. SHORTLY THEREAFTER, THE TWR TRIED TO TAXI THAT SAME MLG OVER US FOR TKOF. WE WERE #l ON THE HOLD SHORT LINE FOR TKOF. TWR REQUESTED THAT WE TURN LEFT AND GET OUT OF THE WAY BECAUSE MLG HAD TO TKOF. WE HAD BEEN SITTING THERE FOR ABOUT 10-12 MINS WAITING TO TKOF WHILE THEY FIDDLED AROUND THE LOST AIRPLANE.
SYNOPSIS: CLOSE PROX 2 GA ACFT IN RNO ARSA. REPORTER QUESTIONS COMPETENCE VIGILANCE OF RNO ATC TRAINING SUPVRS.
REFERENCE FACILITY ID: RNO
FACILITY STATE: NV
DISTANCE & BEARING FROM REF.: 5,,SE
MSL ALTITUDE: 8000,8000

B-99

ACCESSION NUMBER: 142041
DATE OF OCCURRENCE: 9004
REPORTED BY: FLC; ; ;
PERSONS FUNCTIONS: FLC,FO; FLC,PIC.CAPT; ARTCC,RDR;
FLIGHT CONDITIONS: MXD
REFERENCE FACILITY ID:YUL
FACILITY STATE: PQ
FACILITY TYPE: ARTCC;
FACILITY IDENTIFIER: CZUL;
AIRCRAFT TYPE: WDB;
ANOMALY DESCRIPTIONS: NO SPECIFIC ANOMALY OCCURRED;
SITUATION REPORT SUBJECTS: PROC OR POLICY/ATC FACILITY;
NARRATIVE: YOU MENTIONED YOU WANTED INTL COMMENTS. BOTH IN PARTS OF CANADA AND IN FRANCE THE CTLRS REGULARLY SPEAK FRENCH TO FRENCH SPEAKING CARRIERS. THEY DO THIS IN ALL AREAS OF FLT (TAXI, TKOF, CRUISE, APCH ETC). IN BAD WX AND/OR OVERSEAS WHEN YOU ARE UNSURE OF ROUTINES, VORS, ETC, IT IS VERY DISTURBING. MUCH IS GAINED BY HEARING CLRNCS GIVEN TO OTHER ACFT, NOT ONLY IN KNOWING WHAT TO EXPECT, BUT TO BE ABLE AT TIMES TO VERIFY THAT YOU ARE PRECEDING AS YOU THOUGHT CLRED.
SYNOPSIS: U.S. ACR FO COMPLAINS OF USING FRENCH FOR ATC COMS IN PARTS OF CANADA AND FRANCE.
REFERENCE FACILITY ID:YUL
FACILITY STATE: PQ
MSL ALTITUDE: 28000,28000

B-100

ACCESSION NUMBER: 149385
DATE OF OCCURRENCE: 9006
REPORTED BY: OBS; ; ;
PERSONS FUNCTIONS: MISC,OBS; FLC,PLT; FLC,PIC.CAPT;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:STS
FACILITY STATE: CA
FACILITY TYPE: ARPT;
FACILITY IDENTIFIER: STS;
AIRCRAFT TYPE: SMA; LTT;
ANOMALY DESCRIPTIONS: CONFLICT/NMAC;
ANOMALY DETECTOR: OTHER;
ANOMALY RESOLUTION: NOT RESOLVED/UNABLE;
ANOMALY CONSEQUENCES: NONE;
SITUATION REPORT SUBJECTS: PHYSICAL FACILITY/ATC;
NARRATIVE: I WAS STANDING ON THE DECK OF AN ARPT FAC AND WAS TUNED INTO THE 135 KW FREQ SINCE THE CTL TWR CLOSED APPROX 15-20 MINS BEFORE. A LIGHT HIGH WINGED ACFT WAS L DOWNWIND OF SONOMA COUNTY ARPT (I BELIEVE THE CALL LETTERS, WE XRAY SOMETHING OR OTHER) THE PLT WAS CALLING OUT HIS LEGS BEAUTIFULLY AND BY THE NUMBERS. HE ANNOUNCED L DOWNWIND, TURNING R BASE AND AS HE WAS TURNING FOR FINAL FOR RWY 14 (A) COMMUTER ACFT MANUEVERED INTO POS AND ANNOUNCED IT WAS READY FOR TKOF. THE PLT OF THE LIGHT (HE HAD AN EASTERN US ACCENT) PLANE STARTED TRYING TO COM TO THE COMMUTER THAT HE WAS LNDG WITH STILL NO RESPONSE. SO IN COMPLETE FRUSTRATION THE LIGHT PLANE ANNOUNCED THAT SINCE NO RESPONSE IT WOULD GO AROUND. AT ABOUT THE POINT THAT THE LIGHT PLANE WAS OVER THE COMMUTER AT RWY 14, THE COMMUTER TAKES OF AND UP GOING INTO AND IN FRONT OF THE LIGHT PLANE. THE LIGHT PLANE PLT WAS RIGHTFULLY ANGRY AND STARTED ASKING OTHER PLTS IN THE AIR IF SAW WHAT HAPPENED (HE WAS YELLING AT THE COMMUTER). I DOUBT IF THE COMMUTER PLANE EVER SAW THE LIGHT PLANE AND CERTAINLY THEY WEREN'T (OR COULDN'T BE) ON THE SAME FREQ. WHEN I DISCUSSED THIS WITH VARIOUS FLT PERSONNEL AND INSTRUCTORS THEY SAID IT HAPPENS ALL THE TIME AND WHEN THE TWR SHUTS DOWN ITS A FREE FOR ALL. WITH THE COMMERCIAL PLTS NOT GIVING A TINKERS DAMN, THIS WAS A MAJOR DISASTER WAITING TO HAPPEN.
SYNOPSIS: CLOSE PROX COMMUTER LTT ON TKOF AND GA SMA MAKING A GO AROUND.
REFERENCE FACILITY ID:STS
FACILITY STATE: CA
AGL ALTITUDE: 0,1000

ACCESSION NUMBER: 220645
DATE OF OCCURRENCE: 9209
REPORTED BY: FLC; FLC; ; ; ;
PERSONS FUNCTIONS: FLC,PIC.CAPT; FLC,FO; FLC, PIC.CAPT; ARTCC, RDR; ARTCC, RDR;
FLIGHT CONDITIONS: VMC
REFERENCE FACILITY ID:TPA
FACILITY STATE: FL
FACILITY TYPE: ARTCC; ARTCC;
FACILITY IDENTIFIER: ZMA; ZMA;
AIRCRAFT TYPE: MLG; MLG;
ANOMALY DESCRIPTIONS: CONFLICT/AIRBORNE LESS SEVERE; OTHER; ALT DEV/EXCURSION FROM ASSIGNED; NON ADHERENCE LEGAL RQMT/CLNC;
ANOMALY DETECTOR: COCKPIT/FLC; COCKPIT/EQUIPMENT;
ANOMALY RESOLUTION: FLC AVOIDANCE-EVASIVE ACTION; AUTOMATED ACFT SUBSYSTEM INTERVENED;
ANOMALY CONSEQUENCES: FLC/ATC REVIEW;
NARRATIVE: CRUISING ALONG AT FL270 AND RECEIVED AN RA ON THE TCASII SYS -- SOMEBODY JUST BEHIND AND CLBING -- UNTIL IT GOT TO -800 WITHIN MY ALT WE CLBED. WE GOT TO ABOUT 27600 BEFORE I FIGURED OUT THAT THE TARGET HAD LEVELED OFF 1000 FT BELOW US. ATC DID NOT WARN US BECAUSE THAT TFC WAS CLRED TO THAT ALT BY ANOTHER CTLR AND NEITHER I NOR HE WERE AWARE OF THE SITUATION. NO CONFLICT OCCURRED BECAUSE OF MY COMPLIANCE WITH THE RA. THE CTLR SHOULD HAVE BEEN WARNED, IT'S ALSO TOO IMPORTANT FOR ME TO LISTEN TO OTHER CLRNCS TO EXPECT THESE SITUATIONS. SUPPLEMENTAL INFO FROM ACN 220309: OPERATING FROM CLT-RSW UNDER CTL OF MIA CTR (FREQ 127.6) SBOUND ON J75 VICINITY OF TAMPA, PF OBSERVED ANOTHER ACFT ON TCASII CLBING OUT AT A LOWER ALT IN FRONT OF OUR ACFT. CLBING ACFT WAS ON A RECIPROCAL COURSE AND APPEARED TO BE CLBING RAPIDLY.
SYNOPSIS: POTENTIAL CONFLICT SENSED BY TCASII RA AND FLC RESPONSE IS-TO TAKE EVASIVE ACTION CLB.
REFERENCE FACILITY ID:TPA
FACILITY STATE: FL
MSL ALTITUDE: 27000,27600