

What the GNZ Operations Team is Talking About . . .

A summary of key items discussed at the Operations Team on-line meeting on 24 October 2023. David Moody (North), David Hirst (Central), Wal Bethwaite (South) and Martyn Cook (NOO).

This edition of OTT consists entirely of incident reports. The start of the summer soaring season brings some frequent lessons about what we've forgotten over the winter.

1. Incident Reports for August-September 2023

- radio batteries flat, pilot unable to land at controlled airfield due airspace, landed at another field
- pilot did not see electric fence wire and posts until exiting aircraft after outlanding, no damage
- training flight, glider laterally out of position on tow, tug and glider released rope simultaneously
- Cessna aircraft approached tug + glider head-on during launch, averting action required by tug
- two 2-seat gliders joining overhead airfield, inadequate lookout, flarm not updated, near miss
- rear canopy opened during winch launch, occupant was unfamiliar with latch characteristics
- winch launch aborted (due to canopy opening), cable would not release using knob in rear seat
- severely intoxicated club member arrived at gliding site, present at launch point, walking wings
- wheel-up landing after ferry flight, pre-landing check not done, pilot insufficiently prepared
- hatch which secures tail ballast weights lost during flight, attributed to not being fully secured
- single-seater, fuselage broken after ground loop when outlanding, approach deemed high and fast

Further Details on Selected Incidents (extracted from the original OPS-10 report)

1.1 Rear canopy opened during launch: Instructor training flight, with trainee in the rear seat. The rear canopy latch on the Twin Astir was closed with some difficulty, and in hindsight only partial engagement of the latch may have been achieved. The front seat occupant did press up on the rear canopy frame during the preflight checks and the rear canopy appeared to be locked.

On investigation it was learned that other pilots more familiar with the aircraft were aware of, or had experienced, some difficulty engaging the rear canopy latch. The rear seat pilot had not been briefed on this point. The rear canopy did not sit flush even when properly locked, so it was difficult to confirm correct closure from the outside. Submitter states that a small placard is to be added to rear cockpit and all instructors to be briefed that the rear canopy is only locked when no black paint can be seen on the front latching pin (i.e. pin is fully forward and engaged).

There have been a number of recent incident reports concerning the rear canopy latch on this aircraft type. This points to a possible flaw in the original design, or perhaps a weakness in our inspection and maintenance procedures. The Ops Team would welcome comments from operators who have successfully addressed this issue.

1.2 Radio battery failure when operating from controlled airfield: This was the first long flight after the winter break. The batteries were later tested and found to be in working order. They may not have been fully charged because the battery charger only had an analog amp meter and no way of checking how fully they were charged. A similar problem with batteries had been experienced by the club some years ago (prior to this member joining) and was traced to poor-quality battery chargers damaging the batteries. Recommended the purchase of the CTEK XS0.8 charger (as this was what solved the club's problems last time).

The follow-up enquiry established that 7600 had not been selected on the transponder, and suggested that this would have been a prudent action to take should the situation arise again. In this case cell-phone communication was used to advise the pilot not to enter the control zone without radio, but to land at an alternate airfield, which was achieved without further incident. In hindsight it could have been helpful to telephone the alternate airfield and advise arrival of a NORDO glider.

1.3 Ballast check: The DG1000 series has a hatch which secures the tail ballast in place. If this hatch is not fully secured then the hatch may fall out in flight. Worse still, the ballast weights themselves could then fall from the aircraft and cause damage on the ground. The second item in the "pre-boarding" ABCDE check requires that *the glider is correctly ballasted for the flight and that the trim ballast is secure*. This aircraft does have a "flashing indicator light" which signals the number of weights and whether the latch is fully closed or not. It's possible that this signal code was either not understood or not noticed by the pilot-in-command on the day.

1.4 Maintaining lookout when returning to airfield: This near-miss between two gliders circling above the airfield was a complex situation with a number of contributing factors, including:

- radio calls were made by one glider but not heard by the other
- one glider arrived at high speed directly overhead the airfield
- winds light and variable, so instructor and trainee in both gliders trying to read the windsocks
- all 4 occupants looking down at the ground and not including the sky around them in their scan

1.5 Ground loop and broken fuselage after outlanding: The investigation report indicated that a generous height margin over the threshold, plus a generous margin above the minimum safe speed on final approach, may have contributed to the need to initiate a ground loop after landing. The pilot only applied a +4° flap setting when considerably more flap was available. This could have steepened the approach and shortened the landing roll. The pilot admitted being "uncomfortable" with using positive flap settings greater than thermalling flap. Type conversion procedures are being reviewed by the ROO to ensure that pilots transitioning to higher-performance and flapped gliders acquire full competency.

2. Reminder about "Just Culture"

A number of incidents in the above list do not yet have a completed OPS-10 report. Sometimes there is a reluctance to face our mistakes or errors of judgement - this is completely understandable. We also need to be gentle and nurturing towards pilots who have been involved in an incident, and offer genuine support.

The purpose of these incident reports is to keep us aware of the potential hazards in gliding, and hopefully prevent a recurrence. The causes which lie behind an incident are often subtle and may not be immediately obvious. For example, there may have been inadequate training, not enough consolidation, lack of currency, insufficient preparation, a poor attitude towards certain procedures, or simply a gradual erosion of safe standards. It can take an incident to remind us of where we are all slipping up.

As far as possible all identifying details are scrubbed from the above summaries. Sometimes specific glider types need to be named. We are not interested in "who this happened too" or who might be to blame. We are interested in learning about what happened recently, and in probing the underlying causes.

Please encourage operators and observers to fill out an OPS-10 form within 24 hours of an incident, at least in draft form, while the details are fresh and vivid. An observer can also submit a report - it doesn't have to be the pilot. It can be helpful to have reports from different people about the same incident, especially if injury or damage occurred (or could have occurred).

Martyn Cook
National Operations Officer
Gliding New Zealand
30 October 2023