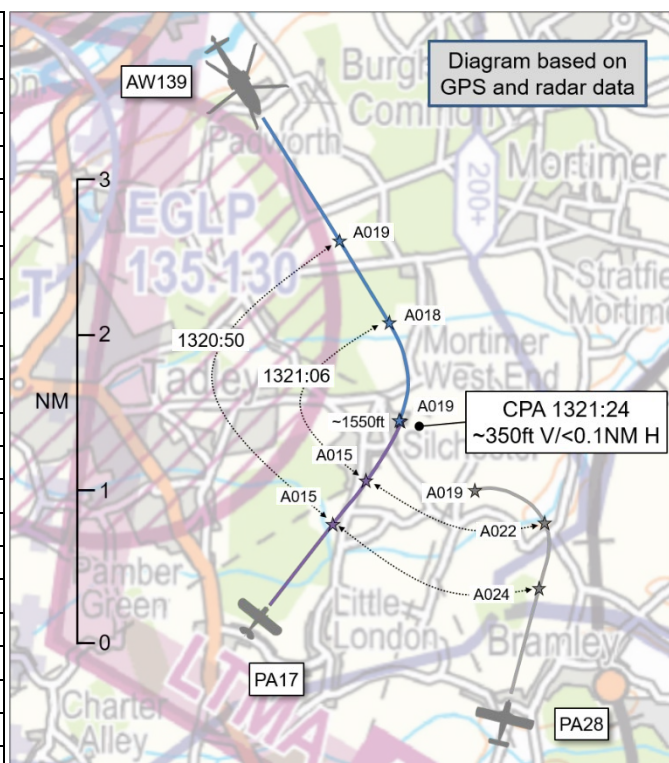


**AIRPROX REPORT No 2026085**

Date: 21 May 2026 Time: 1321Z Position: 5121N 00106W Location: 5NM N Basingstoke

**PART A: SUMMARY OF INFORMATION REPORTED TO UKAB**

| Recorded                 | Aircraft 1         | Aircraft 2    |
|--------------------------|--------------------|---------------|
| Aircraft                 | AW139              | PA17          |
| Operator                 | Civ Comm           | Civ FW        |
| Airspace                 | London FIR         | London FIR    |
| Class                    | G                  | G             |
| Rules                    | VFR                | VFR           |
| Service                  | Traffic            | None          |
| Provider                 | Southern Mil       | N/A           |
| Altitude/FL              | 1900ft             | ~1550ft       |
| Transponder              | A, C, S            | A, C, S       |
| ADS-B Out                | Observed           | Observed      |
| Reported                 |                    |               |
| Colours                  | Company            | Green, yellow |
| Lighting                 | Strobe, pulse, nav | None          |
| Conditions               | VMC                | VMC           |
| Visibility               | >10km              | >10km         |
| Altitude/FL              | 2000ft             | 1700ft        |
| Altimeter                | QNH                | NR            |
| Heading                  | 150°               | 020°          |
| Speed                    | 140kt              | 75kt          |
| ACAS/TAS                 | TCAS II, SkyEcho   | TAS           |
| Alert                    | RA                 | Alert         |
| <b>Separation at CPA</b> |                    |               |
| Reported                 | 100ft V/0m H       | 400ft V/NR H  |
| Recorded                 | ~350ft V/<0.1NM H  |               |



**THE AW139 PILOT** reports that they were in the descent from 5000ft to 1300ft (in the vicinity of 5NM north of Basingstoke). When around 2000ft, they were given Traffic Information from [the controller] on an aircraft in the 11/12 o'clock position (it was also on ACAS). Another aircraft was detected by an ADS-B track (on their iPad) north of Basingstoke on a northeasterly track indicating around 400ft below which was also considered a potential threat but was not on the ACAS display. The RHS pilot deselected the autopilot in case manoeuvring was required, and the crew scanned for the traffic. The LHS pilot gained visual on the aircraft in the 12 o'clock. The LHS pilot instructed the RHS pilot to turn right with a further instruction to tighten the turn as it appeared the aircraft had possibly reversed its initial track. The RHS pilot was blind to that traffic and relying on the LHS pilot to talk them on and avoid, but was also very conscious of the other potential traffic to the east [south]. During that manoeuvre, the crew got a TCAS RA of 'Monitor Vertical Speed' with an indication to maintain altitude. It was thought that this was for the aircraft in their 12 o'clock but they cannot be sure. The RHS pilot was conscious of the potential threat [that they were] now turning towards, and continued scanning for it. The RHS pilot then gained visual on the PA28 in the 12 o'clock and [turned left to] pass behind it on their left [right]. The aircraft appeared to waggle its wings as if to say 'I've seen you'.

[However, before they had passed behind the PA28], the contact from the right [had] suddenly popped up on ACAS in red with an associated aural alert. Clear of the initial contact, [the PA28], the RHS pilot was only too aware that there was another aircraft not yet spotted and potentially at very close range. They then saw a green high-wing aircraft pass under the right chin-window [by] 100-200ft. A further TCAS RA was instructed, this time to 'Climb, Climb' which was followed, but that was after CPA.

ATC was audible, and potentially giving Traffic Information throughout, but the RHS pilot was trying to listen to the LHS pilot and communicate as a crew to avoid the traffic and follow audio cues from the TCAS II (and aural alerts) so there were lots of inputs. They called the TCAS RA on frequency to the

controller but they cannot recall that they acknowledged the first time. They then continued the descent to 1300ft and recovered without further incident.

[After the flight,] the LHS pilot reviewed the Foreflight track logs. The altitude readout said that they had reached 1938ft, then climbed slightly to 2019ft, and then descended to 1954ft before climbing a second time ([possibly due to] the RA) to 2136ft.

[The pilot of the AW139 opined that,] with regards to company MAC strategy, they had all the mitigations in place. They were receiving multiple warnings and multiple inputs; were under a Traffic Service; had ADS-B feeds and TCAS II; and were a well-trained, current and competent twin-pilot crew, yet felt powerless in that position having not seen the [PA17] until too late. It was very, very uncomfortable. In hindsight, they could have potentially stopped their cruise descent (or climbed again) and turned further east but they do not think that they had enough information on the contact in the 12 o'clock to have done so.

The pilot assessed the risk of collision as 'High'.

**THE PA17 PILOT** reports that they headed north-northeast on a local VFR flight in CAVOK [conditions]. Just before the stated position of the incident, they had seen the helicopter in their 11 o'clock about 3-4 miles away. Then, their system gave them an aural warning, after which, they looked at the SkyDemon moving map to see the target. They initiated a descent and, [from] the increasing separation, they believe the helicopter pilot had initiated a climb. The helicopter passed over them at about 400ft above. There being no further problem, they levelled off. They believe they descended about 150-200ft.

The next day, they received a message from the 'Tower' at [their airfield] saying that a helicopter pilot was asking if there was any confusion and "*was I alright?*".

On about 27th May, the airfield manager said that they had been contacted by the pilot [of the AW139] about the matter. [The PA17 pilot] asked the manager to convey their thanks, that they were not concerned, and that this incident was a demonstration of the value of a good lookout and electronic conspicuity.

The pilot assessed the risk of collision as 'Low'.

**THE BRIZE NORTON TATCC CONTROLLER** reports that they were training in the Allocator position for Southern Mil and were handed an aircraft, [the AW139], under a Traffic Service, from Brize Radar. As the aircraft approached [...] the vicinity of the Aldermaston Avoid [EGR101], it started a descent. They gave two Traffic Information calls for two conflicting tracks. One of the conflictors was called; "*Right, 1 o'clock, 4 miles, crossing right-to-left, indicating 400ft below*", and the other was called; "*12 o'clock, 4 miles, manoeuvring indicating above*".

[The pilot of] another aircraft then called up on a separate frequency, requested a Basic Service and recovery back to RAF Odiham. While speaking to [that pilot], they heard a transmission from the [pilot of the AW139], but could not tell what they had said. [The controller] then asked them [to] repeat their message, and [the pilot of the AW139] told them that they had climbed for a TCAS RA and were levelling out. They then informed them that they had started a descent again.

At the time of the incident, they were monitoring the Southern Mil ICF, RAF Benson Approach UHF and VHF, as well as the Radar 3 frequencies. They were also monitoring the Radar 1 position. Radar 1 had a standard workload with Tutor [aircraft] and some VHF zone traffic.

The controller perceived the severity of the incident as 'Low'.

**THE BRIZE NORTON TATCC SUPERVISOR** reports that they were ATCO IC and facilitating training for the Allocator at the time of the incident. Their capacity was sapped training someone in a new position whilst getting to grips with the procedures themselves. They were monitoring too many frequencies whilst controlling the aircraft.

## Factual Background

The weather at RAF Odiham was recorded as follows:

METAR EGVO 211320Z 20009KT 9999 SCT030 21/13 Q1025 NOSIG RMK BLU BLU

## Analysis and Investigation

### Military ATM

#### Background

The controller was training in the Allocator position for Southern Mil with an instructor present. The AW139 was handed over from Brize Radar under a Traffic Service to [...].

The controller was monitoring the Southern Mil ICF, Benson Approach UHF and VHF, as well as the Radar 3 frequencies. They were also monitoring Radar 1 position. Radar 1 had a standard workload with Tutor [aircraft] and some VHF zone traffic.

The operating model [...] has recently changed, where [pilots] will make initial contact on the Allocator frequency and then be forwarded onto an appropriate frequency. The Allocator may choose to work low intensity traffic.

#### Sequence of Events

At 1320:15, the Allocator provided 2 x Traffic Information to the AW139 pilot:

*"Traffic right, 1 o'clock, 4 miles, crossing from right-to-left behind, indicating altitude 1600ft".*  
*"Further traffic 12 o'clock, 4 miles, manoeuvring, indicating altitude 2500ft".*

At 1320:35, [the pilot of] an unrelated rotary aircraft contacted the Allocator for a Basic Service and a visual recovery to RAF Odiham.

At 1321:51, the AW139 pilot reported *"TCAS RA climbing, now levelling off. Resuming, uhm, descent to altitude uhm, 1300ft"*.

CPA occurred at 1321:24 with 0.1NM lateral separation, no vertical separation was recorded.

#### Local BM Investigation

A local investigation (LI) was conducted by RAF Brize Norton following the event to identify the ATS-related causal/aggravating factors.

The LI identified that a Traffic Information error occurred when two GA contacts were passed to a VFR inbound aircraft at 4NM [rather than by 5NM]. The investigation concluded that controller and trainee workload, distraction and limited experience in the newly introduced Allocator position contributed to a degradation in situational awareness and incorrect hazard assessment.

The Allocator was monitoring multiple frequencies, including one not required for the role, which increased distraction and workload. Workforce pressures and the requirement to train personnel in the new position were also assessed as aggravating factors.

Local actions included debriefing the controllers involved, introducing additional supervision requirements for Allocator training, and reinforcing procedures to minimise distractions whilst operating in the role.

An updated brief was sent to all controllers following the event:

ALLOCATOR RESPONSIBILITIES

When operating as JAC Allocator, ATCOs are to be mindful of traffic loading. IFR traffic can be worked by the Allocator when there is no imminent further IFR traffic planned and when chance of multiple free-calling aircraft is low (i.e. CC Green).

With Supervisor permission, the Allocator may choose to work low intensity traffic (a Basic Service transit, VFR recoveries etc.) but must be cautious that their capacity to provide the full service is not hindered. Allocators are reminded that SRE currency cannot be claimed when holding the Allocator position as the role of the Allocator is primarily approach-room management.

The MON function is not to be used to listen to other consoles when working traffic under a Traffic Service or Deconfliction Service on any frequency worked by the Allocator.

No Allocator training will take place without the presence of a Supervisor. Only Suitably Qualified and Experienced Personnel (SQEP) Allocators will be permitted to instruct trainees.

## 2 Gp BM Analysis

The LI identified that limited experience in the newly implemented Allocator position, combined with distraction from monitoring multiple frequencies, reduced controller situational awareness and resulted in incomplete Traffic Information being passed to the pilot.

Of note is the impact of non-essential task loading during safety-critical activities. Monitoring an additional frequency increased controller workload and contributed to interference with operational transmissions at a critical stage [...].

Whilst not limited to RAF Brize Norton, units are facing increasing workforce pressures due to lack of qualified controllers. It is imperative to ensure safe operating models are maintained whilst conducting training duties with adequate supervision provided.

## UKAB Secretariat

An analysis of the NATS radar replay was undertaken and the AW139, PA17 and PA28 were positively identified from Mode S data (Figure 1). All three aircraft were observed by reference to ADS-B data sources. The pilot of the AW139 kindly supplied GPS track data for their flight.

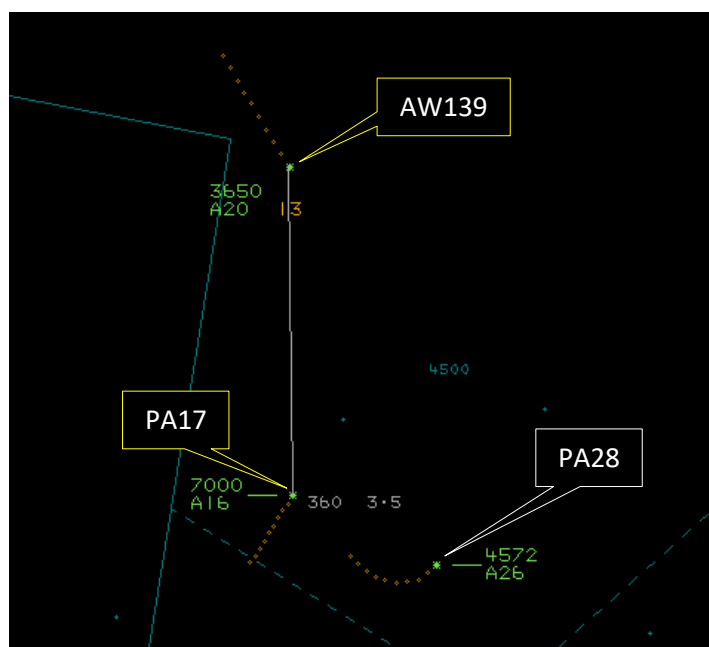


Figure 1 – Aircraft positions at 1320:19

The pilot of the PA28 was contacted and they confirmed that they did not witness the incident involving the AW139 and PA17.

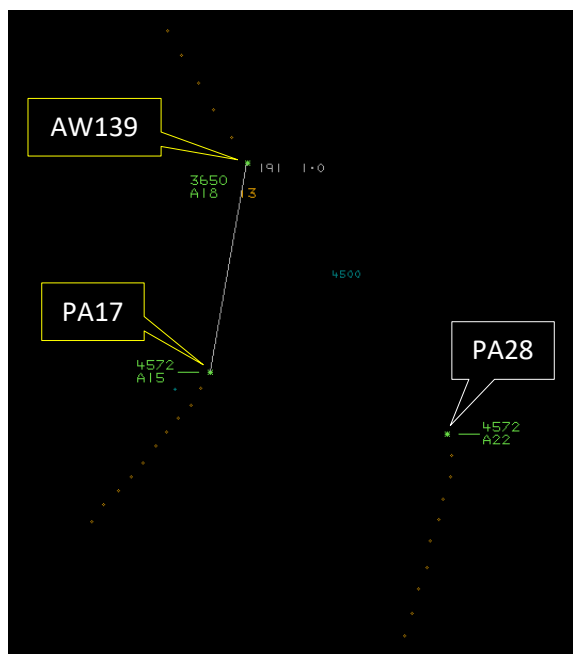


Figure 2 – 1321:06

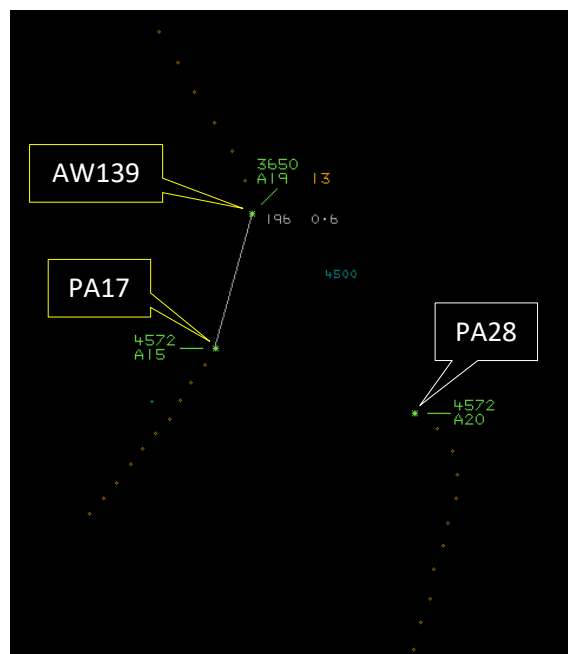


Figure 3 – 1321:14

The diagram was constructed and the separation determined by combining the data sources. The moment of CPA was assessed to have occurred between the radar sweeps at 1321:22 and 1321:26 (Figures 4 and 5). The altitude of the PA17 has been shown as an estimate as it had been at 1500ft 2sec before CPA and 1600ft 2sec after CPA.

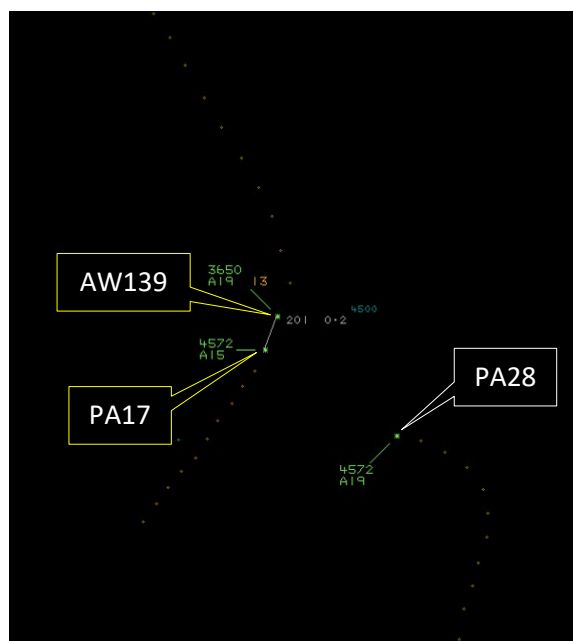


Figure 4 – 1321:22 (2sec before CPA)

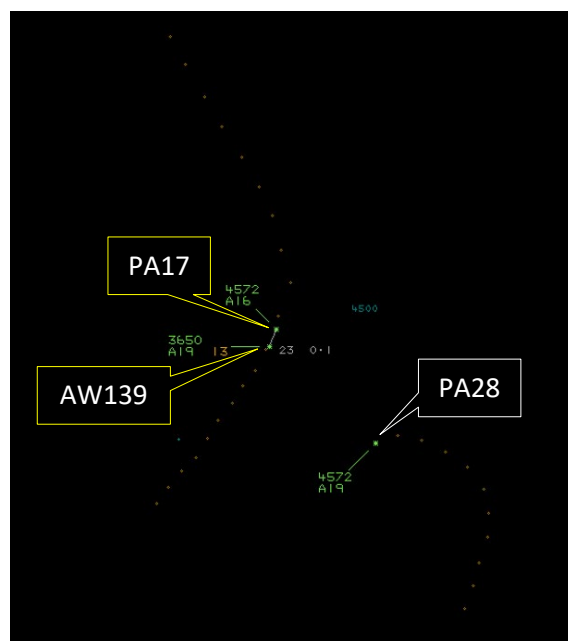


Figure 5 – 1321:26 (2sec after CPA)

The AW139 and PA17 pilots shared an equal responsibility for collision avoidance and not to operate in such proximity to other aircraft as to create a collision hazard.<sup>1</sup> If the incident geometry is considered as head-on or nearly so then both pilots were required to turn to the right.<sup>2</sup> If the incident geometry is considered as converging then the AW139 pilot was required to give way to the PA17.<sup>3</sup>

<sup>1</sup> (UK) SERA.3205 Proximity.

<sup>2</sup> (UK) SERA.3210 Right-of-way (c)(1) Approaching head-on.

<sup>3</sup> (UK) SERA.3210 Right-of-way (c)(2) Converging.

## Summary

An Airprox was reported when an AW139 and a PA17 flew into proximity 5NM north of Basingstoke at 1321Z on Thursday 21<sup>st</sup> May 2026. The AW139 pilot was operating under VFR in VMC, in receipt of a Traffic Service from Southern Mil. The PA17 pilot was operating under VFR in VMC, not in receipt of a FIS.

### **PART B: SUMMARY OF THE BOARD'S DISCUSSIONS**

Information available consisted of reports from both pilots, GPS track data from the flight of the AW139, radar photographs/video recordings, a report from the air traffic controller involved and a report from the appropriate operating authority. Relevant contributory factors mentioned during the Board's discussions are highlighted within the text in bold, with the numbers referring to the Contributory Factors table displayed in Part C.

The Board first considered the actions of the pilot of the AW139, and members noted that their track had passed in very close proximity to the Restricted Area EGR101. One member suggested that it may have been prudent to have selected a track slightly further to the east, one that may have facilitated room to manoeuvre if they were to encounter any traffic in the area. Indeed, members noted that they had been passed Traffic Information on two contacts, both at a range of four miles. Firstly, a PA28 that had been in their 12 o'clock at 2500ft and, secondly, a PA17 that had been "*crossing from left-to-right behind*" at 1600ft. It was suggested that the presence of the restricted area immediately to their right had influenced or, perhaps, had limited the options available to them.

Members noted that the left-hand seat (LHS) pilot had visually acquired the PA28 and had instructed the right-hand seat (RHS) pilot to commence a right turn away from it to increase the separation. Assessing that the PA28 had subsequently descended and had turned towards them, which had effectively reduced the separation gained, the LHS pilot had instructed a further turn to the right. Members noted that they had been conscious of the (as yet unsighted) PA17 to their right that had been called by the controller and of which they had been aware from an ADS-B track on their iPad. Members noted that the TCAS fitted to the AW139 had provided a Resolution Advisory due to the proximity of the traffic (**CF8**) and that the proximity had caused the crew concern (**CF7**).

From the initial geometry of the encounter, the PA17 had appeared to the controller to have been "*crossing from left-to-right behind*" the AW139. However, members noted that, due to the right turn by the AW139 pilot to increase separation from the PA28, the PA17 had now moved, relatively, and had then been in their 12 o'clock. As the AW139 crew had sighted the PA28, but had not yet sighted the PA17, some members suggested that the PA28 had taken priority in their dynamic plan. Further, it was suggested that the presence of the PA17 had not been fully considered, or the crew had not updated the known track and progress of the PA17 in their mental model. Members noted that the pilot of the AW139 had not sighted the PA17 until the moment of CPA, and agreed that that effectively constituted a non-sighting (**CF10**).

Members next considered the actions of the pilot of the PA17, and noted that they had not been in receipt of a FIS. It was also noted that their transponder squawk code had changed from 7000 to 4572 (the Frequency Monitoring Code for Farnborough LARS West) in the minutes before CPA. Members suggested that it may have been prudent to have been in receipt of a surveillance-based service from the Farnborough LARS controller (**CF6**). Notwithstanding, it was noted that they had sighted the AW139 in their 11 o'clock at a range of approximately 3-4NM. Members agreed that the EC device fitted to the PA17 had subsequently provided an alert to the presence of the AW139 (**CF9**). Consequently, members were in agreement that they had had plenty of time to have carefully considered the safest course of action. It was noted that their narrative report suggested that urgent avoiding action had not been necessary but they had initiated a descent to increase the separation.

The actions of the Southern Mil controller were next considered, and members noted that they had been in receipt of training by the ATCO IC in the newly created Allocator position. Whilst it was appreciated that the RAF Brize Norton Local Investigation had identified that 'a Traffic Information error [had] occurred', members noted that they had passed Traffic Information to the AW139 pilot when the

PA28 and PA17 had each been at a distance of 4NM. It was noted that subsequent information, with which the AW139 pilot may have updated their dynamic plan, had not been transmitted. An advisor to the Board explained that the STCA in use at the Southern Mil position would have been expected to have alerted to the proximity of the AW139 and PA17, but no alert was reported (**CF5**).

Members agreed that the provision of training and the monitoring of an additional frequency (that had not been operationally imperative) had contributed to the controller having been distracted from their task (**CF4**). Members noted the conclusion of the Local Investigation that; 'controller and trainee workload, distraction and limited experience in the newly introduced Allocator position contributed to a degradation in situational awareness and incorrect hazard assessment'. Consequently, members were in agreement that the Supervision of ATM activities (**CF1**), the scheduling of personnel (insofar as there had been too few staff present for the task at hand) (**CF2**) and the training of individuals (insofar as it may have been prudent to have postponed the training) (**CF3**) had been contributory factors to the outcome of the encounter.

Concluding their discussion, members summarised their thoughts. On one hand, the pilot of the AW139 had been aware of the presence of the PA17 in the vicinity but had been somewhat startled when it had been subsequently sighted at the moment of CPA. Conversely, members noted that the pilot of the PA17 had sighted the AW139 in plenty of time and had taken effective avoiding action. It was agreed that safety margins had been reduced, but members were satisfied that the separation had been such that there had not been a risk of collision. The Board assigned Risk Category C to this event.

## **PART C: ASSESSMENT OF CONTRIBUTORY FACTORS AND RISK**

### **Contributory Factors:**

|    | 2026085                                                               |                                          |                                                                                                                                                     |                                                                                        |
|----|-----------------------------------------------------------------------|------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| CF | Factor                                                                | Description                              | ECCAIRS Amplification                                                                                                                               | UKAB Amplification                                                                     |
|    | <b>Ground Elements</b>                                                |                                          |                                                                                                                                                     |                                                                                        |
|    | <b>• Manning and Equipment</b>                                        |                                          |                                                                                                                                                     |                                                                                        |
| 1  | Human Factors                                                         | • ATM Leadership and Supervision         | An event related to the leadership and supervision of ATM activities.                                                                               |                                                                                        |
| 2  | Organisational                                                        | • ATM Staffing and Scheduling            | An event related to the planning and scheduling of ATM personnel                                                                                    |                                                                                        |
| 3  | Human Factors                                                         | • Recurrent/OJT Instruction or Training  | Events involving on the job training of individuals/ personnel                                                                                      |                                                                                        |
|    | <b>• Situational Awareness and Action</b>                             |                                          |                                                                                                                                                     |                                                                                        |
| 4  | Human Factors                                                         | • Task Monitoring                        | Events involving an individual or a crew/ team not appropriately monitoring their performance of a task                                             | Controller engaged in other tasks                                                      |
|    | <b>• Electronic Warning System Operation and Compliance</b>           |                                          |                                                                                                                                                     |                                                                                        |
| 5  | Technical                                                             | • Conflict Alert System Failure          | Conflict Alert System did not function as expected                                                                                                  | The Conflict Alert system did not function or was not utilised in this situation       |
|    | <b>Flight Elements</b>                                                |                                          |                                                                                                                                                     |                                                                                        |
|    | <b>• Tactical Planning and Execution</b>                              |                                          |                                                                                                                                                     |                                                                                        |
| 6  | Human Factors                                                         | • Communications by Flight Crew with ANS | An event related to the communications between the flight crew and the air navigation service.                                                      | Pilot did not request appropriate ATS service or communicate with appropriate provider |
|    | <b>• Situational Awareness of the Conflicting Aircraft and Action</b> |                                          |                                                                                                                                                     |                                                                                        |
| 7  | Human Factors                                                         | • Unnecessary Action                     | Events involving flight crew performing an action that was not required                                                                             | Pilot was concerned by the proximity of the other aircraft                             |
|    | <b>• Electronic Warning System Operation and Compliance</b>           |                                          |                                                                                                                                                     |                                                                                        |
| 8  | Contextual                                                            | • ACAS/TCAS RA                           | An event involving a genuine airborne collision avoidance system/traffic alert and collision avoidance system resolution advisory warning triggered |                                                                                        |
| 9  | Contextual                                                            | • Other warning system operation         | An event involving a genuine warning from an airborne system other than TCAS.                                                                       |                                                                                        |

| • See and Avoid |               |                                |                                                                    |                                                                  |
|-----------------|---------------|--------------------------------|--------------------------------------------------------------------|------------------------------------------------------------------|
| 10              | Human Factors | • Monitoring of Other Aircraft | Events involving flight crew not fully monitoring another aircraft | Non-sighting or effectively a non-sighting by one or both pilots |

Degree of Risk: C.

#### Safety Barrier Assessment<sup>4</sup>

In assessing the effectiveness of the safety barriers associated with this incident, the Board concluded that the key factors had been that:

#### Ground Elements:

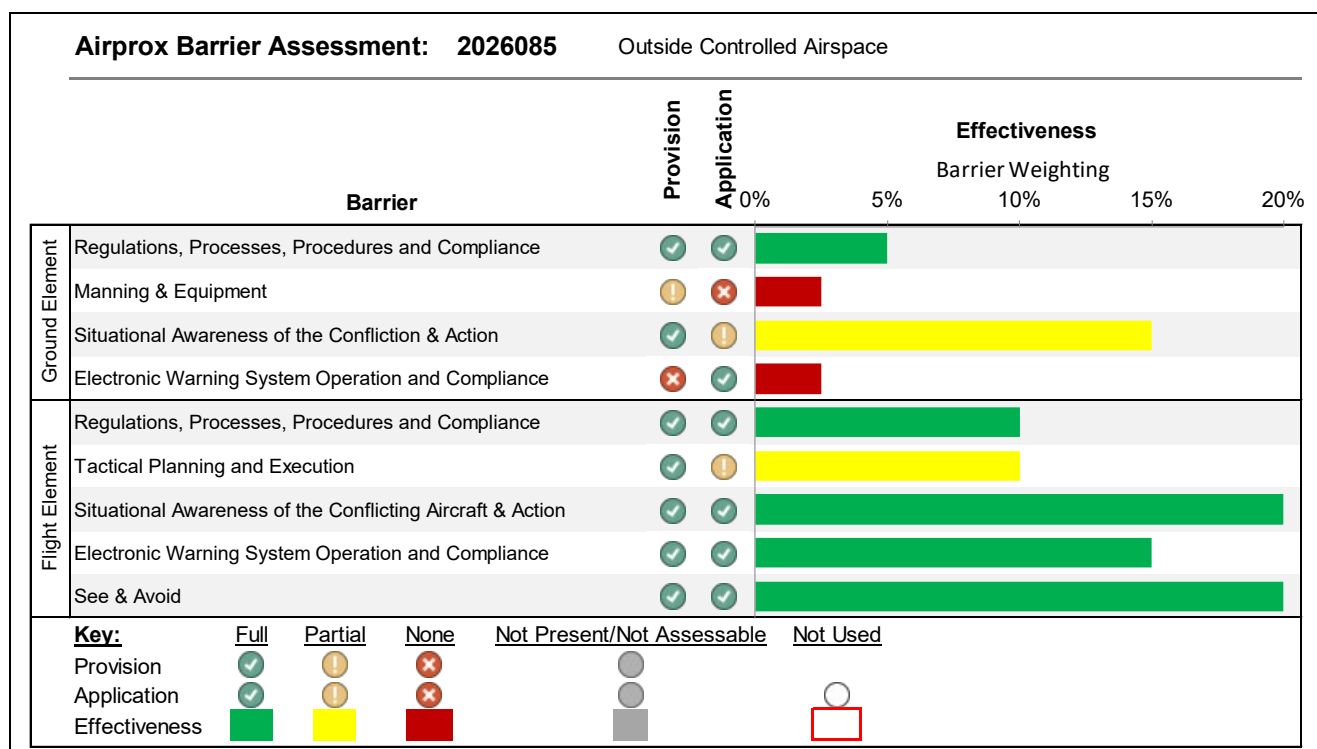
**Manning and Equipment** were assessed as **ineffective** because the task loading and training activities of the Southern Mil controller had interfered with the provision of Traffic Information.

**Situational Awareness of the Confliction and Action** were assessed as **partially effective** because the Southern Mil controller had provided Traffic Information to the pilot of the AW139 when their separation from the PA17 had been 4NM.

**Electronic Warning System Operation and Compliance** were assessed as **ineffective** because the STCA in use at the Southern Mil position would have been expected to have alerted to the proximity of the AW139 and PA17, but no alert was reported.

#### Flight Elements:

**Tactical Planning and Execution** was assessed as **partially effective** because it may have been prudent for the pilot of the PA17 to have been in receipt of a surveillance-based service.



<sup>4</sup> The UK Airprox Board scheme for assessing the Availability, Functionality and Effectiveness of safety barriers can be found on the [UKAB Website](#).