AIRPROX Insight

DIRECTOR UKAB'S MONTHLY UPDATE March 2019

AIRPROX OF THE MONTH

What goes around...

Are you really sure you know what's going on at the airfield?

An instructor in a Cessna 152 was explaining a deadside join to a student as they passed through 1100ft when, moments later, the student suddenly exclaimed, pointed to the right and the instructor saw the bottom of a Bell 206 as it banked hard away.

The helicopter had been flying five-minute pleasure flights in the northern part of Blackbushe's ATZ at about 1000ft deadside but, although he was aware of its activities in general, the Cessna's instructor thought the flights were being conducted below 500ft.

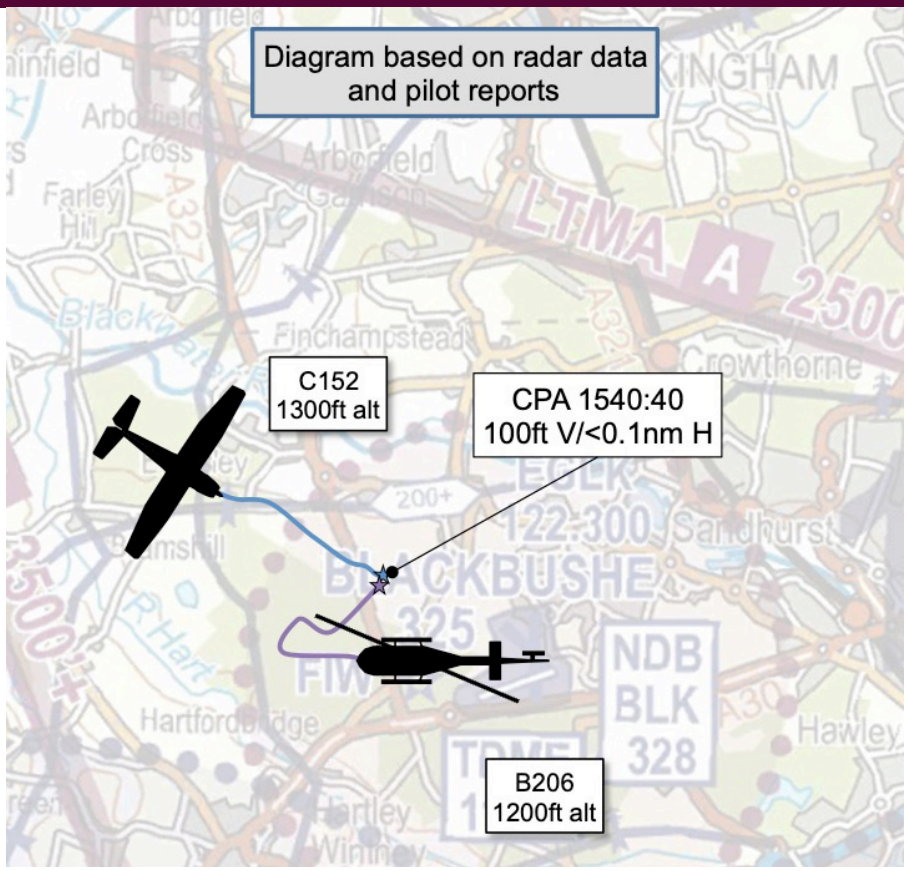
As the helicopter converged from slightly below and right about a mile or so within the ATZ boundary, its pilot saw the C152 slightly earlier than they saw him, and was able to turn away sharply.

It would be easy to criticise the C152 instructor for not maintaining a robust lookout, but the distractions of monitoring, thinking for, and pattering a student should not be under-emphasised as they effectively reduce capacity even for the instructor-gods.

This was a Category B incident (**Airprox 2018253**) and in its discussion the Airprox Board questioned to what extent the helicopter's operating profile had been effectively notified to other airfield users. The Board also felt that the Bell 206 pilot's choice of operating height and location was somewhat unfortunate.

That said, there was also an element of assumption in the Cessna instructor's belief that 'pleasure flights' would be below circuit height, so the message is "make sure you're clear about what's going on at your airfield when you're flying", lest the old adage of 'assume makes an ass out of u and me' comes and bites you on the 'ass'.

Full details of the incident can be found at the links above or at airproxboard.org.uk in the 'Airprox Reports and Analysis' section within the appropriate year and then in the 'Individual Airprox reports' tab.



UKAB MONTHLY ROUND-UP

This month's predominant theme involved poor procedures, procedures not being followed, or poor tactical planning and execution by pilots in seven cases.

Three were at the LAA Rally at Sywell, but there were also incidents where pilots had not checked NOTAM, flew at the limits of VMC close to busy airfields, flew through glider sites or ATZ, or were operating without thinking about, or without consideration for, other pilots and what they might be doing.

The next most common theme was late- or non-sightings (six incidents) which resulted in pilots either not taking any avoiding action because they didn't see the other aircraft, or only being able to take emergency avoiding action in response to seeing it at the last moment.

Finally, inaction on sighting another aircraft or being in receipt of Traffic Information (from ATC or from their TCAS/TAS), was evident in five others.

In total, 27 incidents were reviewed at the Board's February meeting, ten of which were drone/sUAS. Of the 17 aircraft-to-aircraft incidents, seven were risk-bearing (one was Category A, where providence played a major part, and six were Category B, where safety was much reduced through serendipity, misjudgement, inaction, or late sighting).

Although it's early days, the numbers of aircraft-to-aircraft incidents for 2019 appear to be tracking slightly above the expected five-year average (21 actual against an expected 19), as are the reported sUAS incidents (12 actual verses 9 expected).

The three incidents at the LAA Rally gave the Board pause for thought; all involved the join procedures and one was very close indeed (reportedly one-metre vertically).

While understanding the reasoning behind the silent joining procedures, the Board was concerned that there was ambiguity about what to do when things didn't go as planned, and there was seeming self-induced pressure for pilots to press-on regardless and accept circumstances that would not likely be tolerated at their home base.

As with all procedures, when they run like clockwork all will be well; however, once deviation occurs (due to inevitable unexpected influences) it seemed that there were a lack of robust measures to highlight the fact that deviation had occurred, or at least a lack of emphasis that pilots must take an early decision to abandon the join and return to the hold.

As ever, if there's any doubt then there's no doubt — have a Plan B in mind and put it into action when circumstances change sufficiently to make Plan A unsuitable.

The Board made six recommendations during its meeting as shown below.

AIRPROX RECOMMENDATIONS

2018235

1. *Sywell revise the use of 'Sloane procedures' during the LAA Rally.*
2. *Sywell review the AIC to emphasise the importance of going-around if in conflict with other traffic.*
3. *Sywell review the AIC to emphasise that pilots will not be in receipt of an Aerodrome Control Service.*

2018237

Sywell consider specifying that parallel approaches are not to be conducted.

2018239

North Weald consider promulgating specific helicopter procedures.

2018252

Wickenby and Waddington consider the use of the 7010 squawk for Wickenby circuit traffic.

The first four recommendations stem from Airprox 2018235 and 2018237 at the LAA Rally. While accepting the nature of the LAA Rally, they are intended to provide extra guidance within the procedures to emphasise to pilots that they should not just press-on regardless when things start to get uncomfortable.

The fifth recommendation was specific to North Weald and the recent arrival of HEMS and NPAS helicopters, but could serve equally well as a reminder to other mixed-operation airfields of the need to ensure robust deconfliction between fixed- and rotary-wing operations. Now might be a good time to make sure that procedures still make sense, especially if something has changed regarding airspace or airfield operators.

The final recommendation came from an incident where confusion had resulted from Traffic Information that was not as specific as it might have been had the controller known for sure that the aircraft they were reporting was remaining in the circuit.

Again, somewhat specific to the circumstances, but it highlights the need for controllers to provide as much detailed information as practical to improve pilots' situational awareness, and for pilots to seek more information if they are not sure about what they have been told. ■