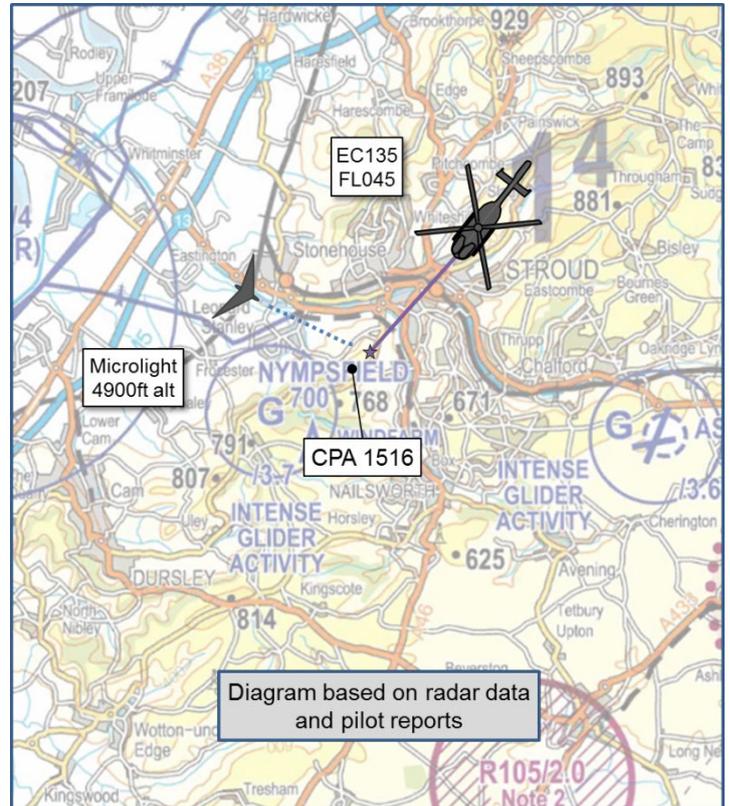


**AIRPROX REPORT No 2015145**

Date: 7 Sep 2015 Time: 1516Z Position: 5145N 00212W Location: IVO Stroud

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

Recorded	Aircraft 1	Aircraft 2
Aircraft	Quik GT450	EC135
Operator	Civ Pte	Civ Comm
Airspace	Lon FIR	Lon FIR
Class	G	G
Rules	VFR	VFR
Service	None	Traffic
Provider	N/A	Unknown
Altitude/FL	NK	FL045
Transponder	Not fitted	A,C,S
Reported		
Colours	Red, White	Yellow
Lighting	NK	Strobes, HISLs, Nav, landing.
Conditions	VMC	VMC
Visibility	>30km	NK
Altitude/FL	4900ft	4000-6000ft
Altimeter	QNH (1030hPa)	QNH
Heading	135°	SSW
Speed	60kt	120kt
ACAS/TAS	Not fitted	TAS
Alert	N/A	Unknown
Separation		
Reported	0ft V/150m H	0ft V/NK H
Recorded	NK	



**THE QUIK GT450 MICROLIGHT PILOT** reports that, whilst flying straight and level, he saw a large yellow helicopter pass from left to right at the same level. There was no risk of collision, but he was concerned about flying through the wake of such a large helicopter and so took avoiding action by entering a steep climbing turn to the left. The helicopter did not appear to deviate from its course.

He assessed the risk of collision as 'None'.

**THE EC135 PILOT** reports that some time had passed since the incident and so his recollection of event was not perfect. He recalled flying at between 4000-6000ft and receiving a Traffic Service from either Brize Norton or Birmingham. They passed Traffic Information on conflicting traffic to his right; he saw the traffic about a mile away, assessed he would pass in front of it and that no avoiding action was necessary. At no time did he think there was a risk of conflict, as he passed the traffic he remembered it turning left.

He assessed the risk of collision as 'None'.

**Factual Background**

The weather at Brize Norton was recorded as follows:

METAR EGVN 071450Z 04008KT 9999 FEW040 19/09 Q1030 BLU NOSIG=

## Analysis and Investigation

### UKAB Secretariat

Brize Norton could find no evidence (flight strip/radar recording) of having provided a service to the EC135 at that time, although they had provided a Traffic Service in the opposite direction earlier that day. Birmingham did not receive notification within 30 days of the Airprox and therefore couldn't confirm whether or not they were providing an ATS at the time. The Microlight didn't show on the NATS radars, and so the exact separation could not be established.

The Microlight and EC135 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 converging then the EC135 pilot was required to give way to the microlight<sup>2</sup>.

### Summary

An Airprox was reported when a microlight and an EC135 flew into proximity at 1516 on 7<sup>th</sup> September 2015. Both pilots were operating under VFR, in VMC, the EC135 pilot in receipt of a Traffic Service and the microlight pilot not in receipt ATS.

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

Information available consisted of reports from the pilots and radar photographs/video recordings.

The Board first looked at the actions of the Microlight pilot. He had seen the EC135 and assessed that evasive action was not necessary to avoid a collision; however, he took avoiding action because he was concerned about the effect wake-turbulence might have on his aircraft. For his part, the EC135 pilot was under a Traffic Service and, although the ATC RT was not available to the Board, had recalled receiving Traffic Information that had enabled him to see the Microlight. Once he had seen it he judged that he had enough distance without taking avoiding action. In pure collision-avoidance terms this was appropriate, but the Board commented that pilots should also take wake turbulence into consideration and remember that lighter aircraft (and especially canopy-suspended air vehicles) usually require a wider berth than they would normally give other aircraft. The Board recalled a previous Airprox between a Sea King and a hang-glider (Airprox 2013162) following which the MOD had issued guidelines to helicopter pilots on the hazards of down-wash and the effects of wake-turbulence on light aircraft. Their advice had been that their pilots try to avoid ultra-light aircraft by 2000m and to avoid over-flying them (available within Issue 25 of [Air Safety Matters](#) on the RAF Air Safety Website at link<sup>3</sup>). The Board considered this to be good advice and wondered whether it might usefully be included in CAA publications such as the forthcoming Skyway Code.

The Board opined that this incident was more about the Microlight pilot's concern about wake-turbulence than the actual risk of collision; because both pilots were visual with each other and had made timely assessments, they considered that the risk of collision was low. Nevertheless the Microlight pilot was rightly concerned about wake turbulence so, for this reason, the Board thought that the cause of the Airprox was that the EC135 pilot had flown close enough to the Microlight to cause its pilot concern. In assessing the risk, the Board agreed that because both pilots had seen each other and the Microlight pilot had taken timely avoiding action, the risk was Category C.

### **PART C: ASSESSMENT OF CAUSE AND RISK**

**Cause:** The EC135 pilot flew close enough to the GT450 to cause its pilot concern.

**Degree of Risk:** C.

<sup>1</sup> SERA.3205 Proximity.

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

<sup>3</sup> [https://cms.raf.mod.uk/rafcms/mediafiles/59B7C234\\_5056\\_A318\\_A8226118E227E2D0.pdf](https://cms.raf.mod.uk/rafcms/mediafiles/59B7C234_5056_A318_A8226118E227E2D0.pdf)