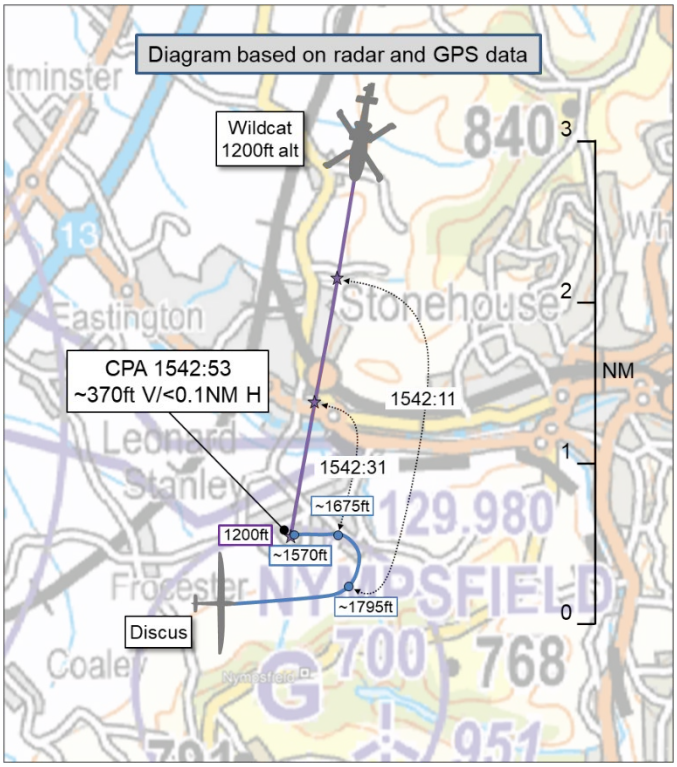
AIRPROX REPORT No 2025093

Date: 20 May 2025 Time: 1543Z Position: 5144N 00217W Location: ivo Nympsfield glider site

PART A: SUMMARY OF INFORMATION REPORTED TO UKAB

Recorded	Aircraft 1	Aircraft 2
Aircraft	Discus	Wildcat
Operator	Civ Gld	HQ JAC
Airspace	London FIR	London FIR
Class	G	G
Rules	VFR	VFR
Service	None	Basic
Provider	N/A	London Info
Altitude/FL	~1570ft	1200ft
Transponder	Not fitted	A, C, S
Reported		
Colours	White	White
Lighting	None	Anti coll, nav
Conditions	VMC	VMC
Visibility	>10km	>10km
Altitude/FL	1500ft	1000ft
Altimeter	QFE	QFE
Heading	270°	190°
Speed	60kt	140kt
ACAS/TAS	FLARM / SkyEcho	TAS
Alert	None	None
Separation at CPA		
Reported	0ft V/200ft H	Not seen
Recorded	~370ft V/<0.1NM H	



THE DISCUS PILOT reports that they were returning from a cross-country flight and descended to their circuit height. On their circuit, they noticed the helicopter approach, fly under them and continue to fly straight across the Nympsfield launch point from northeast to southwest at exactly the height they would be 2min later, as they would be on finals. It carried on flying across the National Trust car park and kept going in that direction. As they descended, they estimated the helicopter was at 500ft above ground, but they were quite busy landing at that point.

The pilot assessed the risk of collision as 'None'.

THE WILDCAT PILOT reports that, while transiting south from [refuel point] post refuel, they inadvertently flew through Nympsfield Gliding site while returning to [destination] at 1000ft AGL. They had misidentified the glider site as a minor aerodrome and elected to cut the corner, passing the landing zone approximately 2km to the west. Once they saw the field, the crew identified that there were aircraft (gliders) out on the grass but no aircraft on the runway. They briefed that it must be active and a mistake must have been made, everyone was 'eyes out' to identify aircraft but none were spotted in the air, they were travelling at 130kt+ and were south of the airfield within seconds of sighting the field so elected to maintain heading and exit expeditiously. As no aircraft were spotted on the runway or in the air, the crew was unaware of an Airprox until notified of the report issued involving them.

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

THE LONDON INFORMATION FISO reports that there was no mention of this [Airprox] event on the frequency and they were unaware of the event until notified [by the UKAB].

Factual Background

The weather at Gloucestershire Airport was recorded as follows:

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METAR EGBJ 201520Z 04002KT 9999 FEW048 21/03 Q1020
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Analysis and Investigation

JAC

[The Wildcat C/S] was detached on a task on 19th May (Monday) to provide a static display on the 20th which they had a booking for. The booking could be seen to request them for 1600 but was granted for 1710. This detail was not picked up the previous day, that the accepted booking time was different to the requested booking time. The implications of this were that the briefed lift times and refuel bookings remained aligned to the original request. This became a contributory factor when, on landing for a refuel and amending the digital flight plan, their estimated time of arrival had them arriving at approximately 1610. To make the booking of 1710 they would be on rest and respite but waiting at Manchester Barton for over an hour.

The crew took the decision to refuel immediately and lift to make best pace to arrive at [destination] on or before airfield closing at 1600. The crew sent details of their change of intentions via text to the flight command team and authoriser who liaised with agencies, and lifted shortly after receiving fuel and confirmation from their authoriser.

Due to the aircraft being away from [base], the onboard mapping was from a digital load the previous day. The crew therefore elected to use [navigation software] on the issued [tablet]. This was to ensure live NOTAM data was available. Whilst enroute to [destination], the crew had noted a new NOTAM which required manipulation of the route. Due to the tight timeline for the crew to make the airfield closing time, the crew elected to manipulate the route on [the navigation software] to expedite the route. During the re-route the glider site was mis-identified for a minor aerodrome. The crew had thought that the “Minor Aerodrome” was inactive and did not realise their mistake until overhead the glider site, at which point it was identified.

Whilst transiting the area of the glider site, the crew had noticed aircraft on the ground, but did not see any gliders airborne. The crew was unaware of the potential Airprox until notified by Swanwick Mil.

Summary – The crew appeared to be trying to complete the return leg of the task as efficiently as possible. This meant that dynamic planning had to be conducted whilst airborne which may have led to some planning errors. What appears to be a classic swiss-cheese model from the out-of-hours booking being the wrong time, through to the new NOTAM and the decision to alter the route whilst airborne, this incident appears to highlight the problems which may be encountered whilst using multiple different planning applications to plan a route, and the errors which can be transferred between systems if due diligence is not adhered to.

Findings – Due to the crew mis-identifying a glider site, they had inadvertently transited the site and an Airprox was filed. Due to multiple levels of mapping giving multiple levels of detail, the crew had mis-identified the glider site leading them to transit the site mistakenly. A lessons learned discussion was held by the crew on return, this was in order to pass the knowledge gained amongst all crew.

The incorrect out-of-hours booking time had not been noticed until the day of the return leg. This appeared to add undue pressure to the crew to achieve the return leg prior to airfield closure. The crew has been reminded that it is up to them to confirm the accuracy of all bookings and documentation.

Due to the use of different documentation available to the crew, this may have led to mis-interpretation and the decision to transit an active site. The crew had mis-identified the site for an

inactive minor aerodrome and not a glider site. All crew have been reminded to apply due diligence when planning for tasks.

UKAB Secretariat

An analysis of the NATS radar replay was undertaken and the Wildcat was positively identified using Mode S data but the Discus was not detected.

Further analysis of aircraft tracking software was undertaken and both aircraft were positively identified, the Wildcat using MLAT data and the Discus using ADS-B data. However, the comparability of this data was slightly unstable.

CPA was assessed to have been at 1542:53 by interpolation of radar and GPS data, with approximately 370ft vertical and less than 0.1NM lateral separation.

The Discus and Wildcat pilots shared an equal responsibility for collision avoidance and not to operate in such proximity to other aircraft as to create a collision hazard.[1] If the incident geometry is considered as converging then the Wildcat pilot was required to give way to the Discus glider.[2] An aircraft operated on or in the vicinity of an aerodrome shall conform with or avoid the pattern of traffic formed by other aircraft in operation.[3]

Comments

JAC

This was a cognitive error made by experienced operators which led to an inadvertent transit of an active glider site. Contributory factors included induced pressures from an incorrect 'out-of-hours' booking time; with the aircrew not having the latest dataset of NOTAM information and utilising third-party software which did not show the same level of detail that military aeronautical data provides. This has provided a worthy reminder for all crews to apply due diligence when planning for tasks.

BGA

Nympsfield is one of about 80 permanent gliding sites in the United Kingdom listed in UK AIP ENR 5.5 and labelled on the CAA 1:500,000 and 1:250,000 charts with a "G" symbol, as shown on the chart segment in Part A. A greater density of gliders may be expected nearby at any time during daylight hours at any altitude up to cloudbase, accompanied by high-tensile-strength winch-launch cables overhead the site at up to 3000ft AAL (3700ft AMSL).

Glider circuits are typically commenced at 800-1000ft AAL (1500-1700ft AMSL at Nympsfield), with the downwind leg flown on a continuously-descending path 700 to 1500m laterally from the intended landing area. The final turn is made no lower than 300ft AAL (1000ft AMSL here).

Summary

An Airprox was reported when a Discus and a Wildcat flew into proximity in the vicinity of Nympsfield at 1543Z on Tuesday 20th May 2025. The Discus pilot was operating under VFR in VMC not in receipt of a FIS, and the Wildcat pilot was operating under VFR in VMC in receipt of a Basic Service from London Information.

[1] (UK) SERA.3205 Proximity. MAA RA 2307 paragraphs 1 and 2.
[2] (UK) SERA.3210 Right-of-way (c)(2) Converging. MAA RA 2307 paragraph 12.
[3] (UK) SERA.3225 Operation on and in the Vicinity of an Aerodrome. MAA RA 2307 paragraph 17.

PART B: SUMMARY OF THE BOARD'S DISCUSSIONS

Information available consisted of reports from both pilots, radar photographs/video recordings, GPS track data from navigation equipment carried in the Discus, a report from the FISO 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 Discus pilot, and noted that the aircraft had carried two types of electronic conspicuity (EC) device for the flight, one of which was ADS-B out only, and neither had been capable of detecting the TAS installed in the Wildcat. Members therefore agreed that the EC equipment of the Discus had been incompatible with the TAS fitted in the Wildcat (**CF8**). Members further agreed that, as a potential consequence of the incompatibility, the glider pilot had had no situational awareness of the presence of the Wildcat (**CF7**). The Board also noted that the Discus pilot had seen the Wildcat approaching the gliding site as they had been proceeding downwind, and members agreed that the Discus pilot had been concerned by the proximity of the Wildcat (**CF10**).

Turning their attention to the actions of the Wildcat pilot, the Board questioned why the pilot had mistaken Nympsfield gliding site for a *'minor aerodrome'* and was disappointed that the Wildcat crew had not considered that either would have been active at the time of overflying them. Members felt that it would have been prudent for the pilot to have called Brize Radar for a Traffic Service instead of having agreed a Basic Service with London Information, although the Board acknowledged that, in this case, it would not have helped with the pilot's situational awareness because the Brize Radar controller may neither have been aware of glider activity at Nympsfield nor detected the Discus on radar as it had not been equipped with a transponder. Some Members felt that it may have been prudent for the pilot to have called Nympsfield on their ground frequency and advise of their intentions, while others noted that, in this case, the pilot had been unaware of the gliding site until the last minute so the opportunity to call on the Nympsfield frequency had been lost. However, the Board thought that it would have been prudent for the pilot to have contacted one of the frequencies supplied on the software available, particularly as the Wildcat pilot had been aware that they had been approaching an airfield of sorts and could have had the appropriate frequency in readiness. Members agreed, therefore, that the pilot's pre-flight planning had been ineffective in this case (**CF6**). The Board further noted that the pilot had been using third-party software for their planning, and members agreed that it had been inappropriate to use flight planning software with which the pilot had not been fully familiar (**CF4**), noting different symbology as an example. The Board noted that the military charts displayed the glider site and continued to be available to the crew, and there was some doubt amongst members as to exactly which third-party software the crew had been using. Members agreed that the Wildcat had flown through an active glider site (**CF3**) and had neither planned to avoid nor avoided the pattern of circuit traffic formed by the Discus glider (**CF5**, **CF2**). Members agreed that the less-than-ideal planning situation and use of the third-party navigation equipment had meant that the pilot had had no situational awareness of the presence of the Discus (**CF7**), noting that if the planning had been more effective then the pilot of the Wildcat would have had at least generic situational awareness of the possibility of gliding activity in the vicinity of a glider site. The Board noted that the pilot's situational awareness may have been enhanced had the Wildcat's onboard TAS been able to detect a transmitting transponder in the Discus, but it had had none, and members agreed that the TAS fitted in the Wildcat had been incompatible with and also unable to detect either type of EC device that had been fitted in the Discus (**CF8**). Members agreed that, although the Wildcat crew had had late awareness of the gliding site and were all *'eyes out'* monitoring the environment, the pilot had not seen the Discus proceeding downwind at Nympsfield gliding site (**CF9**).

The Board briefly considered the actions of the London Information FISO and noted that, as the unit had no surveillance facility, they had neither been aware of the exact positioning of the Wildcat nor had any knowledge of glider activity in their vicinity. Members agreed that the FISO had not been required to monitor the Wildcat under the terms of a Basic Service in any case (**CF1**).

When determining the risk, members considered the reports from both pilots together with the radar and GPS data. They noted that although the glider pilot had assessed the Wildcat as being co-altitude, there had in fact been around 370ft vertical separation and therefore members agreed that there had

been no risk of collision. However, given that the Wildcat pilot had neither seen the Discus nor been aware of gliding activity until the last minute, the Board thought that safety had been degraded and, as such, assigned Risk Category C to this event.

PART C: ASSESSMENT OF CONTRIBUTORY FACTORS AND RISK

Contributory Factors:

	2025093			
CF	**Factor**	**Description**	**ECCAIRS Amplification**	**UKAB Amplification**
	Ground Elements			
	• Situational Awareness and Action			
1	Contextual	• ANS Flight Information Provision	Provision of ANS flight information	The ATCO/FISO was not required to monitor the flight under a Basic Service
	Flight Elements			
	• Regulations, Processes, Procedures and Compliance			
2	Human Factors	• Use of policy/Procedures	Events involving the use of the relevant policy or procedures by flight crew	Regulations and/or procedures not complied with
	• Tactical Planning and Execution			
3	Human Factors	• Aircraft Navigation	An event involving navigation of the aircraft.	Flew through promulgated and active airspace, e.g. Glider Site
4	Organisational	• Flight Planning Information Sources	An event involving incorrect flight planning sources during the preparation for a flight.	
5	Human Factors	• Monitoring of Environment	Events involving flight crew not to appropriately monitoring the environment	Did not avoid/conform with the pattern of traffic already formed
6	Human Factors	• Pre-flight briefing and flight preparation	An event involving incorrect, poor or insufficient pre-flight briefing	
	• Situational Awareness of the Conflicting Aircraft and Action			
7	Contextual	• Situational Awareness and Sensory Events	Events involving a flight crew's awareness and perception of situations	Pilot had no, late, inaccurate or only generic, Situational Awareness
	• Electronic Warning System Operation and Compliance			
8	Technical	• ACAS/TCAS System Failure	An event involving the system which provides information to determine aircraft position and is primarily independent of ground installations	Incompatible CWS equipment
	• See and Avoid			
9	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
10	Human Factors	• Perception of Visual Information	Events involving flight crew incorrectly perceiving a situation visually and then taking the wrong course of action or path of movement	Pilot was concerned by the proximity of the other aircraft

Degree of Risk: C.

Safety Barrier Assessment[4]

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

Ground Elements:

Situational Awareness of the Confliction and Action were assessed as **not used** because the London FISO was not required to monitor the Wildcat under the terms of a Basic Service.

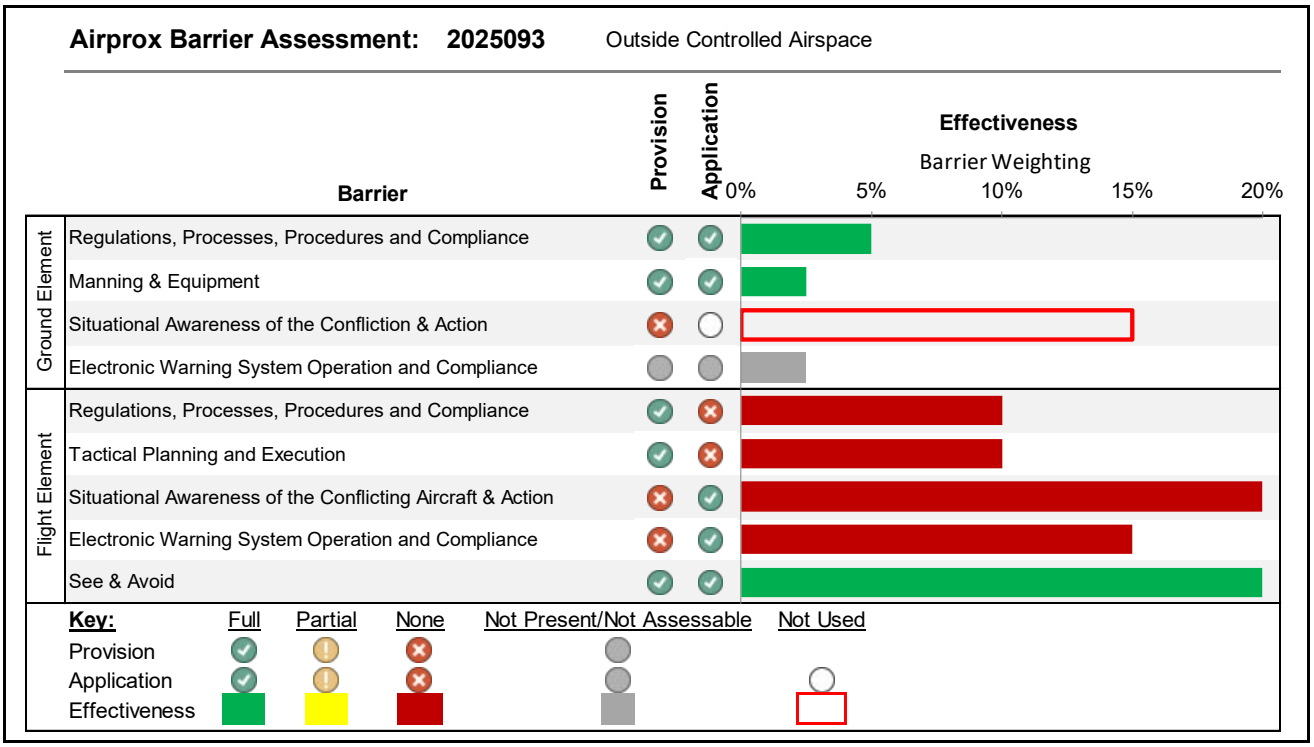
Flight Elements:

Regulations, Processes, Procedures and Compliance were assessed as **ineffective** because the Wildcat pilot had not complied with regulations pertaining to avoidance of circuit traffic.

Tactical Planning and Execution was assessed as **ineffective** because the Wildcat pilot's ineffective preflight planning led them to mistakenly overfly an active glider site.

Situational Awareness of the Conflicting Aircraft and Action were assessed as **ineffective** because neither pilot had any situational awareness of the presence of the other aircraft.

Electronic Warning System Operation and Compliance were assessed as **ineffective** because the EC equipment fitted in the Discus was unable to detect that of the Wildcat, and the TAS fitted in the Wildcat was unable to detect the signals emitted by the EC equipment fitted in the Discus.



[4] The UK Airprox Board scheme for assessing the Availability, Functionality and Effectiveness of safety barriers can be found on the UKAB Website.