

AIRPROX REPORT No 2026056

Date: 27 Apr 2026 Time: 0951Z Position: 5143N 00135W Location: IVO Brize Norton

PART A: SUMMARY OF INFORMATION REPORTED TO UKAB

Recorded	Aircraft 1	Aircraft 2
Aircraft	C17	Unk Light Aircraft
Operator	HQ Air (Ops)	Unknown
Airspace	London FIR	London FIR
Class	G	G
Rules	VFR	NK
Service	ACS	Unknown
Provider	Brize	Unknown
Altitude/FL	FL041	NK
Transponder	A, C, S	None
ADS-B	Observed	Not Observed
Reported		
Colours	Grey	White
Lighting	HISL, Landing, Taxi, Nav	NK
Conditions	VMC	NK
Visibility	>10km	NR
Altitude/FL	4000ft	NK
Altimeter	NK	NK
Heading	130°	NK
Speed	NK	NK
ACAS/TAS	TCAS II	Unknown
Alert	None	Unknown
Separation at CPA		
Reported	0ft V/100-150m H	NK
Recorded	NK V/<0.1NM H	



THE C17 PILOT reports that, during a co-ordinated VMC descent through 4000ft in the overhead of RAF Brize Norton, ATC (Tower Frequency) notified the C17 crew of an intermittent contact in the vicinity of RAF Brize Norton. Shortly after this notification, a high-wing light aircraft was spotted by the C17 crew, in the low 10 o'clock, traveling in the same direction on a slightly converging heading. The C17 descent and speed differential was increasing separation by the time a flightpath adjustment could be made. The closing speed of the C17 was assessed as in excess of 100kt and it was considered unlikely that the pilot in the light aircraft would have seen the C17 due to the high wing configuration of the light aircraft. The GA traffic was considered by the C17 crew to be close enough (approximately 100-150m) to require an Airprox report, and the crew was concerned that the light aircraft could have been adversely affected by wake turbulence. The light aircraft did not appear on TCAS, and no TCAS TA/RA alerts were displayed to the C17 pilots. The light aircraft pilot did not make themselves known on the Brize Tower frequency. The pilot noted that the Pilot Flying (PF) was on the side of the cockpit nearest the contact, however, the PF was glancing at their TCAS display to see if the intermittent contact notified by ATC was depicted (it was not). The aircraft was spotted cross-cockpit by the Pilot Monitoring.

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

THE LIGHT AIRCRAFT PILOT could not be traced.

THE BRIZE ADC CONTROLLER reports that they were band-boxing Tower and Ground, with 2 aircraft on Ground and none on Tower. Approach called and warned in [C17 C/S] for a steep descent visual recovery from the northwest to touch-and-go and join the visual circuit. They had contact with the C17 on the ATM and noted a non-squawking contact approximately 2NM north of Brize tracking south.

[The C17 pilot] called for join and was given join instructions. As they passed 1NM west of Brize the controller realised that the previous non-squawker was continuing to track south and was in conflict with the C17 so they called it to them using the ATM. The pilot acknowledged, then shortly afterwards called visual. [The controller] asked what altitude they believed the aircraft to be at, the pilot replied 3500ft, which would put the aircraft on the vertical limits of the CTR, but outside it. Nothing further was mentioned.

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

THE BRIZE APPROACH CONTROLLER reports that they were screening a UT in the Approach position at the time of the Airprox. Prior to recovery, the C17 was operating to the north of the CTR; during this period, the non-squawking aircraft interacted with the C17 and Traffic Information was passed on two occasions, however, the aircraft was not sighted. On a steep descent recovery into Brize Norton, the C17 pilot became visual with the field at approximately FL095; at this time the non-squawking return was fading and intermittent in the Brize overhead, approximately 6-7NM ENE of the C17, and was not called again prior to the aircraft being transferred to the Tower frequency.

THE BRIZE SUPERVISOR reports that they were in the Approach Control Room at the time of the C17 recovery. During the recovery of the aircraft, Traffic Information was passed on conflicting traffic that was in the area prior to the transfer to Tower. Following a normal recovery and landing with nothing being declared on frequency at the time, they were unable to add any further information.

Factual Background

The weather at Brize Norton was recorded as follows:

METAR EGVN 270950Z 24002KT CAVOK 18/05 Q1024 NOSIG=

Analysis and Investigation

Military ATM

Background

The C17 was returning to base for a steep descent visual recovery with the intentions of conducting a touch-and-go to join the visual circuit.

Sequence of Events

At 0942:25 App to C17 "[C/S] *previously called traffic northwest 5 miles tracking southeast no height information*". The C17 pilot replied "[C/S], *and eh we'd like to eh fly to the west to conduct a steep approach RW25 with a downwind join lefthand*".

(The quarantined recording does not capture if or when this traffic was called before.)

At 0944:36 App to C17: "[C/S] *eh flight level 100, previously called traffic northwest 2 miles tracking south*". This was acknowledged by the crew.

The C17 routed west and passed the track before turning back towards the airfield in the descent. The traffic was not called again by App before sending to Tower.

At 0949:21, the C17 pilot contacted the Brize Norton Tower controller "*request join 25LH QNH 1024 for a 2800ft circuit touch and go*." The C17 pilot was instructed to join and told that the circuit was clear.

At 0950:10, the Brize Norton controller passed Traffic Information to the C17 "*intermittent contact 12 o'clock two miles crossing left-to-right slow moving no height information*".

At 0950:55, the C17 pilot reported visual with the reported traffic.

At 0951:00, the Brize Norton controller requested the approximate altitude of the aircraft as the contact did not appear to have a transponder.

At 0951:13, the C17 pilot estimated about 3500ft.

CPA occurred at 0950:38 with 0.1NM lateral separation. There was no report of the vertical separation.

Local BM Investigation(s)

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

The Tower controller correctly identified and passed Traffic Information on the conflicting aircraft.

Whilst operating within the requirements of Class G [airspace], the presence of a non-cooperative GA aircraft operating close to CAS without [its pilot] establishing comms with Brize Norton ATC significantly reduced the situational awareness of both controller and pilot.

The intermittent nature of the STARNG return further degraded situational awareness. The known MARSHALL speed gate characteristic (...) resulted in intermittent display of the slow-moving contact. Combined with the absence of Mode A, this made the aircraft difficult to observe and track.

During the transfer of control from Approach to ADC, a prolonged landline coordination discussion relating to circuit procedures created task fixation for the trainee Approach controller. This reduced capacity to monitor developing traffic and contributed to the omission of a repeated traffic warning prior to transfer. The extended coordination period delayed the transfer of the C17 [pilot] to Tower frequency, reducing the opportunity for further Traffic Information to be passed.

2 Gp BM Analysis

This occurrence highlights the ongoing hazard posed by non-cooperative traffic operating near CAS. Whilst the GA aircraft was [reportedly] operating legitimately within Class G airspace, the absence of radio contact and/or Mode A significantly reduced controller situational awareness and limited surveillance-based conflict detection.

ATC actions and Traffic Information were assessed as appropriate. However, the event was exacerbated by known radar limitations and a period of task fixation, reducing opportunities for earlier recognition of the developing conflict.

UKAB Secretariat

An analysis of the NATS radar replay was undertaken, the C17 could be seen and identified using Mode S data. A primary-only track could be detected, transiting southbound approximately through the Brize Norton overhead, no height information was available. Further analysis of ADS-B data sources was undertaken, but only the C17 could be seen.

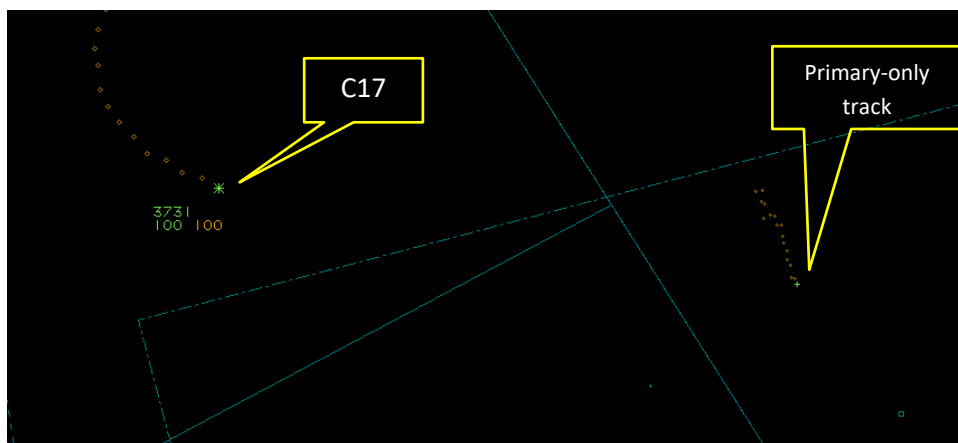


Figure 1 - 0947:52

The C17 could be seen to descend, converging with the unknown aircraft until CPA at 0950:41 (Figure 3). Radar CPA was 0.1NM laterally, but the horizontal CPA was likely to have been between radar sweeps and, because the height of the light aircraft was unknown, vertical separation could not be ascertained.

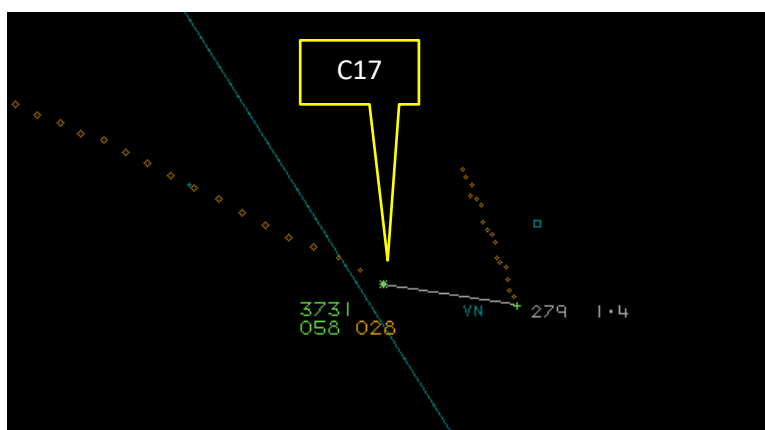


Figure 2 - 0950:11

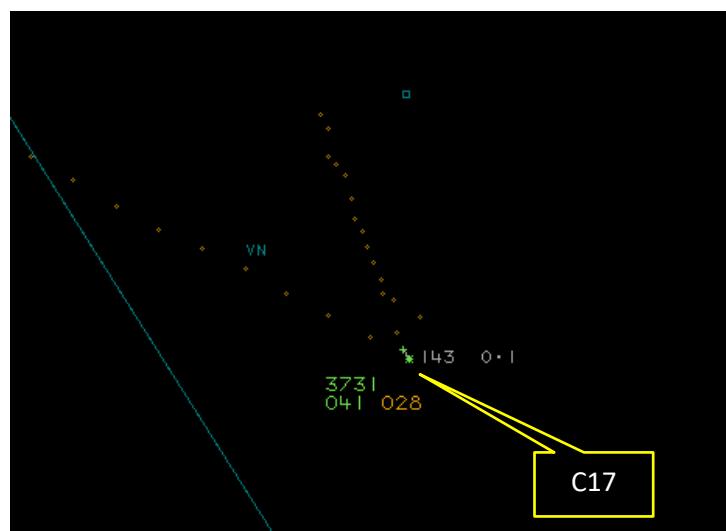


Figure 3 - CPA 0950:41

The C17 and unknown light aircraft 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 light aircraft pilot was required to give way to the

¹ (UK) SERA.3205 Proximity. MAA RA 2307 paragraphs 1 and 2.

C17.² If the incident geometry is considered as overtaking then the light aircraft pilot had right of way and the C17 pilot was required to keep out of the way of the other aircraft by altering course to the right.³

Comments

HQ Air Command

The Airprox occurred in Class G airspace as the C17 was descending to join the visual circuit at RAF Brize Norton. The unknown light aircraft is civilian operated, so no route information was available on the Centralised Aviation Data Service (CADS), and it was not possible to deconflict the sorties at the planning stage. The C17 is fitted with TCAS II, but as the unknown light aircraft was not transponding the C17 crew received no TCAS indication that another aircraft was in their vicinity. The ADC controller used information from the ATM to alert the C17 crew to the presence of the other aircraft and this aided the C17 crew in visually acquiring it. Unfortunately, this visual acquisition was at or after the CPA and the crew was unable to manoeuvre to increase the minimum separation.

The unknown light aircraft was not transponding and was not in receipt of an ATS from RAF Brize Norton, which is a LARS unit. While neither of these are a requirement for flying in the airspace where the Airprox occurred, both would have aided the situational awareness of the C17 crew and the RAF Brize Norton controllers and potentially increased the separation at the CPA or prevented the Airprox [from] occurring.

AOPA

Whilst it is perfectly legal to transit above a CTR without communicating with ATC, it is not recommended. To improve everyone's situational awareness it would be very useful if pilots communicated with air traffic control and, if available, turn on their transponders.

Summary

An Airprox was reported when a C17 and an unknown light aircraft flew into proximity in the vicinity of Brize Norton at 0951Z on Monday 27th April 2026. The C17 pilot was operating under VFR in VMC in receipt of an ACS from Brize Tower, but the light aircraft could not be traced.

PART B: SUMMARY OF THE BOARD'S DISCUSSIONS

Information available consisted of a report from the C17 pilot, radar photographs, reports from the air traffic controllers involved and reports from the appropriate operating authorities. 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 looked at the actions of the C17 pilot. They noted that the crew had been undertaking a procedure which required a steep descent into the airfield. Traffic Information had been passed on a non-squawking light aircraft by the Approach controller when some distance away from the airfield, some 4min before the crew called the Tower controller. Once on the Tower frequency, the controller had again passed Traffic Information, although this had been generic Traffic Information with no height information, because the light aircraft was non-squawking (**CF5**). Some members thought that the crew could have altered their track at this point, whilst there had been no height information, the Tower controller had given the position of the light aircraft as *'12 o'clock, 2 miles crossing left-to-right'* which should have provided enough information to warn the C17 crew of its position relative to their own. Whilst some members thought that potentially the C17 crew may not have expected to see an aircraft so close to the top of the CTR, still members agreed that a heading change of just a few degrees would have made a difference (**CF4**). The Board agreed that the TCAS on the C17 could not have detected

² (UK) SERA.3210 Right-of-way (c)(2) Converging. MAA RA 2307 paragraph 12.

³ (UK) SERA.3210 Right-of-way (c)(3) Overtaking. MAA RA 2307 paragraph 14.

the non-transponding light aircraft (**CF6**) and members thought that the C17 crew had seen the light aircraft late, too late to have taken avoiding action (**CF7**).

The Board members then briefly discussed the actions of the light aircraft pilot. They were disappointed that the light aircraft pilot could not be traced because, without a report from that pilot, it was not known whether the pilot had been aware of the C17. Members agreed that, because the aircraft had been reported as operating just above the top of the CTR, it had been likely that the pilot had been aware of the CAS below them. Members therefore thought that it was disappointing that the pilot had not called Brize ATC, if only to give them information about their routeing just above the CTR (**CF3**). Acknowledging that it was possible that the pilot may not have held a FRTOL and therefore could not have called on the radio, still members thought that when routeing that close to the CTR and directly through the Brize overhead, if they had been unable to make a call on the radio, then the pilot could have made a telephone call prior to getting airborne.

Turning to the actions of the controllers, members noted that the Approach controller had called the non-squawking traffic at least twice prior to the C17 pilot making their approach. Members were told that the track had been intermittent, however, members agreed that the controller had missed an opportunity in not calling it for a final time just prior to sending the C17 crew to the Tower frequency, in order to update the crew on the traffic and its anticipated trajectory of routeing through the Brize overhead (**CF1**). However, the Tower controller had noticed the non-squawking aircraft on the ATM and, although they had only been able to pass generic Traffic Information due to not knowing the height, they had passed timely information to the C17 crew (**CF1**, **CF2**), which had cued the crew to look for the other aircraft.

When determining the risk, members assessed the reports from the C17 pilot and the controllers, together with the radar replay screenshots. Although the exact separation was not known, and it was not known whether the light aircraft pilot had been visual with the C17, the C17 crew had reported that they had seen the light aircraft too late to take any action and that the separation had been between 100-150m. Members therefore agreed that safety had been much reduced (**CF8**); Risk Category B.

PART C: ASSESSMENT OF CONTRIBUTORY FACTORS AND RISK

Contributory Factors:

	2026056			
CF	Factor	Description	ECCAIRS Amplification	UKAB Amplification
	Ground Elements			
	• Situational Awareness and Action			
1	Human Factors	• ANS Traffic Information Provision	Provision of ANS traffic information	TI not provided, inaccurate, inadequate, or late
2	Contextual	• Traffic Management Information Action	An event involving traffic management information actions	The ground element had only generic, late, no or inaccurate Situational Awareness
	Flight Elements			
	• Tactical Planning and Execution			
3	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
4	Human Factors	• Insufficient Decision/Plan	Events involving flight crew not making a sufficiently detailed decision or plan to meet the needs of the situation	Inadequate plan adaption
	• Situational Awareness of the Conflicting Aircraft and Action			
5	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			
6	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				
7	Human Factors	• Identification/ Recognition	Events involving flight crew not fully identifying or recognising the reality of a situation	Late sighting by one or both pilots
• Outcome Events				
8	Contextual	• Near Airborne Collision with Aircraft	An event involving a near collision by an aircraft with an aircraft, balloon, dirigible or other piloted air vehicles	

Degree of Risk: B.

Safety Barrier Assessment⁴

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 **partially effective** because the light-aircraft was displaying as a primary-only track and so the controllers could only pass Traffic Information without height information.

Flight Elements:

Tactical Planning and Execution was assessed as **ineffective** because the light-aircraft pilot did not call Brize to advise ATC of their intentions. Additionally, the C17 crew could have adapted their planned track once they had been told about the unknown traffic.

Situational Awareness of the Conflicting Aircraft and Action were assessed as **partially effective** because the C17 crew only had generic information on the light aircraft as there was no height information.

Electronic Warning System Operation and Compliance were assessed as **ineffective** because the TCAS on the C17 could not detect the non-transponding light aircraft.

See and Avoid were assessed as **partially effective** because the C17 crew had sighted the light aircraft at a late stage.

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

