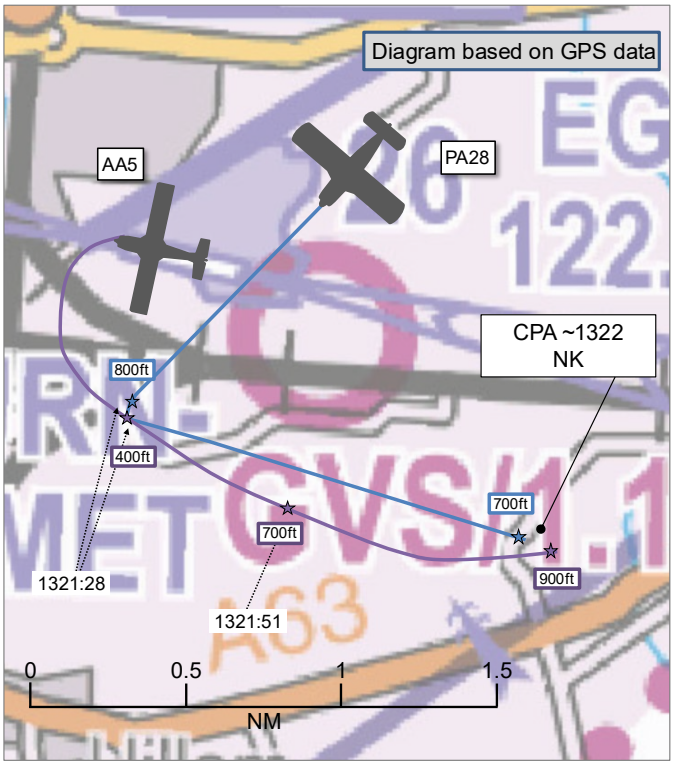
AIRPROX REPORT No 2026118

Date: 20 Jun 2026 Time: ~1322Z Position: 5347N 00113W Location: Sherburn

PART A: SUMMARY OF INFORMATION REPORTED TO UKAB

Recorded	Aircraft 1	Aircraft 2
Aircraft	PA28	AA5
Operator	Civ FW	Civ FW
Airspace	Sherburn ATZ	Sherburn ATZ
Class	G	G
Rules	VFR	VFR
Service	AGCS	AGCS
Provider	Sherburn Radio	Sherburn Radio
Altitude/FL	NK	NK
Transponder	A, C, S	A, C, S
ADS-B Out	Not Observed	Observed
Reported		
Colours	White	White, Red
Lighting	Strobe, Nav, L'ding	Strobes, Beacon
Conditions	VMC	VMC
Visibility	NR	>10km
Altitude/FL	1000ft	NK
Altimeter	QFE (1018hPa)	QNH
Heading	100°	NK
Speed	100kt	NK
ACAS/TAS	Not fitted	FLARM, SkyEcho
Alert	N/A	None
	Separation at CPA	
Reported	0ft V/30m H	Not Seen
Recorded	NK	



THE PA28 PILOT reports that they were a solo student returning from a cross-country solo flight. They saw the [AA5] taking off from RW28 at Sherburn when they were in the overhead for a standard overhead join. They lost sight of it while manoeuvring for the join. Once downwind, it suddenly rose up in front of them, crossing through their path slowly from left-to-right and continued to climb. They slowed their own aircraft and adjusted the heading to the left to avoid flying into the back of it. It appeared that the other pilot turned left immediately after take-off and climbed underneath their aircraft. They did not believe that the other pilot had been aware of their position and made no changes to their flightpath. The PA28 pilot opined that they had made what they understood to be correctly timed 'overhead', 'descending deadside' and 'downwind' radio calls.

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

THE PA28 INSTRUCTOR (Witness) reports that their student was returning to Sherburn after completing a cross-country exercise. They executed a standard overhead join for RW28, they heard the AA5 pilot on frequency, observed it taking-off and as they flew crosswind, lost sight of it. When turning downwind the AA5 appeared close to the PA28's right side, coming as close as 100ft, having turned before South Milton and possibly climbing through the downwind leg, not levelling off as expected at 1000ft.

THE AA5 PILOT reports that this was, unfortunately, a simple case of flying the wrong departure route from RW28. As a returning member from several years ago, having briefly checked SkyDemon circuits, they all looked the same, unless you enlarge the circuit shown on SkyDemon, the information shows only RW10, as the circuit extended out between Sherburn and South Milford. The old departure circuit, as shown in Pooley, 2020, shows a left-turn climb-out before South Milford, which was the route that

they were flying. The information for visiting pilots provided by Sherburn is correct, but they had made the mistake of flying the old departure route. They did not see the other aircraft.

THE SHERBURN AGO reports that nothing was observed by the AGO to indicate that an Airprox had taken place.

Factual Background

The weather at Leeds/Bradford was recorded as follows:

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METAR EGNM 201250Z 28011KT 9999 SCT041 19/09 Q1019=
METAR EGNM 201320Z 28011KT 250V310 9999 SCT045 20/09 Q1020=
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The Sherburn airfield website provides pilot information on the RW28 visual circuit as follows:

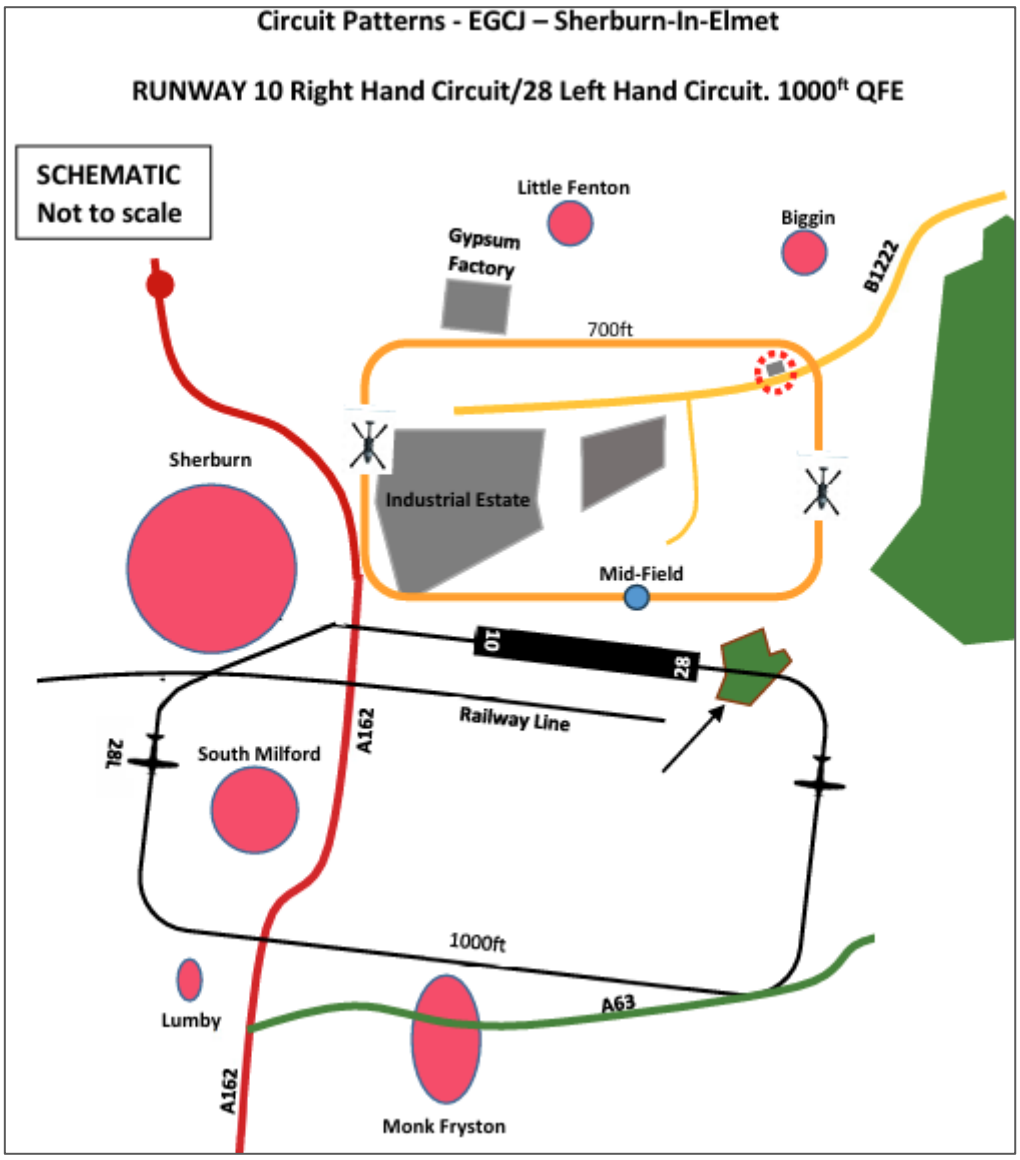


Figure 1 – Sherburn RW28 visual circuit diagram

Additionally, the following information on departure procedures, dated 17th August 2020, is as follows:

Arrival and Departure Procedures – EGCJ, Sherburn-In-Elmet

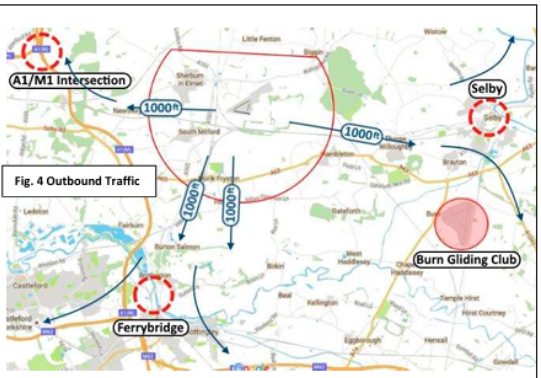
Departure (Outbound):
Initial contact with SHERBURN RADIO (A/G) 122.610

- Outbound traffic (Figure 4), whilst within the Sherburn ATZ, initially route towards:
  Direction S, SW, W **FERRYBRIDGE**
  Direction S, SE, E, NE, N **SELBY**
  Direction N, NW, W **A1/M1 Intersection**
- Fixed wing to depart the circuit remaining clear of dead side and local villages at all times.
- Traffic to depart the circuit and ATZ at circuit altitude following Figure 5:
  a) on runway heading
  b) extended crosswind, as required
  c) on completion of the downwind leg, as required
- Helicopters to depart not above 700ft QFE, and when it is necessary to cross the active runway, to do so at midpoint not below 200ft.
- Departing aircraft shall remain clear of Leeds East Airport ATZ. (Figure 2)

Aircraft may at times depart from the airfield overhead at 2000ft QFE for training purpose.

***Note**: This document is not intended to replace published Rules Of The Air, or, including but not limited to, the Air Navigation Order (ANO), Aeronautical Information Publication (AIP) the Aerodrome Flying Order Book (FOB).*

***Mandatory Noise Abatement Procedures**: All pilots shall make themselves aware of Sherburn Aero Club Noise Abatement Procedures and, not withstanding safety, remain clear of local villages and noise sensitive areas at all times (Figure 3)*



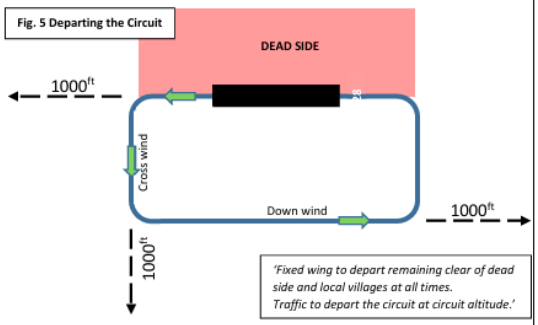


Figure 2 – Sherburn departure procedures

Analysis and Investigation

UKAB Secretariat

The NATS radar replay was reviewed and although the PA28 could be seen approaching Sherburn before the Airprox and the AA5 could be seen departing after the Airprox, the event itself could not be seen. An ADS-B data source was also analysed and the PA28 could be seen in MLAT only, which unfortunately was sporadic throughout the incident, whilst the AA5 was showing in ADS-B; the lack of accurate data meant that a precise assessment of the separation could not be made. Whilst the diagram of the top of the report was compiled using this data, the routeing of the PA28, shown as a straight line purely to join the data points, was not an accurate reflection of the PA28's actual route as flown.



Figure 2 – screenshot of ADS-B data

The PA28 and AA5 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] 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.[2]

Summary

An Airprox was reported when a PA28 and an AA5 flew into proximity in the Sherburn circuit at around 1322Z on Saturday 20th June 2026. Both pilots were operating under VFR in VMC and in receipt of a AGCS from Sherburn Radio.

PART B: SUMMARY OF THE BOARD'S DISCUSSIONS

Information available consisted of reports from both pilots, radar photographs/video recordings, GPS track data and a report from the AGO involved. 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 PA28 pilot. They were a student pilot flying a cross-country solo flight, and had been conducting an overhead join in accordance with local procedures. They had seen the AA5 on the runway and, the Board agreed, had therefore had generic situational awareness from the RT that the AA5 pilot had been departing (**CF5**). However, it would have been logical for the PA28 pilot to have assumed that the AA5 pilot would have departed in accordance with the normal Sherburn procedures, and so members agreed that the PA28 pilot had not been expecting the AA5 pilot to climb through their level on the downwind leg of the circuit. Members noted that, as an inexperienced pilot, this had been understandable, but with time pilots should endeavour to maintain situational awareness on other aircraft in the circuit, for precisely this reason, in order to ensure that the other pilots are acting as expected and that, if uncertain, pilots can always ask on the RT for an updated position report on other aircraft in the circuit. In this situation, members agreed that there had been little more that the PA28 pilot could have done in the circumstances and that, once they had seen the AA5 pilot climb in front of them, it had been too late to have taken any avoiding action to increase the separation, other than to slow down to avoid running into the back of the AA5, so this had effectively been a non-sighting.

Outwith the actions of the PA28 pilot, members noted that this had been a training school aircraft and expressed their disappointment that it had not been equipped with any form of electronic conspicuity equipment. They opined that, even if the student pilots were too preoccupied with flying the aircraft to monitor such equipment, ADS-B out equipment would at least provide a warning to other pilots of their presence, and in this particular case may have alerted the AA5 pilot, who had been equipped to receive such alerts.

Turning to the actions of the AA5 pilot, they reported that they had previously been a member at Sherburn and, on returning, had not familiarised themselves with the current procedures. Members opined that this incident highlighted why it was so important to fully brief for every flight, no matter how familiar a pilot was with the route. In using out-of-date pre-flight documents to plan (**CF4**), the AA5 pilot had not adhered to the Sherburn procedures, as clearly published on their website (**CF1**) and in doing so had subsequently flown an incorrect departure route (**CF2**) that had conflicted with other circuit traffic, namely the PA28 (**CF3**). The Board felt that the AA5 pilot should have heard the PA28 pilot making their joining calls from the RT (**CF5**), but members noted that it appeared that the AA5 pilot had not assimilated these calls (**CF6**). The Board noted that the AA5 had been equipped with electronic conspicuity equipment, but this system had been unable to detect the PA28 (**CF7**) which, although it had had a functioning transponder, had not had any compatible equipment on board. Therefore, the AA5 pilot, believing there not to have been any traffic established in the circuit, had not expected their departure to affect any downwind traffic. Members opined that it was always good practice to take a moment to check the intended flightpath prior to turning on any leg in the circuit, and that had the AA5

[1] (UK) SERA.3205 Proximity.
[2] (UK) SERA.3225 Operation on and in the Vicinity of an Aerodrome.

pilot done so, they might have become visual with the PA28. In the event, the AA5 pilot had climbed up through the circuit and had not seen the PA28 at all (**CF8**).

Members briefly discussed the role of the AGO, but agreed that they had not been required to sequence the aircraft in the circuit. Nevertheless, members thought it disapointing that the AGO had not noticed the AA5 pilot taking the incorrect departure profile, as there may have been an opportunity to provide information on the joining traffic.

When determining the risk of the Airprox, members considered the reports from both pilots together with the GPS and MLAT data. Members lamented the fact that the MLAT data on the PA28 had been sparse and had only provided a few points of definitive data, which then had to be extrapolated in order to estimate where the PA28 had flown. Consequently, members believed that the two aircraft had been closer vertically between the data points than the data appeared to show; it was apparent that the AA5 pilot had climbed up through the level of the PA28 as they departed, but it was not possible to know how close laterally the two aircraft had been. Nevertheless, the PA28 pilot's account, together with the instructor's witness report, indicated that they had been extremely close. Members noted that the PA28 pilot had not been visual with the AA5 until it appeared in front of them, too late to take any meaningful avoiding action, and that the AA5 pilot had not seen the PA28 at all. Some members thought that this indicated that there had been a serious risk of collision where providence had played a major part in the separation, whilst others countered with a lesser risk category in that there had been a risk of collision and that safety had been much reduced (**CF9**), the Chair put it to a vote and, by a narrow majority, the latter view prevailed; Risk Category B.

PART C: ASSESSMENT OF CONTRIBUTORY FACTORS AND RISK

Contributory Factors:

	2026118			
CF	**Factor**	**Description**	**ECCAIRS Amplification**	**UKAB Amplification**
	Flight Elements			
	• Regulations, Processes, Procedures and Compliance			
1	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			
2	Human Factors	• Action Performed Incorrectly	Events involving flight crew performing the selected action incorrectly	Incorrect or ineffective execution
3	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
4	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			
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
6	Human Factors	• Understanding/ Comprehension	Events involving flight crew that did not understand or comprehend a situation or instruction	Pilot did not assimilate conflict information
	• Electronic Warning System Operation and Compliance			
7	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			
8	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
	• Outcome Events			
9	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 Assessment[3]

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 AGO was not required to sequence the aircraft.

Flight Elements:

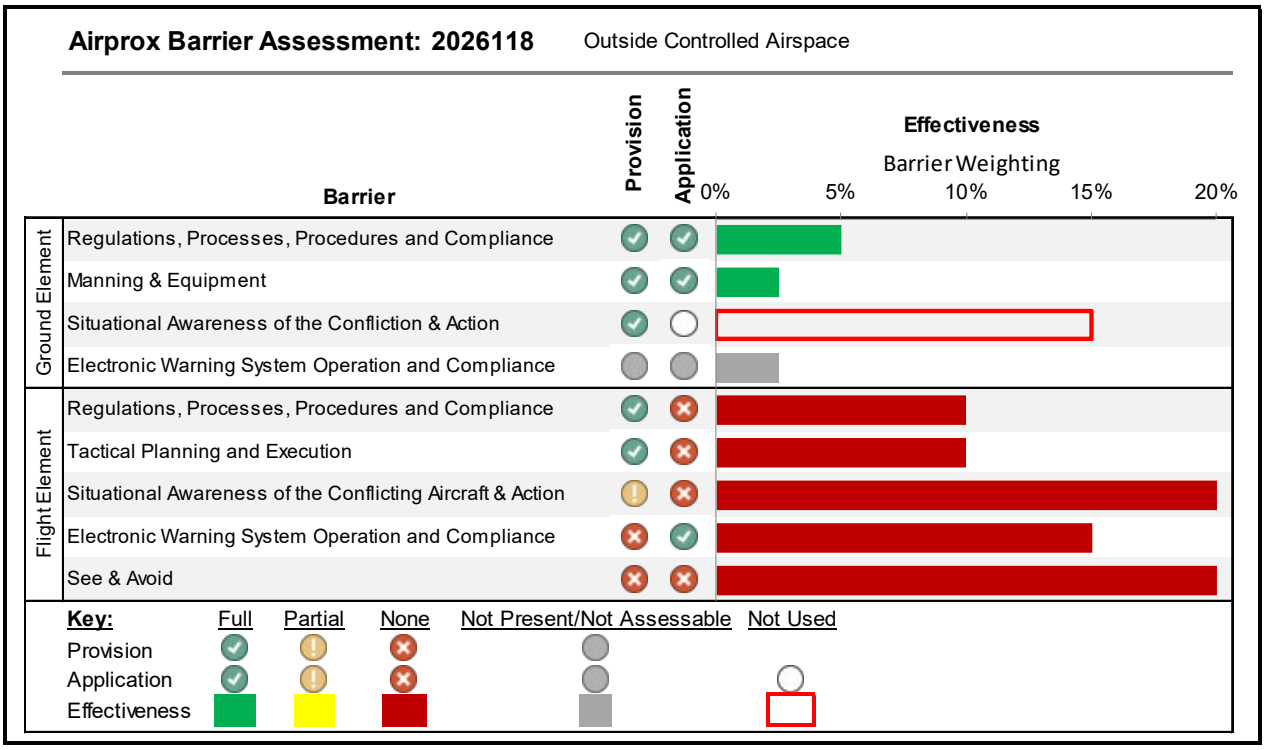
Regulations, Processes, Procedures and Compliance were assessed as **ineffective** because the AA5 pilot did not depart in accordance with the Sherburn procedures.

Tactical Planning and Execution was assessed as **ineffective** because the AA5 pilot did not check that they were using up to date planning sources and departed incorrectly, without avoiding the circuit traffic.

Situational Awareness of the Conflicting Aircraft and Action were assessed as **ineffective** because both pilots had generic situational awareness from the RT calls, but the AA5 pilot had not assimilated that the PA28 was joining through the overhead and would be in the downwind position.

Electronic Warning System Operation and Compliance were assessed as **ineffective** because the EC equipment on the AA5 could not detect the PA28.

See and Avoid were assessed as **ineffective** because the PA28 pilot did not see the AA5 in time to take any avoiding action, and the AA5 pilot did not see the PA28 at all.



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