AVIATION FEEDBACK

CHIRP
An independent and confidential reporting system for the Aviation industry

GENERAL AVIATION

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Attention Under Pressure

Contents

Nicky Smith
Director Aviation

Distraction and Task Focus: The Unseen Threats

Aviation is often described as a discipline of managing limited resources – time, performance, fuel, weather, altitude – but perhaps the most limited and important resource is attention. No matter how experienced, every pilot, skydiver, or controller has only so much cognitive bandwidth to work with at any one time. When that bandwidth becomes overloaded, even small slips can lead to serious consequences.

As workload increases, attention naturally starts to narrow, enabling maximum concentration on a problem or threat. This task focus is a double-edged sword. On one hand, it allows us to complete complex aviation procedures accurately. An air traffic controller managing busy airspace or a light aircraft pilot handling an engine failure after take-off must be disciplined, prioritise effectively, and focus without extraneous distraction. This is especially pertinent in general aviation, where we're often airborne without the backup of a crew to monitor and support us.

On the other hand, when left unchecked, task focus can blind us to critical elements of the flight. Aviation is a cognitively demanding activity, with the ever-present need to navigate both the skies and our own limitations. It's easy to become engrossed in one element of the flight, especially when things get hectic. The danger is that attention can become so narrowly focused that we lose sight of the bigger picture, potentially missing vital signals, including warnings that are seemingly highly alerting. There are repeated stories of pilots continuing to land despite loud gear warnings all the way down the approach.

In this edition of GA FEEDBACK, several reports illustrate how easy it is to focus on one item during high workload moments, leading to missed cues, misjudged priorities, or delayed decisions. Whether it's a forgotten aircraft configuration during circuits, a misread situation when trying to take off, or hesitation under a parachute canopy, the common thread is distraction and task fixation. It's natural to become immersed in the task at hand, especially when pressure mounts; but that very focus can block external cues, reduce situational awareness, or reinforce assumptions that turn out to be wrong.

So, how do we develop better attention management, to monitor multiple sources of information simultaneously without becoming fixated on just one? The goal isn't to eliminate task focus (it's necessary and often beneficial), but to ***balance*** it. Build habits that support a continual cycle of scanning, reassessing, and asking: "What am I missing?"

One of the best ways to reduce the risk of overload is through preparation and planning. Taking time before the flight or jump to mentally rehearse 'actions on,' consider potential snags, identify decision points and think through 'what ifs' helps lighten the mental load when things start happening quickly. Having a clear plan creates space to make good choices under pressure. This is the essence of Threat and Error Management (TEM) and if you'd like to know more, check out the excellent resources at Skybrary – TEM.

The skydiver featured in this GA FEEDBACK experienced a line twist shortly after canopy deployment. Focused on clearing the twist, they didn't recognise that the canopy wasn't fully functional. Despite altitude cues and growing urgency, they repeatedly missed opportunities to cut away the main canopy. By the time the true nature of the problem was recognised, it was too late to act. The partially functional canopy collapsed during flare, but remarkably the reporter walked away with only relatively minor injuries.

This report is powerful, not only because of how close it came to a serious accident, but because it reflects the mental dynamics that resonate across all aviation: fixation on the visible problem, reluctance to make a decisive call, and steadily narrowing options as altitude (or time) runs out. With hindsight, the reporter acknowledged what they ***should*** have done, but in the moment, task focus and distraction combined to cloud judgment.

All the reports in this issue are commendable for their honest reflection and a willingness to share hard-earned lessons (via the big orange **SUBMIT** REPORT button on the CHIRP website or app). Whether it's forgetting the basics in the circuit, a near miss on a crowded taxiway, a busy controller, or a difficult parachute malfunction, each one offers insight into how focusing too much on one thing can lead us to lose sight of everything else. In aviation – whether in an aircraft or under a canopy – that can be a dangerous place to be! If you've ever had a moment where things didn't go to plan and you learned from it, please consider submitting a report to CHIRP. These reports are what make aviation safer for everyone.

Grab a coffee, relax and take some time out to enjoy this edition of FEEDBACK.

Nicky Smith, Director Aviation

Report to CHIRP!

Our reporting process is simple and quick using either our website portal or our App (scan the appropriate QR code shown or search for 'CHIRP Aviation' – avoiding the birdsong apps that come up!). In our reporting portal you'll be presented with a series of fields to complete, of which you fill in as much as you feel is relevant – not every field is mandatory, but the more information you can give us the better. Although you'll need to enter your email address to get access to the portal so that we can screen out bots etc, none of your details are shared outside CHIRP, and we have our own independent secure database and IT systems to ensure confidentiality. That way you can help to improve safety by sharing important lessons without worrying about possible consequences. Anything that could identify a reporter is removed from our reports before progressing or publishing them, and we liaise with the reporter in every step of the process. Each report plays its part in raising awareness of important safety issues and wider trends and provides lessons for all to learn from. Report-by-report we can make aviation safer – as our strapline says,

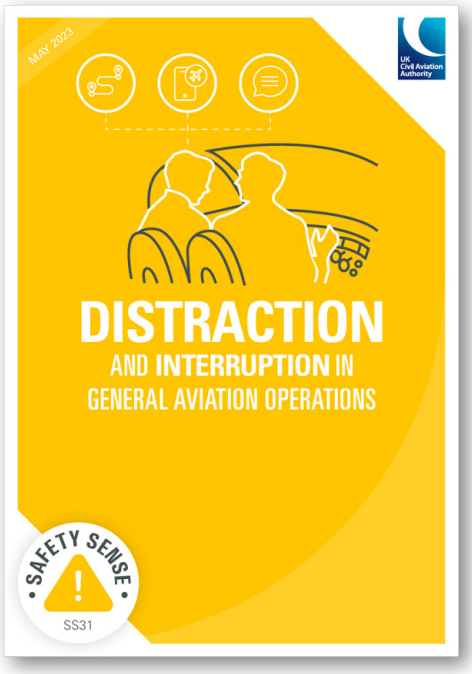
"you report it, we help sort it."

CAA Safety Sense leaflet SS31

Distraction & Interruption in GA Operations

Distraction and interruption are unavoidable aspects of flying that require consideration and mitigation. Many occurrences, serious incidents or accidents have been caused by apparently trivial distractions or interruptions, with examples including loss of control, collisions, aircraft configuration errors or airspace infringements. In most cases, the attention of the pilot or crew was diverted from the primary task of flying and navigating the aircraft. With the right strategies and self-discipline in place, it is possible to be more aware of the dangers and reduce the risk to your flying. Consider mitigations within your Threat and Error Management (TEM) approach. More information on TEM can be found on the Airspace & Safety Initiative website.

This very readable CAA Safety Sense leaflet (https://www.caa.co.uk/publication/download/20402) is pertinent to some of the themes raised in this edition of CHIRP GA FEEDBACK and well worth a read.



5% discount at Pooleys

Pooleys have kindly agreed to support CHIRP's fund-raising activities by allocating us a discount code on their website shop. Enter the code '**Chirp**' (case sensitive) at the appropriate point at the payment stage to get 5% discount and generate some commission for CHIRP. Sadly, this doesn't apply to the purchase of Bose headsets, but everything else qualifies. If you do use Pooleys (https://www.pooleys.com) for your purchases, or know other people who do, please do share the code. The more the code is circulated, the more it is used and the greater the commission generated to help CHIRP build its resources to do more.

POOLEY'S
FLIGHT EQUIPMENT

COMMENTS ON GAFB 103

Comment about report GA1377 – Tall trees on approach at Popham

I am on the 'team' at Popham and also fly there and concur with the airfield response. It's worth noting that an aircraft managed to collide with an HGV at Henstridge recently on final approach! The consequences of something similar on the A303, which is a very high-speed road, doesn't bear thinking about.

General Comment (with many thanks from the CHIRP team for the positive feedback)

Another excellent CHIRP GA FEEDBACK. As an avid reader this is one of the best. Thank you. If as they sing 'things can only get better'...I look forward, as ever, to the next. I will put a reminder on our club's WhatsApp and Message board as I believe that CHIRP, as well as being a fundamentally useful reporting tool, is 'essential reading'.

I'm pleased to report re I Learnt About Human Factors From That and A Sting in the Tail that Bees (aka Brentford Football Club) are currently 5 places above West Ham!

I Learnt About Human Factors From That

The Poltergeist Instructor

A recent challenging experience during a night-rating flight took me back to a spooky experience of my youth.

It was in the 1990's, at RAF Sealand, the base of the Air Cadets' 631 Volunteer Gliding School. I was a teenage staff cadet, meaning that in exchange for tireless labour every weekend I would get a few instructional flights here and there, eventually becoming a 'G1' and be allowed to take cadets up for their first air experience flights.

I'd become quite suspicious of the un-natural handling of one of our Grob G103 'Viking' gliders and had a plan for how to catch the entity responsible. I pre-flighted the aircraft, strapped into the front seat and gave the cadet on the wing-tip the instruction to level the wings. So far, so normal. After a standard launch, climb and level off, I lowered the nose to unweight the cable, released it, and trimmed for 50kts. At this point, with plenty of altitude, I gently took my hands and feet off the controls to see what would happen.

Initially, it flew straight and level (clearly my trimming was pretty good), however after flying for a short while, as predicted the poltergeist made its presence felt, and the aircraft gently banked to the left, and then levelled off again after turning through 90 degrees, all on its own, bringing us nicely onto the crosswind leg. Uncanny.

Image courtesy of author

A short while later, as is the custom when a little high entering the circuit, the paranormal aircraft gently banked itself to the right, and didn't level out again until completing a perfect 270º orbit, leaving us heading downwind straight and level. At this point, I was thinking that flying would be very relaxing if aircraft were like this all of the time, but the apparition was losing interest and the nose started to droop a little lower, with airspeed gradually creeping up...

Just then, snapping me out of my reverie came a loud noise from behind me (the first sound since getting in) "speed... SPEED! What the hell are you doing, boy?" Having caught the poltergeist red-handed, I responded: "I haven't touched the controls since we released the cable! If you want me to fly the aircraft, then say ***"YOU HAVE CONTROL!"***

We concluded our circuit uneventfully and had a good chat on the ground about handover protocol. The gruff, but well-loved senior instructor in the rear seat had been frustrating me for some time with his heavy presence on the controls, especially the rudder, and it made it quite difficult to understand when it was the wind nudging the aircraft, when my flying was responsible or when it was him.

But what his response in this flight showed me was more surprising than what I'd first set out to prove – he wasn't just 'ghosting' the controls a little too heavily while keeping an eye on what the student was doing, he was ***unaware that he was actively flying the aircraft much of the time!***

I'd recognised that, having flown a few hundred launches, I no longer consciously thought about separate control movements, but simply looked in the direction I wanted to go, and the aircraft would move under me to where I wanted. The same was naturally happening to this instructor with significantly more time in these aircraft than me, but with potentially worse results when he thought that he was letting students fly the aircraft.

There were 2 issues here:

1. A new solo pilot taught in this way might not really know what the aircraft feels like without another hand guiding the controls. This significantly increases the mental load on the student, trying to second-guess which forces are from air over the control surfaces versus intentional (or unintentional) deflections from the unseen instructor in the rear seat. These 'hints' through the controls won't be available when the student finally flies solo, of course.

2. If the instructor moves in and out of active control without formal and explicit handover, then at a critical phase of flight (launch/landing) key seconds may be lost while the two pilots first discover their mistake in assuming that any unexpected force on the controls was/wasn't the other person or thinking that in fact the other was in control, and then having to agree who will take charge now.

It's no surprise that so many RAF accident reports on our coffee table at the time cited issues from 'Cockpit gradient' (where P2 has a higher military rank or flying experience than P1) and 'confusion as to which pilot was flying the plane' as significant factors in a number of avoidable accidents.

Handover Protocol, as I was taught it:

The pilot handing over will say ***"You have control"*** and the recipient takes the controls and says ***"I have control"***, at which point the pilot that relinquished will let go of the controls completely.

One person should be in control at any time. If there is something that the instructor wants the student to feel on the controls with the instructor still in charge, then they should be formally told ***"follow me through"*** [on the controls], and the student replies ***"following through"***.

In an emergency, if the instructor wants to seize control, it should be with the words ***"I HAVE CONTROL"*** to clearly show that they are taking control, and that they won't be letting go again without also using the handing-back protocol.

A common thing (which I have experienced) is an instructor making a brief intervention during landing such as pulling the nose forcefully back 5 degrees, with the student not knowing if they should politely let go of the controls to let the instructor continue to fly the recovery without distraction, or to actively resume control after the momentary input?

Yoke wrestling matches in the dark

This danger played out almost verbatim for me in December 2020 (inspiring me to write this, in the hope that it might help others) while doing my first night rating sortie with a load of circuits, in which an instructor with 'heavy hands' (and even heavier feet) was hinting and guiding the aircraft throughout the circuit by nudging the control yoke, and then completely dominating the controls during finals and round-out each time, to the point where they were saying "feel for the ground" and I complained back "I can't feel a damn thing with you so heavy on the controls". At times they were like a moving cage on the controls, with me having to wrestle hard to get any movement on the controls other than where they wanted it to go.

Image courtesy of author

During a particularly joyless bout of wrestling on the final turn I gave up and simply let them land it, but 10 seconds after the wheels touched down, they stopped controlling the aircraft without warning, and directional control went sketchy on the ground, and I had to dive back onto the controls to fly the touch-and-go. The rest of the flight was a tense guessing game of trying to follow what they wanted, and not knowing when their control inputs would come and go, while simultaneously trying to learn something about night flying in a busy circuit.

After the tiring and challenging flight (8 circuits, of which I didn't land one of them), I retreated shaken and worried, questioning my own skills. However, I wondered if the instructor was fully aware of how much they were making control inputs, and how confusing that is to their students, and how dangerous it is for that control to vary between totally dominating to completely non-existent without any warning? Needless to say, I didn't return to that instructor, and happily completed my night rating at another school without any drama.

I respect that the instructor is in charge of aircraft safety, and is a far more experienced pilot, but students also have a flight safety responsibility and should not tolerate dangerous behaviours or habits from anyone, regardless of rank.

Thanks to this reminder I have resolved that from now on whenever I get in with a new instructor (or co-pilot), I will make it my habit to set expectations from the start that naturally I want them to take over if I am putting us in danger, but that to avoid any confusion ***I want their hands & feet completely off the controls unless they have used clear handover protocol!***

CHIRP Comment

The author identifies the risk linked to a lack of clarity over who is actually flying the aircraft and ambiguous handover/takeover protocol. Poor practice in this area can readily lead to an accident or serious incident, especially near the ground. The 4th August 2022 PA28 occurrence at Kemble is a case in point. A summary is provided below and the full AAIB report can be accessed at this link – https://www.gov.uk/aaib-reports/aaib-investigation-to-piper-pa-28-140-g-bcjn

During an attempted go-around the aircraft veered left from the runway track. The instructor was unable to establish a climb and the aircraft touched down approximately 350 m from the end of the runway, tracking approximately perpendicular to the left of the runway track. As the aircraft touched down it passed between two parked, out of use, airliners and its right wing tip struck the nose landing gear of one of the parked aircraft. The outer portion of the right wing was severed and the aircraft continued across the grass. It passed through the airfield perimeter fence, crossed the A429 road and came to rest in a ditch adjacent to the road.

There had been a confused handover of control between student and instructor *that meant the go-around actions were not completed effectively. This resulted in the aircraft flying at very low height at an airspeed that was probably below the minimum power speed, leaving it with insufficient power to climb away.*

We need your ILAHFFT stories!

The value of ILAHFFT is that it provides insights from those who have been there, done it, and have lessons for all of us to learn. If you have any anecdotes or amusing 'there I was…' stories then please do share them with us so that we can pass on the messages and inform others (ideally in a light-hearted and engaging manner). Send any interesting tales to mail@chirp.co.uk and put ILAHFFT in the subject header – we promise full confidentiality to protect the innocent (and not so innocent!).

Reports

Report No1 - GA1386 – Flap forgotten during touch and go

Initial Report

I attended the airport to conduct three circuits in a PA28 Warrior. There was an airliner in the circuit carrying out circuit and landing training for trainee airline pilots. This was not unusual and I had conducted many circuits in the past few years whilst they were training. The airport is full ATC in controlled airspace. I called ATC and asked if I would get clearance for circuits and was told I would be given clearance for the circuits. The aircraft needed fuel and unfortunately the fuel truck was delayed by 45 minutes. After the aircraft was fuelled, I checked the weather and the cloud base had dropped to a level that was marginal for circuits, so I waited. The airliner landed. After around 40 minutes the low cloud passed and I called ATC for clearance to do the circuits. This time I was given clearance but told that if the airliner resumed their training I would have my clearance cancelled and would have to land. After carrying out all my checks, I taxied, completed my power checks and was cleared to take off for my circuits. The first circuit and landing went well. On the second circuit I was on final and given clearance for touch and go when I heard the airline captain/trainer on the radio. I was around 300ft agl about to land, I heard the airline captain mention the light aircraft in the circuit, but I was concentrating on landing the aircraft and didn't hear the whole message. This was likely due to auditory exclusion as I was focused on the task of landing the aircraft. As I touched down I was fully expecting ATC to cancel my flight and tell me to taxi back to the apron. After a few seconds ATC did not speak to me so I continued with my flight. I put the power to full and took off. As I began to climb, I noticed that I was not achieving the expected climb rate and the aircraft was struggling to climb, the engine note was good and sounded normal. I immediately put the nose down and scanned the instruments, RPM, fuel pressure, oil pressure were all good. I then looked at the flaps and realised I had not retracted them. I maintained level flight to increase my speed and took one stage of flap off. When I had achieved the desired speed and positive rate of climb I further reduced the flaps, in stages. After climbing to circuit height ATC contacted me and asked if I could state the actual cloud base height and visibility for the airline captain. The third and final landing was uneventful.

CHIRP Comment

CHIRP commends the reporter for their open and honest account of this event. It takes integrity and professionalism to share experiences that could easily be kept private, and doing so contributes significantly to the learning and safety of the wider aviation community. This is precisely the kind of valuable reporting we aim to encourage at CHIRP. In many ways the candid report speaks for itself. The reporter identifies that they were concentrating on a demanding phase of the flight, ie the landing, became distracted and just didn't hear (or fully process) comms between the airliner and ATC. Listening whilst anticipating something specific (in the reporter's case to be told to land) can, owing to confirmation bias (in this case a mention of a light aircraft), lead to the brain hearing what it's expecting to hear.

It's possible that the reporter felt that they were a lower priority than the airliner, leading to expectation bias and implicitly receiving the corresponding message. The problem seems to have been compounded by a reduction in capacity owing to focus on another task ie landing. To their credit, throughout finals and the landing, the reporter did absolutely the right thing in prioritising flying the aircraft.

It's worth remembering that if you've missed an ATC call, partially heard something, or are just not sure what was said, rather than assuming it's ok or hoping it wasn't relevant to you, then requesting a "say again" never harms; it's better to be safe than sorry. The reporter did particularly well to identify on go around that something wasn't right, then calmly and systematically work through the possible causes, finally correcting the mistake without rushing and potentially compounding the error. Sometimes unexpected things happen in flying; working through the issue and always remembering to **Aviate, Navigate, Communicate** will lead to a better outcome. Then debrief yourself afterwards when you're on the ground and assess what went wrong, how you dealt with it, what you did well and what could have been done better. There are invariably lessons to be learned; maybe consider reporting to CHIRP so that others can benefit from the experience too.

In general, it's also worth highlighting that ATC are very unlikely to call for a touch-and-go to be converted to a full landing once an aircraft is on final, unless there is some sort of emergency. For safety reasons, ATC try to avoid issuing changes of instructions to pilots during high-workload activity. Finally, for unusual operations eg in this case an airfield in controlled airspace and with regular airline training traffic, some thorough Threat Error Management and having a plan for potential eventualities is always a good idea.

Key Issues relating to this report

Dirty Dozen Human Factors

The following 'Dirty Dozen' Human Factors elements were a key part of the CHIRP discussions about this report and are intended to provide food for thought when considering aspects that might be pertinent in similar circumstances.

Distraction & Deviation – Focus on landing led to missed cues and flap oversight.

Pressure – Presumed themselves to be a lower priority and determined not to inconvenience airliner.

Awareness

- Assumed flight would be terminated, affecting perception (expectation bias).
- Heard what was expected on R/T rather than full message (confirmation bias).
- Calm identification and resolution of error during climb-out (good airmanship).

Communication – Missed partial R/T highlighting need to request clarification.

Resources – High-task phase reduced cognitive bandwidth.

Awareness | Communication | Deviation | Distraction | Pressure | Resources

Report No2 - ATC862 (2 x issues) – Poor controller attitude

Initial Report

This report highlights two occurrences during one flight which had a common theme.

Issue 1 – Similar callsigns equally abbreviated causes confusion

Departed out of [Airfield] in [aircraft] on a FI revalidation flight and switched frequency to Farnborough North for a Basic Service. Our registration G-**IG. We confirmed a basic service (with the Farnborough ATC now abbreviating our callsign to "G-IG"). At this point we had heard no other traffic on the frequency.

About 3 minutes later (there had now been radio traffic previous to this to other aircraft) we heard

> "G-IG traffic in your 1 o'clock, same level, 2 miles".
> The candidate queried "G-IG, was that for us?" as he had not heard the entire message.
> The reply was "G-IG no, that's not for you. You are on a Basic Service – you don't get traffic".

At that point we understood that there was obviously another aircraft on frequency with the abbreviated callsign G-IG (and they subsequently responded to the message) but at no point did the controller ask for both aircraft to use their full callsign. We had not heard the other aircraft with the similar callsign at this point and so would have had no idea that there was an issue. The controller had the information and should have informed both aircraft to use full callsigns.

I understand that traffic advisory is not a feature of the Basic Service, but many stations will give limited information if they have time and the controller's response was not only unnecessarily harsh but also incorrect. He should have realised the similar callsign on frequency and asked to adopt full callsigns. Until this point we had not heard the other aircraft and were unaware that there was a similar callsign.

If this had been a call to the other aircraft about traffic in a potentially dangerous situation, the delay caused by us answering could have reduced safety margins to an unacceptable level.

Issue 2 – Limitations of a traffic service

Later in the flight we then overheard another conversation between the same controller and "G-SN":

> Farnborough: "G-SN how much further north are you intending on going?"
> G-SN: "We are about to commence a general handling climbing and descending exercise in this area"
> Farnborough: "Well, you're going to have to tell me every time you are changing level"
> G-SN: "In which case, we are going to be operating in a block between 2000 and 3000 feet."
> Farnborough: "I can't possibly be expected to give you traffic information for a block. I'm too busy. You need to tell me every time you're changing altitude"
> G-SN: "In which case, we will downgrade to a Basic Service"

It was a murky day with the visibility about 8km in haze. Not only was the controller incorrect with stating that the aircraft needed to tell him altitude changes if he wanted a Traffic Service (obviously recommended but by no means a requirement of the service) – the controller's actions effectively forced the instructor of the aircraft to downgrade a service rather than being required to have the requirement of making a call about every 2 minutes! Again, the controller was snippy and unhelpful.

I understand that controllers are busy but the way this controller talked to us and to the other aircraft was not only rude, it was incorrect and did nothing in either case to make flights safer. Quite the reverse.

CHIRP Comment

This report addresses two separate but related issues. It's a valuable contribution, bringing attention to two minor events that might have been overlooked but instead sparked important and lively discussion about aspects of air traffic services and human factors in aviation safety.

Issue 1 – Similar callsigns equally abbreviated causes confusion

The controller's handling of the situation certainly seems to have been lacking in some respects. Firstly, if there are multiple callsigns on frequency with the same final two letters then, to mitigate confusion, the controller should immediately revert to full callsign and advise pilots that similar callsigns are on frequency. Therefore, it wasn't unreasonable for the reporter's candidate to request clarification, especially since he hadn't heard the entire message. CHIRP always advocates the use of "say again" or similar if there is any doubt. It's not safe or sensible for a controller to assume that a pilot will ignore calls for their callsign just because the call isn't strictly relevant to the service they're receiving. Overall, an unnecessary level of ambiguity ensued owing to this mistake and, as the reporter identifies, safety margins were reduced by superfluous R/T.

The second area where the controller wasn't overly helpful was in the tone and manner of their response to the candidate's question. Even if the controller had been in the right, such a brusque response seems at best unconstructive and could even have unsettled the pilot, especially if they were under pressure or with a high workload, leading to distraction and impacting safety. An angry or even curt approach on the R/T will never improve matters. For pilots and controllers alike, patience, courtesy and consideration, no matter how frustrating the situation or pressure of workload, should always be the overriding consideration on the radio.

Notwithstanding the above, CHIRP does have a degree of sympathy with ATC. Farnborough is a notoriously busy airspace with the same controller often running several frequencies at once. It's useful if pilots can be aware that when receiving a service from Farnborough, an additional level of vigilance may help controllers manage a challenging task. In this circumstance, controller workload is unknown; but if it was particularly high then they may not have had the bandwidth to realise there were similar callsigns on frequency. We understand that this would not be uncommon with Farnborough. Similar callsigns can be difficult to pick up and are sometimes only noticed when a controller gets an 'odd' response to a transmission or a reply from a different voice to what their brain is expecting. Even if the controller had realised, in the heat of the moment it was probably better to call the traffic than not. At worst, this leads to two aircraft looking out, which is better than none if there is the chance of an imminent conflict. The controller's subsequent response may well have been indicative of someone under considerable pressure with multiple inputs who just didn't have the capacity to explain the full picture. Nonetheless, as a rule of thumb, pilots and controllers can usually save time by sticking to standard phraseology and not reacting/escalating on the airwaves. Although everyone must achieve a minimum standard to qualify them to participate in aviation, competence and quality will vary with both controllers and GA pilots. Humans, by their very nature are not perfect and changing circumstances affect performance, so 'cutting some slack' both ways is the best approach and working together as a team to achieve a more effective, enjoyable and ultimately, safer, day out.

As an aside, regarding the level of information provided, the controller is correct that calling traffic is not a feature of the Basic Service and indeed controllers are not even required to monitor such flights. However, controllers should give Traffic Information about general aerial activity and will do so when they perceive a definite risk of collision exists, so it is not uncommon to hear this practice. Indeed, the controller has a 'duty of care' and cannot let a collision occur if they've noted a conflict on the radar screen, therefore some kind of deconfliction action should be taken where possible. CAP 774, para 2.5-2.9 provides further information. Alternatively, for general, easily accessible, reference material covering the different air traffic services available to GA pilots, try these:

- The Skyway Code https://www.caa.co.uk/publication/download/16112
- CAA Safety Sense leaflet SS22, Radiotelephony, https://www.caa.co.uk/media/vfybdggv/safetysense22-radiotelephony.pdf.

Issue 2 – Limitations of a Traffic Service

To clarify a pilot's responsibility under a Traffic Service – pilots are required to advise the controller of altitude changes under a Traffic Service as noted in CAP774 'UK FIS' Chapter 3 'Traffic Service' Para 3.11 'Levels' which states:

> *Unless safety is likely to be compromised, a pilot shall not change level or level band without first advising and obtaining a response from the controller, as the aircraft may be co-ordinated against other airspace users without recourse to the pilot.*

Although CAP774 para 3.11 does allow for pilots to request a block to operate within, this is at the discretion of the controller,

who may not have the capacity to provide such a service or may be aware of other aircraft that prevent the allocation of a block. This was communicated to the reporter, who was grateful for the update and responded.

> ***Response from Reporter:*** *I have to admit to a slight misunderstanding of the pilot responsibility in terms of level changes under a traffic service so that's definitely one I can pass onto my students. I don't often operate under a traffic service as it generally isn't that suitable for instructional flights for exactly the reasons I believe the other pilot then changed service.*

While the controller's message was technically correct, their tone came across as abrupt and unhelpful. As in the earlier example, they may have been under pressure owing to traffic levels, but being antagonistic on the radio rarely helps and can unsettle less experienced pilots, potentially affecting their performance. This report highlights the importance of staying constructive on the radio and remembering that pilot skill levels vary widely in general aviation—something controllers should always keep in mind.

As with the previous issue from this report, there was also some sympathy for the controller. Non-face-to-face communication is particularly prone to misinterpretation and it's unclear whether the Farnborough controller was indeed 'snippy' or it was a case of the reporter interpreting it as such. Either way, some consideration for controller workload, especially in busy airspace like Farnborough, can help with a smoother service. By all means ask for a block but expect to be advised "unable due workload" or "reduced traffic information due controller workload" and have another plan (such as downgrade to a Basic Service, which is what the pilot did here). In quieter parts of the country, it's much more reasonable to expect to be able to operate in a block whilst receiving a Traffic Service, but with Farnborough, especially at busy times of day, it's highly unlikely that any controller would have the capacity to accommodate such a request. As with so many reports to CHIRP, this highlights the importance of being aware of and making allowance for the situation of others in the wider team. Everyone remembering the '3 Cs' will go a long way to safer skies – **Caution, Courtesy and Consideration**.

Finally, although not specifically germane to this report, did you know that there are recourse options if airspace access doesn't work out as hoped. It's frustrating — you plan a route, note the frequencies you need, refresh your RT wordage, get well into the flight, request a transit through a piece of controlled airspace and are refused entry. What do you do? Ideally you fall back on Plan B and continue outside that piece of airspace. But what about after landing? Do you simply shrug your shoulders, or perhaps complain to a few friends, and then forget about it? While some pilots do follow up a refusal to try to find out why they were denied access, many others don't which is a pity because there's a straightforward system to record these denials and, importantly, this provides data for the CAA to use to help improve airspace access for all. It's called the UK Airspace Access or Refusal of ATS Report Form and is designed to highlight airspace refusal issues that can be resolved so that others might in future get the access you were denied. If you haven't yet come across it, it's an online form (technically known as FCS 1522 – UK Airspace Access or Refusal of ATS Report) that lets the CAA know you were denied access, refused an air traffic service, or type of service you wanted. Read more about it in this edition of Clued Up – GA Update.

Key Issues relating to this report

Dirty Dozen Human Factors

The following 'Dirty Dozen' Human Factors elements were a key part of the CHIRP discussions about this report and are intended to provide food for thought when considering aspects that might be pertinent in similar circumstances.

Communication – Confusion caused by similar callsigns not being used in full.

Awareness – Controller may not have realised similar callsigns on frequency.

Pressure & Stress – High controller load likely impacted capacity and tone.

Teamwork – Mutual respect and professionalism on the RT essential for safety.

Distraction – Confusion with similar callsigns distracted candidate on test flight.

Awareness | Communication | Distraction | Pressure | Stress | Teamwork

Report No3 - GA1389 – Runway incursion narrowly avoided

Initial Report

I flew into [Airfield] in February. As usual at this time of year, the grass runway XX/YY was NOTAM'd out of use. Arrival on runway ZZ was not exceptional. [Diagram of runway orientation provided below for clarity]

On taxiing for departure in early afternoon, it was clear that the need to backtrack ZZ was going to lead to a bit of delay due to circuit and arriving traffic. I joined the departure queue as number 4 behind a weight shift microlight and two light twins. The microlight managed to take advantage of a runway slot and quickly departed before the stream of crosswind arrivals and circuit traffic resumed.

After several minutes, another brief slot opened and the first twin backtracked and departed. Once again, the relentless stream of arrivals and circuit traffic resumed. All this time, aircraft were calling to taxi and joined the queue. After several more minutes, one of the circuiting aircraft extended downwind to allow the second twin to get away on his pipeline inspection task.

I was now at the head of the queue for the runway, but the relentless stream of arrival and circuit traffic resumed. As the circuit aircraft landed, it was a relief to see a slow-moving aircraft join downwind and I estimated I had sufficient time to backtrack and depart without impacting his approach.

I called "backtracking ZZ" and started to move forward. Immediately an aircraft behind me in the queue called "I would remain where you are if I were you, there is an aircraft about to depart". Somewhat baffled, I executed a quick 360, resumed my position and transmitted a sheepish apology. I will be forever grateful to whoever made that call.

A few seconds later, a high-performance aircraft took off from ZZ and cleared to the north west.

My departure plan had assumed that, with the XX/YY NOTAM in place, that the only available route to the runway was via QQ threshold. This expectation was reinforced by the local aircraft who were clearly respecting the NOTAM.

The departing aircraft had indicated its intentions on the RT as the local aircraft had clearly picked up on it. I had assumed that departing aircraft were all joining the queue behind me, and didn't really listen to them. My focus was on aircraft in the circuit and trying to identify a suitable gap.

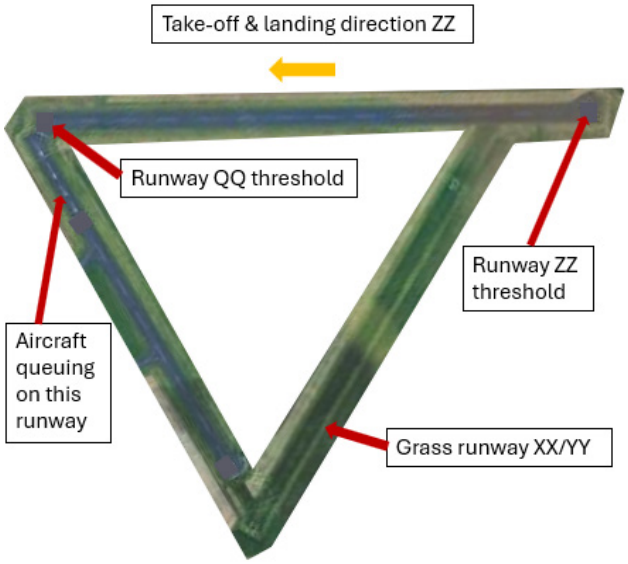
I would like to claim unfamiliarity with [Airfield] as a visitor, but I am quite a regular visitor – probably 4 or 5 times a year. I should have picked up on the transmissions of the departing aircraft. My only explanation is that the NOTAM had created a blind spot to the possibility of aircraft disregarding or being unaware of it.

Reporter's lessons learned

Complacency – just because a facility is unavailable, doesn't mean someone will not use it

Pressure – this was probably the busiest circuit I have ever experienced.

Resources – my focus was on airborne traffic to the detriment of aircraft behind me.



CHIRP Comment

The airfield concerned is a CAA licensed aerodrome with Air Ground radio only.

This report highlights just how easily expectation bias and task focus can influence decision-making even before getting airborne, especially in a busy, high-workload environment. The reporter had formed a mental ground picture, based on the NOTAM and their expectation. This was reinforced by the other visible aircraft and led to an understandable but incorrect assumption about where aircraft could be expected to route. Combined with the reporter's strong focus on airborne traffic and finding a precious gap to depart, this created a blind spot to the radio transmission which would have provided vital spatial awareness. This report also highlights the importance of careful reading and interpretation of NOTAMs; on this occasion, was the runway out of use for all operations including taxying, or was it just unavailable for take-off and landing?

In aviation, it's easy to make assumptions and become fixated on one element of the task, especially when there's a high workload and pressure, real or perceived. In this case, it was uncertainty about squeezing into a busy circuit and the knowledge of aircraft queuing behind. The key takeaways are: how quickly situations can change and how it is easy to miss a vital piece of information when attention has been prioritised elsewhere.

Fortunately, the reporter made a timely R/T call to announce their intentions; thus, the unfolding hazardous situation was picked up by another waiting pilot, who spoke up and saved the day. What a great example of successful teamwork and therefore the incident being just chalked up to a 'near miss'. This radio intervention prevented a potential runway incursion and underlines the value of good communication and mutual vigilance, particularly at airfields with only an Air Ground service where pilots carry more responsibility for situational awareness and separation.

The reporter did an excellent job of analysing the human factors at play here, even if they were a little hard on themselves. We all make mistakes, but what and how we learn from them is a measure of our calibre as aviators. We commend the reporter for their honesty and willingness to share this experience. Rather than brush it off, they reflected, identified where assumptions had crept in, and recognised how their attention had narrowed. This kind of insight is exactly what helps others avoid similar situations. It's a valuable reminder that, even at familiar airfields, staying alert to the big picture and expecting the unexpected is essential to safe operations.

Key Issues relating to this report

Dirty Dozen Human Factors

The following 'Dirty Dozen' Human Factors elements were a key part of the CHIRP discussions about this report and are intended to provide food for thought when considering aspects that might be pertinent in similar circumstances.

Distraction – Focused on finding a gap in airborne traffic therefore missed important R/T call.

Complacency – Familiarity with the airfield may have led to overlooking potential changes.

Awareness – Assumed only one runway access point due to NOTAM and local behaviour.

Pressure – Busy circuit traffic and long queue created time pressure and decision stress.

Communication – Effective R/T call alerted others; another pilot's prompt warning averted conflict.

Report No4 - GA1383 (Skydiving & Parachuting) – Twists and tangles

Initial Report

Report text: [Parachute was] deployed at 3,000ft, fully open at 2,432ft, line twist so decided kick and pull.

Mistake no.1 – I did not look above line twist. Lines untwisted at 1,410ft and realised slider was snagged high up toward canopy.

Mistake no.2 – should have cutaway. Decided instead to release brakes to see if snag could be resolved, canopy bowed in middle, 1,000ft.

Mistake no.3 – should have cutaway. Instead decided canopy could be flown and landed. Canopy would only turn partially so ended up way off landing zone. Approaching ground only then realised how fast I was descending.

Mistake no. 4 – flared. Canopy did not slow it collapsed, fortunately landed on grass between trees and flat on my back. I think if I had done parachute landing fall broken leg(s) would have ensued.

Overall issue: Observation, altitude decision, slider design.

Main points: Slider strings have end tabs. Cutaway before hard deck

Lessons Learned: Look beyond obvious faults. Do not attempt to fly anything that is not big and rectangular. Decide early, if in any doubt whatsoever cutaway. Awareness, distraction.

Images show triangular tab on slider string tangled in parachute lines and deformed parachute

CHIRP Comment

This was an honest and insightful report. The reporter has candidly identified the causes of the problem and some nodal points where, in hindsight, different decisions could have been made. This rather fraught experience will almost certainly have permanently altered their skydiving behaviour.

For our skydiving readers, there is a detailed explanation of the equipment factors that led to the incident and additional specialist considerations at https://chirp.co.uk/hot-topic/skydiving-special/. In summary for non-skydiving aviators, one of the drawstring tabs had been able to come free and tangle in a 'cascade' (where two lines attached to the parachute are fused into a single line halfway down to the parachutist). This is a known but infrequent cause of malfunctions. While it is disappointing that the reporter has received no direct response to their email to the manufacturer, it is of note that the manufacturer is currently advertising this make of canopy as having 'continuous Dacron lines' (i.e. no cascades) and a 'snag resistant collapsible slider' so that 'cascade related malfunctions are impossible'. It appears that the technical issue may have now been addressed.

Images show a normal parachute opening with the uninhibited slider descending

CHIRP has a deal of sympathy for the reporter since jettisoning a main parachute which appears mostly open takes a degree of resolve, particularly if it looks as if it may improve shortly. It is easy to keep on trying to sort it out well past decision altitude, or even to forget about decision altitude, and then find one is also too low to cutaway and there is no easy way out. So, by 'decision height', the jumper should be sure that the canopy is large, rectangular and undamaged with lines that are clear, untangled and undamaged and that the canopy is fully controllable with turns in each direction and normal flare response to using the brakes. The controllability check is an essential part of a canopy check, which should follow immediately after ensuring there is no risk of collision with other canopies. If the canopy is flared for the first time at 20 feet above the ground, it is too late to do anything if it stalls or collapses (except for attempting a good landing roll if possible).

The reporter states that when their canopy collapsed near to ground level, they were thrown onto their back. They expressed the view that they may have broken their legs if they had attempted a PLF (parachute landing fall – a technique which spreads the impact across multiple body areas and reduces the risk of injury). The CHIRP skydiving members were of the unanimous view that a PLF remains the best way of reducing the risk of serious injury during a hard landing, even if a lower leg injury may occasionally be the price of avoiding a spinal, chest or head injury.

For a safe jump, the jumper will need to have a clear plan in their head long before walking out to the aircraft. The plan will include choreography of all jumpers to ensure clear airspace in time to deploy at an altitude which gives them an open and controllable canopy at or above their minimum opening height. They must have a clearly defined decision height in their head and be resolute that they will commit to emergency procedures if their canopy and lines do not look normal and behave normally by that height. The jumper must be resolute that any attempt to clear a problem will be interspersed with frequent altitude checks and will not go past decision altitude. Finally, they must have a clear minimum cutaway altitude since low cutaways may be fatal or life altering. Exact decision altitudes and minimum cutaway altitudes are determined by many considerations including exact type of equipment, Automatic Activation Device settings, local geography, jumper experience and currency. Student skydivers under training must do exactly as instructed. Licensed skydivers who are not clear about these altitudes should discuss with an advanced instructor before manifesting for their next jump. Any skydiver will benefit from regularly practising emergency drills in a suspended harness. Many drop zones run a safety day each Spring, providing supervised simple and complex emergency drills for any skydiver who wishes it.

Key Issues relating to this report

Dirty Dozen Human Factors

In addition to the reporter's own excellent analysis, the following 'Dirty Dozen' Human Factors elements were a key part of the CHIRP discussions about this report and are intended to provide food for thought when considering aspects that might be pertinent in similar circumstances.

Knowledge
- Information from manufacturers manual needs to be read and understood.
- Required opening height should be known and its implications understood.

Distraction
- Concentrated on twists rather than looking for problem above twists.
- Focused on task of resolving twists to the detriment of effective cutaway decisions.

Complacency
- Over-assumption of ability or habitual behaviour eg twists have always been resolved in the past

Assertiveness
- Indecisive about committing to a cutaway either above or at safe predetermined height (pressonitis)

CHIRP

The CHIRP Charitable Trust,
167-169 Great Portland Street,
5th Floor, London, W2 6BD

020 4543 2881
mail@chirp.co.uk
reports@chirp.co.uk
chirp.co.uk

Nicky Smith
Director Aviation – ATC & General Aviation

Jennifer Curran
Cabin Crew Programme Manager – Cabin Crew

Bill Dean
Air Transport Programme Manager – Flight Crew, ATC & Advanced Air Mobility

Kuldeep Nothey
Engineering Programme Manager – Engineering

Rupert Dent
Drone/UAS Programme Manager – Drone & UAS

Ernie Carter
GHS Programme Manager – Ground Handling & Security