AVIATION FEEDBACK

✈ **CH!RP**

An independent and confidential reporting system for the Aviation industry

GENERAL AVIATION

Beyond Human Error

Contents

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Setting the conditions for success

Whenever an accident or incident occurs, we rightly focus on Human Factors to understand what happened and why. But there's often a tendency to concentrate on the negatives – what the humans did wrong and the reasons for mistakes. This is entirely valid when it comes to preventing things from going wrong by identifying and eliminating hazards, errors and failures.

Rather than solely examining human error, we might also consider 'human saves'. On 16th May 1995, I was airborne in a Search and Rescue Sea King helicopter when I witnessed a BAE Nimrod R1 ditch into the Moray Firth after suffering a double engine fire. The perceived wisdom at the time was that ditching a Nimrod was unsurvivable; it wasn't even trained in the simulator. Faced with confirmation from the crew that the aircraft was on fire, the wing was melting and panels were falling

off, the Captain – Flt Lt Art Stacey – made a decisive call to ditch, without flaps and only a few miles from a runway. Thanks to outstanding airmanship, captaincy and flying skill, all seven crew members survived, and were rescued by a certain young Sea King pilot.

A similarly astonishing display of calm decision-making and piloting skill occurred in January 2009, when Captain Chesley Sullenberger landed a powerless Airbus A320 on the Hudson River after a bird strike disabled both engines. With little time, no thrust and limited options, he made a bold and skilful choice to ditch in the river. Once again, all on board survived.

These are two remarkable Human Factors *success* stories. Each involved critical decisions under extreme pressure, shaped by experience, skill and composure. Both offer us plenty to learn from, not just in terms of technical flying ability, but also in how humans adapt and perform when it really matters.

Analysing what leads to success in challenging situations, as well as enhancing everyday performance, is the basis of the Safety-II approach. It focuses on the adjustments and adaptations people make to deal with real-world variability. By understanding how and why things *usually* go right, we can reinforce and build on effective practices.

In CHIRP General Aviation FEEDBACK, we've historically focused on the more negative side of Human Factors. The Dirty Dozen remains a useful starting point, but it's undeniably skewed towards what went wrong. So, in this edition, we're introducing more of a Safety-II flavour to our analysis, identifying what went well, why it went well and what others can learn from it. Let us know what you think and whether any of the success stories resonate or prompt your own reflections. After all, aviation goes right over 99% of the time; let's tap into that rich seam of learning.

Speaking of things going right, how much do *you* do to set the conditions for success before you go flying? For those of us who learned in the previous century, instructors used to say: "If your planning is shorter than your flight, you're doing it wrong." Does that still hold true, or has intuitive, powerful technology changed the game? While most GA flying is for fun, we still owe it to ourselves and others to do some proper Threat & Error Management (TEM) before launching into the wild blue yonder

That doesn't mean poring over endless pages of NOTAMs or memorising the map until you can fly it in your sleep anymore. But knowing how your nav kit is set up, what information it displays, and how to use it in a diversion or emergency, should ideally be done on the ground. There are plenty of 'what ifs' that can and should be rehearsed, setting you up for success when the unexpected happens in the air.

This is especially relevant when taking friends or family flying. It's one of the great joys of GA, particularly in summer, but it also adds a significant layer of responsibility. A bit of extra planning and briefing set the scene for a safe, fun and relaxed experience. The CAA's helpful [Safety Sense Leaflet 2 – Care of Passengers in GA Aircraft](#) covers everything from weather and safety briefings to ensuring everyone enjoys the flight.

One final food for thought while you're doing your TEM is pilot incapacitation. I recently read of a passenger in the back of a Chipmunk who noticed the incapacitated pilot's head droop forward as the aircraft flew itself gently into the ground. Miraculously, both survived. Incapacitation is rare, but not unheard of. The FAA Aeromedical Institute reviewed six years of flying data and found 39 incapacitations and 11 impairments in 47 aircraft. The average age was surprisingly low – 47 for incapacitation and 43.3 for impairment – with respective in-flight rates of 0.045 and 0.013 per 100,000 flying hours. While unlikely, the consequences are potentially catastrophic, so it's worth giving your passengers a few basic tips 'just in case'.

So, once you've rehearsed the worst-case scenarios and set yourself up for success, get out there and enjoy the thrill of flying, especially while the weather's kind. Or if you'd prefer, pour yourself an iced coffee, put your feet up and take a few minutes to enjoy this edition of FEEDBACK.

Nicky Smith, Director Aviation

Report to CHIRP!

Have you had an incident or a near miss? Could CHIRP help or offer advice on a safety concern? Perhaps you've experienced or observed something with a human factors angle

that you think the wider aviation community could learn from. Why not report it to CHIRP?

Every report helps raise awareness of safety issues, highlights emerging trends and shares valuable lessons with others. Report by report, we can all contribute to making aviation safer – as our strapline says:

<div align="center">

"You report it, we help sort it."

</div>

Reporting to CHIRP is simple and quick using either our website portal or the CHIRP App (scan the relevant QR code or search for 'CHIRP Aviation', but watch out for the birdsong apps!). The portal presents a series of fields for you to complete, but not every field is mandatory – just tell us as much as you can. The more detail you provide, the more helpful we can be. Although you'll be asked for an email address to access the system (to screen out bots and spam), your personal information is held securely within CHIRP's independent systems and is never shared outside the organisation. Importantly, nothing that could identify a reporter is included in any report we progress or publish. We liaise with you at every stage and no information is passed on without your express consent.

So rather than 'fly and forget', please consider working with CHIRP to help make the skies safer for everyone. However, it's important to note that reporting to CHIRP is not a substitute for submitting a Mandatory Occurrence Report (MOR) when required, for example, when there has been a significant risk to safety, or an event that could have endangered the aircraft, its occupants, or others. MORs should be submitted via the CAA's ECCAIRS 2 portal.

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The fact that you're reading this means you already know about CHIRP General Aviation FEEDBACK? In case you don't receive our emails with links to new editions, as well as our sister Air Transport, Drone/UAS and Cabin Crew versions, please use the *subscribe* option, which can be found at the bottom of our website https://chirp.co.uk/aviation/subscribe/. Through this link you will soon have the option to request paper copies of GA FEEDBACK too. Alternatively, email us at mail@chirp.co.uk with your name, address and number of copies required, and we'll add you to our mailing list.

Good Ideas Shared

On the British Skydiving website homepage there is a link to a page (https://britishskydiving.org/reporting-chirp/) specifically about the CHIRP Programme and how to report to us that appears when the mouse pointer hovers over "Safety". Could you include something similar in your club or organisation website?
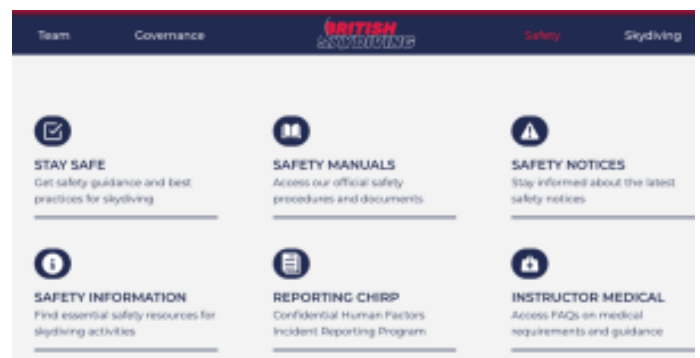
VFR Moving Map Devices

In line with this edition's theme of Threat & Error Management, please consider having a read through Safety Sense leaflet 29 – VFR Moving Map Devices.

VFR Moving Map devices, supported by GNSS, are transforming flight planning and navigation for General Aviation pilots. These tools improve situational awareness, streamline planning and provide timely alerts to airspace hazards. Available as tablet/smartphone apps, portable GNSS systems, or panel-mounted devices, they offer features like route simulation, NOTAM/weather integration and Weight & Balance calculations. However, pilots must ensure proficiency, update software and carry paper charts as backups. Effective use minimises

distractions, enhances lookout and mitigates risks like airspace infringements. The CAA encourages their use but emphasises traditional navigation skills and understanding device limitations. For more information, visit caa.co.uk/skywaycode.

Comments on GAFB 104

Type Before Tail: A Simple Fix for R/T Confusion?

A reader got in touch after reading report ATC862: Poor Controller Attitude in GAFB Edition 104, noting that some of the issues raised stemmed from callsign confusion. One idea they suggested – also previously discussed by GASCo with the CAA – is to follow the US practice of prefixing callsigns with the aircraft type (e.g. "Supercub G-IG" or "Warrior G-IG"). Doing so would help distinguish between aircraft where the last few letters of the registration are the same, reducing ambiguity for controllers and other pilots alike.

While not currently standard under CAP 413, the reader pointed out that many pilots are already informally using this approach with positive feedback from some A/G operators. They also questioned whether the 'Golf' country prefix is always necessary in routine transmissions, suggesting that aircraft type may be more operationally useful, particularly in circuit traffic, to help pilots anticipate relative speeds and manoeuvrability.

As a sensible compromise, the country prefix could be retained (alongside the aircraft type) for the initial call-up to an R/T station, then omitted in subsequent transmissions.

CHIRP Comment: We think this is an interesting idea. In an era of increasing R/T congestion and high cockpit workload, anything that improves clarity and situational awareness (SA) without adding undue complexity is worth exploring. While this approach could enhance SA for many aircraft types, it may be less effective for microlights and other aircraft where the type designator is often just a string of letters and numbers. In these cases, using a more generic descriptor – for example, 'helicopter' or 'microlight' – might offer a similar benefit while being easier for both pilots and controllers to interpret.

This feels like a modest, low-risk change that could positively influence safety and communication in the GA environment and one the CAA might usefully revisit, particularly given alignment with established practices in other countries.

A Tale of Two G-JXs

I noted the report (ATC862) on similar call signs which reminded me of a similar occurrence.

Some years ago, a friend and I had flown northwards for lunch and on return were coming past a military airfield. I gave a call to alert them to my existence. He replied to me with an abbreviated call sign. It would seem therefore that I was the only G-JX around. Yet some of his calls did not seem to tally with us as we were not orbiting over a cathedral. Then I heard a call from presumably the orbiter saying where he was going next, in a northerly direction, and signing off with G-JX. It would appear he had not been heard as the controller kept calling him. I had to explain politely to the military controller that there were two G-JX, I had used my full call sign, and that the other one had gone north, saying where he had gone, whereas I was southbound. Needless to say, I was not especially impressed! Maybe the military frequency he was also operating was busy and so got the civilian one mixed up.

CHIRP Comment: A cautionary tale that again illustrates the hazards of similar callsigns. The idea from the previous reader would have prevented the confusion in this case. A useful reminder that many military controllers are working both UHF and VHF and that, with the exception of a few aircraft, most can't hear all transmissions; the conditions for confusion are increased. Helpfully, our reader realised there was a problem in this case, that they had better SA than the controller and thus jumped in to assist. A super example of a collaborative, safety-minded approach.

I Learnt About Human Factors From That

Inside the Envelope – Or So I Thought

How a mis-labelled graph and a heavy take-off became an early lesson in safety, instinct and shared experience. Reproduced with kind permission from 22 Group RAF Air Safety.

Having been in the RAF for 18 years, I've been fortunate to fly many aircraft – each of which have added to my overall experience base. Now I seek to draw upon my experience and knowledge to add to the safety of those flying today, via my air safety role.

My flying experience started prior to the RAF, as a very keen but inexperienced private pilot, flying a Cessna 172 from the grass of Redhill aerodrome, near to Gatwick. I'd completed my PPL in the minimum hours and now wanted to take my family flying (given this is a safety "dit" – you can likely already sense that some cheese-holes are shortly to align!) I was 17 and had decided to

take my Mum, Dad and Sister for a lunch-away to Bembridge, on the Isle of Wight.

With four of us and the requisite fuel, my take-off weight would be far greater than I'd experienced before. Recognising this, I chatted with the instructor who'd trained me – I also asked them to check my weight and balance calculations, especially given my own had identified that I would be operating the aircraft within (or so I thought) but close to the limits of the aircraft operating envelope. They checked and confirmed all was good (or so they thought). They also chatted me through flying the aircraft at heavier weights.

In what to experienced aviation professionals reading this may seem noddy stuff, at 17 years old and with very limited experience, any advice was gratefully received! They recommended I use every inch of the grass runway and hold the aircraft against the toe brakes on full power for a few seconds before release, to help with acceleration. They described how the aircraft would feel slower to accelerate but that that was normal and to be expected at those weights and that it would of course take more of the runway to get up to take-off speed (we'd performed take off distance available calculations and all appeared fine). All simple stuff but a picture was building in my mind – for it to seem different to what I had previously experienced and my goodness it was!

Sat right at the top of the runway, take-off clearance received, full power set against the toe brakes – all was ok so far. Brakes off and I started bounding down the runway, gently bouncing up and down with small undulations from the grass runway bumps – feeling a bit like what you see on a WW2 Spitfire film for the take-off roll; though in a distinctly less cool aircraft! The speed was building, though not rapidly – my initial thoughts; that's ok, it's in line with what I expected and had been briefed and all the calculations proved it was close to limits but within and therefore "ok".

There was no formal V1 point of rejection for the take-off etc – not then for my Cessna PPL flight. I was using up available runway, but my acceleration was not great – I just didn't have the experience to fully appreciate it at that split second, though I would learn a lot about flying within the minute that followed! Soon after, despite my inexperience, it became apparent that I didn't have enough speed to take-off, nor enough runway left to stop (not a scenario I recommend you ever find yourself in!). I had two choices; try and stop, (without enough runway left to fully stop, the aircraft fully fuelled and thus heavy, high aircraft momentum, less than amazing braking performance on grass and a large hedge at the airfield boundary) or make something work and continue.

Whilst inexperienced, the instant outside visual picture meant I knew I'd impact the hedge before stopping if I tried – yes, it would be slower but a crash for certain (with risk of fire, being

trapped etc). The other option, which I took, was to make the take-off work, somehow! I was willing the speed to increase but to a degree, at this point, I had temporarily become an unwilling passenger! I had to visually assess when to rotate, prior to the correct rotate speed or I'd hit the hedge at high speed, with my family onboard also. I made my assessment of the last credible point to attempt rotating and limped the aircraft into the air – but it wasn't over yet! The stall warner started to go, then the aircraft started turning left (not from any control input of mine though).

I balanced the below optimum (my polite understatement) airspeed; not pulling back on the control column to the degree I'd cause a full stall – balancing it all so that I had enough speed to stay airborne (just – not in the position I'd want to be on the drag curve!) but not going for optimum speed or I'd impact the obstructions/ground. As the aircraft started to gently turn to the left of its own accord, I remembered a mere passing comment my instructor had mentioned – if you ever get the aircraft turning close to the ground and it's not you doing it, it may be the incipient stall – don't turn out of it or you'll likely deepen it towards or to the full stall. I instantly remembered this gem of a comment and just kept with the (very) low level gentle turn!

Gradually, the situation improved. I built the aircraft speed to normal parameters and climbed away. I had a quiet think – I didn't know exactly why it had happened but it certainly was not good. But now what? With the aircraft now flying normally, I decided that to then return to Redhill would only mean me landing whilst heavy on a short grass strip, compounding the less than optimum flight so far with an unnecessary risk...so, to Bembridge we went.

On the plus side, our lunch was lovely! I spoke to Redhill by phone from Bembridge – it had certainly raised the attention of ATC at Redhill, who criticised themselves for not pre-emptively pushing their crash alarm, as they described that from what they saw on take-off, they were very surprised it didn't end in a crash.

I also spoke with the flying school – it took a good while to ascertain what had happened; especially as I'd checked all the figures during the planning process with my previous instructor and the Chief Flying Instructor. They retrieved the documents and re-ran calculations – then a startling admission from the Operations personnel; they'd realised that they'd incorrectly labelled ***several of another aircraft type's weight-and-balance / performance graphs*** as the Cessna 172 I'd planned the trip against and flew! There had been no way of either me or the two instructors realising that during the planning process, as the information was presented in an identical fashion – the only way of knowing was the aircraft label on the top, which Ops had applied with a ticker tape strip, stating the registration for the aircraft I was flying, when it wasn't. Something so simple nearly had fatal consequences. Had I not been operating the aircraft

close to the limits, that error wouldn't likely have mattered for my or other flights for a long time beyond to come.

For me, there were several obvious take-aways; Ops had made a genuine honest mistake and could certainly tighten that labelling process but had that not occurred, the aircraft wouldn't have ended up in that position, as the fact the weight and balance was not in limits would have been apparent at the planning phase (had the graphs in fact been those for the Cessna 172!). Had my instructor not said that if low to the ground and the aircraft turns and you're not doing it, don't try and level the turn – then I may well have, with disastrous consequences. Had I decided earlier that the aircraft acceleration on the ground was insufficient, I would have aborted the take-off before being faced with the option of hitting a hedge or limping into the air with my fingers crossed, using every bit of flying ability I could muster – though my experience then was low.

With many people reading this being aviation professionals, it is easy to apply our collective thought processes and training to this. At 17, I was a keen PPL pilot, not a highly trained military pilot. So, why have I chosen to write about this from before my military flying career? Because there are useful take-aways from it for all aviators. I'll list my own immediate thoughts below but it's far from an exhaustive list:

1. If it feels wrong, it may well be – use your training but also trust your instincts and experience. It's better to be on the ground wishing you are in the air than in the air wishing you are on the ground.

2. Talk about your experiences and the expertise you have, especially to those less experienced. A "dit" spun to people whilst having a coffee, a presentation, or a passing comment of useful information about something you've previously learnt from could be critical to someone in their future, without you or them realising it at that time.

3. Be willing to learn from others' experiences – so much of policy, rules and regulations are borne out of previous incidents and accidents. You may not know the full background as to why a rule exists, but they're not put in for the fun of it.

4. Something may seem small, but errors can have disastrous consequences – if you notice something wrong, speak up. It may seem something small but the effect otherwise later on may be large.

5. If it does start to go wrong, remember the basics – Aviate, Navigate, Communicate; fly the aircraft safely first as the priority.

Yellow is not Mellow

Our NASA counterpart's Aviation Safety Reporting System sister safety publication Callback Issue 545 featured this honest account from a GA pilot who learned an invaluable lesson for future flights.

I was flying a small aircraft for my first IFR solo cross country. … After departing Jacksonville flying as filed at 6,000 ft, I was asked to descend down to 4,000. I noticed I would be flying straight into the clouds – which by the looks of them seemed fine. I am an instrument rated pilot and current for IFR flying. I advised Orlando ATC [of] my request to deviate from buildups – they agreed. I deviated and then I requested an altitude change to 3000 ft to avoid the large build ups. I requested further deviations for weather avoidance several times but I was denied. I found myself in a rain shower which pushed my plane down due to the downdrafts. I was rapidly descending at this point. My airspeed was in the yellow and the aircraft was getting increasingly difficult to control. While trying to maintain control over the aircraft, I advised ATC my concerns for the safety of flight, requesting an altitude change, I was denied again and advised to fly at 3,000 ft which I flew. I believe if I had requested to stay at 6,000 ft when the controllers gave me 4,000 initially instead of descending down into the worse weather, I might not have broken aircraft separation.

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 - GA1384 – Sleap / Wickenby radio interference

Initial Report
When operating above 2000ft at Sleap it is usual to hear circuit traffic transmitting at Wickenby since both Sleap Radio and Wickenby Radio share frequency 122.455 kHz. This can lead to confusion and has the potential for flight safety implications.

For example, during an overhead circuit join at Sleap it is not uncommon to hear a previously unannounced aircraft transmitting that it is "downwind to land" or that it is "going

around", only later to realise that the traffic is, in fact, not at Sleap at all, but at Wickenby. Until this is understood, situational awareness can be compromised. Also, frequency 'blocking' is a possibility such that calls from other proximate aircraft are missed.

Given the abundance of 8.33kHz frequencies now available, one might reasonably question whether this frequency duplication is necessary.

CHIRP Comment

Sleap and Wickenby, separated by 106nm, both operate on the same frequency, which under certain conditions (notably during high pressure systems) leads to interference and confusion. Although this might seem surprising at such a distance, the issue likely stems from atmospheric ducting, a recognised phenomenon where signals travel well beyond their intended range.

Edited excerpt from Skybrary:

"Radio Interference" can occur when two airports share the same aeronautical frequency but are several hundred nautical miles apart. Atmospheric conditions result in aircraft inbound to one airport having interference from the ATC and aircraft using the same frequency at another airport. The controller on the ground may have no knowledge that the aircraft they are controlling is suffering radio interference because they may not be able to hear the transmissions relating to the other airport. Specifically, in unusual propagation conditions, especially high-pressure situations, transmissions from authorised aeronautical transmitters using the same frequency may interfere with transmissions from stations which are well beyond the protected range.

While both airfields have a standard Designated Operational Coverage (DOC) of 10nm and 3000ft – though not published – it appears this protection is being exceeded in certain conditions. DOCs define the volume of airspace within which transmissions are expected to be reliable and free from interference. If transmissions from another airfield's aircraft are being heard within this protected zone, there are clear safety concerns.

It was not clear whether both airfields were aware of the problem, whether other pilots had experienced it, or if it had previously been reported. CHIRP followed up with the reporter and received the following clarifications:

- **Does the issue affect both airfields?** Yes, it sounds virtually identical at each end. The issue is apparent only when airborne above 2000ft; only aircraft are heard, not ground stations. The issue is most apparent when descending for the overhead join procedure.

- **How often does it happen?** Fairly regularly above 2000ft, and more so during high-pressure (ducting) conditions.
- **Are other pilots affected?** Likely, based on anecdotal responses from pilots at both airfields.
- **Are the airfields aware?** Unclear.
- **Has it been reported before?** Not to the reporter's knowledge.
- **Any MORs submitted?** No.

CHIRP has now raised the issue with the CAA, who are working with both airfields to explore a resolution – likely involving a frequency change at one or both. It's a strong example of how reports to CHIRP can drive real safety improvements; as an independent and trusted voice, we're able to bring concerns to the right people and help shape practical outcomes. But it all depends on your input – meaningful change starts with someone choosing to speak up and report.

Meanwhile, whilst the frequency overlap still exists and we await a resolution, local mitigations could reduce the risk when the atmospheric conditions dictate. For instance, pilots could consider including the airfield name or runway orientation in all joining and circuit calls, eg "Downwind 23 at Sleap"; this would provide better situational awareness than standard calls. While this goes beyond CAP413 standard phraseology, good airmanship and judgement should always prevail where confusion may arise. Clarity is more important than strict adherence to brevity when safety is at stake.

As to why the issue has persisted, this may be a case of normalisation of deviance, where an abnormal situation becomes accepted simply because "it's always been that way". The airfields and/or regulator can't address a risk they don't know about and which hasn't been reported. Some GA pilots are understandably hesitant about using the Mandatory Occurrence Report (MOR) MOR system, but reporting helps build a clearer picture of risk leading to safety improvements. Without reports, patterns go unnoticed and hazards persist.

A short guide to occurrence reporting

Under UK regulations, pilots must submit an MOR for any event that *could* affect flight safety. Just as valuable are voluntary reports about less serious incidents or potential hazards. Near-misses, navigation errors, airspace infringements, technical issues, or even uncertain situations that "could have gone wrong" all provide valuable learning opportunities. Whether mandatory or voluntary, reporting near-misses, miscommunications, technical issues or situational confusion helps improve safety for all in the wider GA community by building awareness of risks.

Submitting an MOR is straightforward using the CAA's ECCAIRS2 online portal, which works on most devices. Here are two useful links:

- Submit a Report via ECCAIRS2
- CAA Overarching Guidance & Portal

If something didn't feel right, it's worth sharing. You might help someone else avoid the same problem.

Key Issues relating to this report

The following 'Dirty Dozen' and other Human Factors 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.

Positive Considerations:

- *Situational Awareness* – The reporter recognised a pattern of confusion and considered its potential impact on others, not just themselves.
- *Communication Vigilance* – Careful listening and interpretation prevented assumptions that could have led to conflict or unsafe actions.
- *Safety Mindset* – The reporter raised concerns rather than accepting a flawed norm.

Negative Influences:

- *Ambiguity in SA* – Generic traffic calls (e.g. "Downwind") without location details contributed to uncertainty.
- *Complacency/Normalisation* – An ongoing problem not previously challenged may have led to a false sense of acceptability.
- *Reluctance to Report* – No MORs or other reports appear to have been submitted, possibly due to lack of awareness or confidence about reporting.

Encouraging open reporting and considering clear, proactive communication can significantly improve safety, even when the problem lies outside the cockpit.

Report No2 - GA1387 – Parachute drop conflict on final

Initial Report

Summary of report: A student pilot, close to completing their PPL, submitted a report about a go-around decision taken after encountering parachutists on final approach at their home airfield. The report is long, detailed and nuanced; therefore, a summary of the salient points is reproduced here.

The pilot had limited experience flying beyond the local area and had not previously encountered unusual operational scenarios.

During a local solo flight following a period away from flying, they elected to conduct some circuits on return. On short final at around 700ft, they suddenly became aware of multiple parachutists descending over and near the runway, something they had not been briefed on nor experienced before. Although they had started monitoring the airfield frequency once in the circuit, they hadn't heard any transmissions from the parachuting aircraft or others and assumed they were alone in the circuit.

Feeling uncomfortable, the pilot initiated a go-around at approximately 400ft but, concerned about overflying descending parachutists, turned 90° left at low level towards the circuit side. They transmitted a go-around call, but, as it was an air-to-ground service, the only response was a "roger". Hesitant to declare the non-standard manoeuvre, they planned to climb to circuit height, turn 180° near the base leg position and rejoin the circuit. However, this resulted in a near-conflict with the parachute drop aircraft, which was converging on a steep, fast downwind. A collision was avoided only because the pilot heard the aircraft's downwind call, saw it visually, and adjusted their course.

The reporter noted that they had never been briefed on what to do in the event of a parachuting conflict while on final and were unsure of the priority rules; they also reported feeling 'panicked'. They reflected that they should have asked more questions during training, particularly given how routinely parachute operations occurred at the airfield. The incident was not followed up with any kind of instructor debrief or discussion at the flying club. Although solo flights were loosely monitored via ADSB, there was little active oversight or supervision.

The pilot also cited under-confidence with radio calls, cockpit distractions (such as listening to music via their headset) and a general lack of situational awareness as contributing factors.

Finally, the culture at the airfield was highlighted. The pilot described a reluctance to seek post-flight guidance due to past experiences of cold or dismissive attitudes on the radio and a general lack of engagement when things go awry.

CHIRP Comment

This was a complex and honest report with multiple learning points for students, instructors and clubs alike.

The Reporter

This was a brave and mature submission from a student pilot, showing an impressive level of honesty, reflection and a proactive approach to safety by choosing to report to CHIRP. They showed good situational awareness (SA) in identifying the parachutists at around 700ft and continued to monitor and reassess the situation before deciding to go around at 400ft.

Although the manoeuvre was non-standard, their actions to turn away from the parachutists and rejoin late downwind were sensible under the circumstances. The pilot also maintained a visual lookout, saw the parachute aircraft and took timely avoiding action. Their self-awareness and willingness to critique their own decision-making – including distractions, lack of knowledge and missed opportunities to seek guidance – demonstrates a commendable attitude.

The reporter did a lot well, however, there also appear to have been elements of overconfidence and complacency. Not bringing up the airfield frequency early enough and listening to music probably reduced their SA at a critical time. The go-around call was not accompanied by an explanation of the non-standard manoeuvre, which created a potential for increased risk for other circuit users. The pilot was unsure about the rules regarding parachutist priority; while SERA does not explicitly give right of way to parachutists, good airmanship and a 'least manoeuvrable' principle apply. The reporter's uncertainty and reluctance to communicate openly over the radio was concerning and may reflect broader cultural issues at the airfield.

Flying School & Supervision

Given the airfield's regular parachuting operations, it's concerning that the student had not been thoroughly briefed on how to handle such conflicts, especially so late in training. The flight appears to have lacked appropriate pre-flight planning and instructor supervision, placing a low-hours student in a high-risk situation. While ADSB tracking was in place, the lack of visible supervision or post-flight debriefing suggests weak oversight and missed opportunities for learning.

Airfield & Club Culture

The student felt unable to speak up during the flight or seek help afterwards, citing previous negative experiences with radio operators and a lack of engagement at the club. This suggests a concerning safety culture where students may feel unsupported or even discouraged from asking questions. A perceived dismissive or unapproachable attitude from ground personnel can act as a significant barrier to safe decision-making and post-flight reflection. A flying environment that encourages openness and dialogue will help embed good habits in the next generation of pilots.

Although the flying school's perspective is not available, the report raises legitimate questions about briefing standards, student support and instructor follow-up. It's possible the student had been taught what to do but either didn't retain it or lacked the confidence to act. Regardless, clubs and instructors should actively ensure that all student solos are fully briefed, especially when operations like parachuting are routine hazards.

Key Issues relating to this report

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

Positive HF Elements

- *Situational awareness* – The pilot recognised a hazard mid-approach and made a prompt, considered decision to go around.
- *Decision-making under pressure* – Demonstrated capacity to analyse a novel risk and act, despite being unsettled.
- *Self-reflection and learning mindset* – Honest evaluation of limitations, distractions and missed opportunities.
- *Visual scanning* – Maintained a lookout that enabled them to avoid conflict with the parachute aircraft.

Negative HF Elements

- *Distraction and complacency* – Listening to music and late to monitor the airfield frequency reduced capacity and awareness.
- *Communication breakdown* – Not fully informing others of a non-standard go-around created potential for conflict.
- *Knowledge gaps* – Uncertainty around parachutist right-of-way and appropriate conflict responses.
- *Under-confidence* – Hesitance to ask questions or request debrief, influenced by a perceived unsupportive environment.
- *Supervisory lapse* – Insufficient oversight, briefing and post-flight engagement left the student without vital preparation or feedback.

Report No3 - Disp21 – Paramotor display over populated area

Initial Report

Report text (summary): A screen shot from social media was provided of someone performing high-performance paramotor manoeuvres over [City]. This activity, especially over built-up areas, is highly risky and leaves minimal room for error. In the event of a wing collapse or engine failure, the pilot has limited emergency options. Deploying a non-steerable reserve chute in such an environment would result in a vertical descent, increasing the likelihood of landing on buildings, roads, or other hazards, which poses significant risks to both the pilot and the people below.

High-G manoeuvres also place additional stress on the wing, increasing the chance of a collapse, especially in turbulent air.

Conducting such advanced flying over open areas or water would be far safer, offering emergency landing options and reducing risks to public safety. While the pilot's skill is evident, this scenario sacrifices critical safety margins. Choosing appropriate locations and equipment, such as steerable reserves, is essential for responsible paramotoring and ensuring the safety of both the pilot and the public.

CHIRP Comment

The material provided with this report included a social media screenshot clearly showing high-performance paramotor manoeuvres directly over a densely built-up urban area. CHIRP reviewed the associated content, which was publicly available and almost certainly authentic; it did not appear to be AI-generated or manipulated. Based on the posts, the activity described was assessed as both highly hazardous and almost certainly in breach of the Rules of the Air.

Although paramotoring is currently unregulated in the UK – requiring no licence, training, or aircraft certification – paramotor pilots remain bound by the same airspace rules (Standardised Rules of the Air) as other aviators. The *Paramotor Code* (CAP2562) reinforces the requirement to avoid endangering persons or property, and to ensure that, except for take-off and landing, congested areas are overflown at safe heights (1,000ft above the highest obstacle within 600m) and only when the aircraft can glide clear in the event of an engine failure.

In this instance, the pilot was flying a basic paramotor wing, not one certified for aerobatics, and certainly not designed for the dynamic stresses of high-G manoeuvres. Any structural failure, turbulence-induced collapse, or engine malfunction would have left almost no margin for recovery and limited, if any, safe landing options. Such activity is not only dangerous for the pilot but poses serious risk to members of the public on the ground.

Notably, the individual featured is not a member of the British Hang-gliding and Paragliding Association (BHPA). BHPA membership offers structured training, access to qualified instructors and £5 million third-party liability cover. Pilots affiliated with the BHPA are generally more aware of their responsibilities and legal obligations and benefit from operating within a safety-focused community. CHIRP strongly encourages all paramotor pilots to consider BHPA membership as a matter of good practice. This incident also underscores the case for reconsidering current legislation, with a view to bringing paramotoring into line with other forms of crewed, powered aviation through appropriate training and regulatory oversight.

CHIRP advised the reporter to notify the CAA, who may choose to investigate or take enforcement action where aviation regulations have been breached. These reports can be made via either of the following:

- Report a potential breach of aviation law – to highlight unsafe flying.
- CAA Whistleblowing report – a confidential option if there are concerns about reprisals.

While social media has become a powerful tool for sharing flight experiences, it also risks encouraging copycat behaviour. Inexperienced pilots may view such content as aspirational, without understanding the hidden dangers or legal boundaries. 'Likes' and positive comments on unsafe content can normalise reckless behaviour if it goes unchecked. As an aviation community, we all have a role in calling out dangerous practices when we see them – and this reporter is to be applauded for doing exactly that.

Key Issues relating to this report

The following 'Dirty Dozen' and other Human Factors were especially relevant to this report. They are offered to prompt reflection for pilots of all disciplines, particularly those flying in relatively unregulated environments where informal behaviours can quickly become embedded.

Negative Influences:

- *Lack of Knowledge* – Without formal instruction, pilots may not understand the aerodynamic limits of their wing or the legal requirements of flight over congested areas. Performing aerobatics in uncertified equipment compounds this risk.
- *Lack of Awareness* – The lack of viable landing options in the event of an emergency, particularly in urban areas, reflects poor situational awareness. The impact of wing collapse or engine failure in such an environment could be catastrophic.
- *Complacency* – Familiarity with advanced manoeuvres can create a false sense of safety. Just because it's gone well before doesn't mean it will again, especially when flown at low altitude or over unsuitable terrain.

- *Lack of Teamwork* – Operating outside the BHPA means reduced access to constructive critique, mentoring and formal safety frameworks. Without peer accountability, risky behaviours may go unchallenged and become normalised.
- *Pressure* – Social media can introduce subtle but powerful pressures to perform for an audience, leading to escalating levels of risk-taking in pursuit of validation, approval, or online following.
- *Distraction* – Filming and flying at the same time can divide attention, especially if managing camera positioning, audio, or trying to capture the 'perfect shot'. Focus that should be on airspace, terrain and safety may instead be drawn to content creation.

Positive Considerations:

- *Aircraft Handling Skills* – The pilot clearly has high levels of control and confidence in their equipment, developed through practice. However, skill must always be tempered with good judgement, appropriate environment and suitable equipment.
- *Community Vigilance* – The reporter demonstrated the kind of proactive safety culture we hope to encourage. Speaking up about unsafe activity, particularly when visible to the public, is a responsible and necessary act that contributes to overall aviation safety.

Final Thoughts:

Paramotoring offers a unique and exhilarating way to experience flight – but its freedom comes with a duty of care. Without formal oversight, pilots must take personal responsibility for their actions, equipment and environment. Airmanship isn't just about skill in the air; it's about foresight, restraint and understanding the wider impact of how we choose to fly.

Report No4 - GA1378 UPDATE – Gliding competition NOTAMs

Initial Report

In GAFB103, we featured a report (GA1378) from a glider pilot highlighting the challenges of submitting accurate details for NOTAM applications. For weekend operations, NOTAM requests must be submitted several days in advance to meet the 48-hour (weekday) guaranteed turnaround for publication.

Because gliding competitions are highly weather-dependent, organisers often submit NOTAMs covering large geographic areas to account for various possible task areas. While this ensures coverage, overly broad NOTAMs risk being disregarded by others during flight planning. The more accurately a NOTAM

reflects where gliders are likely to operate, the more useful it is for route planning and effective deconfliction.

Following this report, CHIRP met with the CAA's Airspace Regulation Utilisation Operations (AROps) team to better understand the process and offer additional advice for airspace users whose activities are influenced by weather on the day – such as gliders, paragliders, hang gliders, balloons, and model aircraft.

CHIRP Comment

NOTAM timescales

Due to weekday-only working and high workload – with over 10,000 NOTAMs processed annually – AROps guarantees a 48-hour / two-working-day turnaround for standard NOTAMs. For weekend flying, requests must be submitted by 16:00 on the preceding Wednesday. More complex or large-scale activity may require up to five working days for processing.

The CAA NOTAM Application Portal provides some flexibility in exceptional cases:

> *Airspace Regulation hours are 08:30 to 16:30 local time, Monday to Friday (excluding UK Public Holidays).* ***Notifications or messages submitted after 16:00 will not be actioned before 08:30 on the next working day.***
>
> *Whilst it is understood that some activities by their nature will be unable to provide much notice, for activities to be appropriately assessed and promulgated, timely submission of notifications is essential. If notification of this activity is less than 2 working days prior to the proposed start date, in addition to completing this form, please contact Airspace Regulation by e-mail at arops@caa.co.uk as soon as possible after submitting the notification, including the wording "less than 2 days' notice" and your submission reference number in the email subject line.*

NOTAM process

AROps scrutinises every NOTAM request, checking for potential conflicts with known activity. Where necessary, they will contact the applicant or facilitate discussions with other airspace users to enable safe coordination. Importantly, AROps is the only route for official scrutiny and deconfliction, so all events – including weather-dependent competitions – should be submitted via this process. If required, sponsors should submit a generic NOTAM that covers all likely areas of activity.

Updates via CANP

If the precise competition area becomes clearer closer to the event, such as during a weekend, the NOTAM can be supplemented via the Civil Aircraft Notification Procedure (CANP). Although designed to notify military aircrew of low-

level (<2000') civil aviation activity, CANP details are also published as NOTAMs and visible to both civil and military users. CANPs are managed by Low Flying Coordination at the Military Airspace Management Cell, and it may take up to four hours for the information to be processed and distributed. For best effect, submissions should be made the evening before flying. However, CANP is a notification-only process; it does not provide scrutiny or deconfliction. Therefore, it should only be used as a follow-up to a CAA NOTAM, not a replacement.

Submissions should be sent to: Swk-mamclfcoord@mod.gov.uk

Summary
To maximise airspace safety and situational awareness:

- Submit NOTAMs early through the CAA – ideally 5 working days in advance.
- Include the broadest reasonable area if weather may affect the location.
- Use CANP as a tactical amendment once the area becomes clear, but never as a substitute for the formal NOTAM process.
- Always coordinate directly with AROps if timelines are tight.

Key Issues relating to this report
Human Factors considerations

This report highlights a number of classic Human Factors themes: planning under uncertainty, communication across organisational boundaries and the need for realistic mental models when interpreting NOTAMs.

From the perspective of the event organiser, the challenge lies in trying to balance compliance with formal notification timelines against the inherently variable nature of weather-dependent activity. The temptation is often to 'play it safe' by submitting an overly large NOTAM; but, this can be counterproductive if it reduces the likelihood that other airspace users will treat it as meaningful. The risk is that NOTAMs become 'background noise' if perceived as too vague or covering implausibly large areas.

For other pilots, Human Factors come into play when reviewing and interpreting NOTAMs. If we assume a NOTAM is irrelevant or overly cautious without taking the time to read it properly, we increase the risk of an unintended airspace conflict. Maintaining a healthy respect for published NOTAMs and understanding why they may sometimes be broad in scope, helps support collective situational awareness.

At the systemic level, this issue also reflects a wider Human Factors challenge: the tension between bureaucratic process versus operational practicality. Everyone involved – regulators and pilots alike – must work together to create processes that are usable, timely and trusted.

For weather-sensitive operations, a two-stage approach (early submission plus timely tactical update) may offer the best compromise between accuracy and compliance.

Ultimately, good planning and mutual understanding are key to safe and efficient shared use of airspace.