

## AIRPROX REPORT No 2010027

Date/Time: 25 Mar 1115

Position: 5212N 00137W  
(Wellesbourne - elev  
159ft)

Airspace: ATZ (Class: G)

Reporting Ac Reported Ac

Type: PA28 PA28

Operator: Civ Trg Civ Pte

Alt/FL: 500ft 1000ft  
(QFE 994mb) (QFE 994mb)

Weather: VMC CLBC VMC CLBC

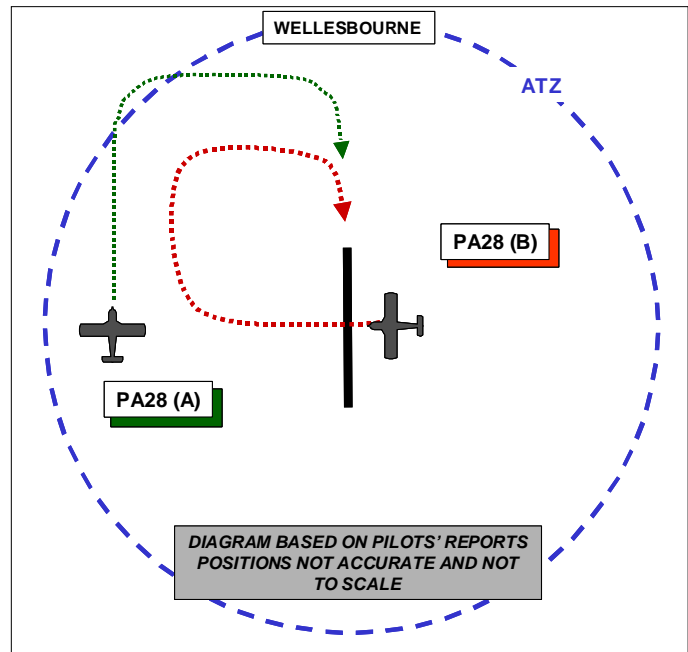
Visibility: >10km >10km

Reported Separation:

100ft V/50m H 0ft V/300m H

Recorded Separation:

NR See UKAB Note (1).



### PART A: SUMMARY OF INFORMATION REPORTED TO UKAB

**THE PA28 PILOT (A)** reports flying a local training flight with a student as the handling pilot in a white and green ac with HISLs switched on, squawking 7000 with Modes C and S and in contact with Wellesbourne Info. They were downwind in the RH cct for RW18 when a dark blue and white PA28, joining from the deadside onto the downwind leg, turned inside them in a tight and unconventional cct. The AFISO alerted them to look for the ac, but they already had him in sight. The other pilot was alerted to them when he made his downwind call and he also stated that he had their ac in sight. The ac passed a few hundred feet behind them and then positioned to their 7 o'clock but they were unable to see it due to the blindspot behind the cabin. They continued to final approach at normal speeds (initially 70kt) being aware of several other ac ahead and made the appropriate RT call in the correct position. They checked their 5 o'clock and 7 o'clock positions looking for the other ac but since nothing was seen and the pilot had stated he had them in sight they assumed it was positioning behind them on final; further no RT calls was heard from the ac indicating that it was in any other position.

They established their ac on a 3-degree glidepath but when they were at about 500ft they saw the front of the other ac immediately below them on a very shallow glidepath at a distance estimated as less than 100ft. He immediately took control and initiated a missed approach and reported the Airprox on the frequency; the FISO confirmed this with a time check. He considered that there was a risk of collision on final approach and, had PA28 (B) corrected its shallow glidepath, he would have climbed up into their ac having not been seen. He assessed the risk as medium.

Since the other PA28 was then seen also commencing a missed approach from a very low level over the RW, due to traffic occupying it, they elected to extend upwind for safety as the missed approach executed by the other ac took it over a local village that is a noise abatement area, thereby putting it ahead of their ac. They maintained good separation from the other ac for the rest of the circuit, as its flightpath was unpredictable and not in accordance with local procedures.

**THE PA28 PILOT (B)** reported that he was flying a blue and white ac with all lights switched on, squawking with Mode C, on a local solo flight from Wellesbourne and in receipt of a FIS from them. He was downwind to land at 1000ft, heading 003° at 90kt, with a 30kt tailwind and the cct was very busy when he saw another PA28 ahead of him initially descending through about 500ft on the crosswind leg, flying what appeared to be a wide circuit. The ac appeared to be extending downwind

and he erroneously turned base in front of it but he was visual with an ac on late final. He recognised that he had made an error that had placed him in front of the other ac but he did not believe that there had been a risk of collision at any stage.

**The FISO** reports that the RW18 was in use with a RH cct, which was busy with around 5 ac. The pilot of PA28 (A) reported downwind and shortly afterwards he watched PA28 (B) turn downwind; PA28 (B) was 'closer in' than PA28 (A) and slightly behind. As he thought that there was a risk of the ac getting closer round the base-leg turn, he confirmed over the RT that both pilots were aware of each other. PA28 (A) reported 'final' followed shortly afterwards by PA28 (B) also reporting 'final'. Because it appeared to be very close behind PA28 (A), he asked PA28 (B) pilot if he would be going around; the pilot replied that he had the other ac in sight, but did not immediately go around. About 10sec later PA28 (B) initiated a go-around and shortly afterwards PA28 (A) also initiated a go-around; the ac appeared to get quite close, he estimated less than 150ft.

**ATSI** had nothing to add to the FISO's report

UKAB Note (1): The recording of the Clee hill radar shows the incident. There are 5 ac in the Wellesbourne cct, all squawking 7000 with Mode C so it is not possible to identify specific ac with any degree of certainty. At 1112 one contact appears to cut inside another in the cct, but this also happens some 2min later. It is not possible, therefore, to determine which incident is the one reported.

## **PART B: SUMMARY OF THE BOARD'S DISCUSSIONS**

Information available included reports from the pilots of both ac, radar recordings and a report from the FISO involved.

The Board noted that at the time of the incident the Wellesbourne cct had been busy, so much so that the radar recording was inconclusive. A member of the Secretariat pointed out that, although it was not possible to identify which ac was which, the pattern being formed extended to/beyond the edge of the ATZ; GA Members considered this to be large, but not unreasonably so. They also agreed that the cct had not been excessively busy and that the respective pilots should have been able to cope with the traffic situation. Members also agreed that despite any frustration regarding the pattern being formed by others, pilots are required by the Rules of the Air (Rule 12 (a)) to conform with it and not 'cut inside' others; all 3 reports available to the Board agreed that the pilot of PA28 (B) had not conformed to the pattern formed by PA28 (A) ahead of him and this had been the sole cause of the incident. It was also pointed out by a Member who flies both military and light ac that while military fixed wing ccts are standardised, the same does not apply to civil airfields where both the teaching and local procedures can differ widely.

Although they agreed that there had been no risk, the Board agreed that this had been an unnecessary incident that could have been avoided by a more professional approach and an open dialogue on the ground.

## **PART C: ASSESSMENT OF CAUSE AND RISK**

Cause: The pilot of PA28 (B) did not integrate into the circuit pattern established by PA28 (A) ahead.

Degree of Risk: C.