Adventure Aviation occurrence insights

Insights period: 1 January 2025 through to 31 March 2026

Executive summary

The Civil Aviation Authority is working to share insights into safety risks in a way that leads to greater awareness across the aviation sector. By highlighting key occurrences and trends, we aim to provide access to timely and relevant safety and security information that helps industry to assess the risk to their own operation, improve existing controls, meet safety obligations, strengthen collaboration, and ultimately contribute to a safer, more resilient aviation environment.

This report provides an overview of occurrence data from the adventure aviation sector between 1 January 2025 and 31 March 2026, highlighting emerging patterns and system-level risks. This is to support proactive safety management.

Key system insights

Across the adventure aviation sector, several patterns consistently appeared in reported occurrences. This section highlights these key insights, which are further expanded on later in this report.

1. Weather doesn't cause most occurrences – decisions about weather do

Across multiple adventure aviation activities, deteriorating or marginal conditions repeatedly increased workload, reduced options, and encouraged "press-on" decisions.

Weather was rarely the sole cause. More often, it interacted with operational pressure and judgement to erode safety margins.

2. Recovery systems work well – but they're masking recurring problems

- Emergency procedures were generally effective
- Reserve parachutes were deployed correctly
- Pilots landed safely after technical issues
- Crews recovered from abnormal situations.

This demonstrates a system with people and procedures that can prevent incidents from escalating into accidents. However, the frequency of these recoveries suggests that there are underlying technical and operational problems that continue to generate those emergencies.

The goal isn't simply good recovery – it's preventing recovery from becoming routine.

3. Small variations in equipment setup continue to produce avoidable events

Equipment preparation featured repeatedly across skydiving and other sectors. Examples included:

- inconsistent packing
- configuration differences
- equipment wear, and

- variation in individual technique.

These are rarely dramatic failures. They're small inconsistencies that align with human factors to create recurring incidents. Consistency is becoming as important as equipment quality.

4. Shared airspace remains one of the sector's biggest risks

Aircraft, parachute operations, gliders and other users continue to share increasingly complex airspace.

Repeated occurrences involved:

- airspace infringements
- communication breakdowns, and
- aircraft entering active parachute drop areas.

Many resulted in no loss of separation – but they depended on detection and recovery rather than robust planning.

5. Training environments deserve continued attention

Tandem operations and early-stage learning operations depend heavily on:

- instructor judgement
- passenger behaviour
- effective communication, and
- timely intervention.

The data reinforces that instructor decision-making remains one of the strongest safety defences in adventure aviation.

6. Bottom line

Overall, the system demonstrates strong recovery performance (eg, effective emergency procedures), but underlying risks remain and aren't always addressed at the source. Residual risk appears to be partly managed through pilot judgement and decision-making, meaning human factors continue to play an important role in preventing adverse outcomes.

How to read this report

We highlight selected examples and patterns providing the greatest value for understanding emerging risks. These insights are indicative, not exhaustive, and are intended to support early awareness and proactive risk management.

The insights provided are high-level and may not yet be fully analysed. They are not shared to attribute blame, but to reinforce that aviation safety depends on shared responsibility and collaboration across the system. It's also expected these insights may help you to identify and mitigate potential risks in your own aviation activities.

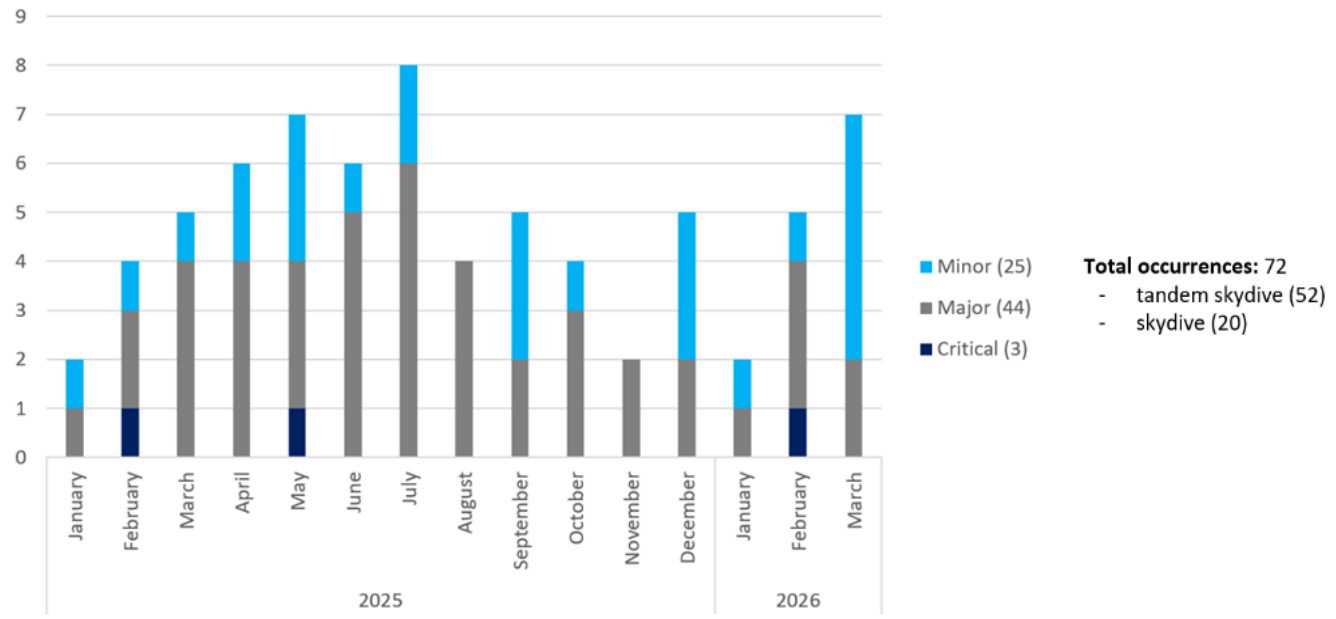
Please note that the data referred to in this insight report was pulled on the 7th of May 2026 and reflects the reported information available at that time.

Key themes and insights

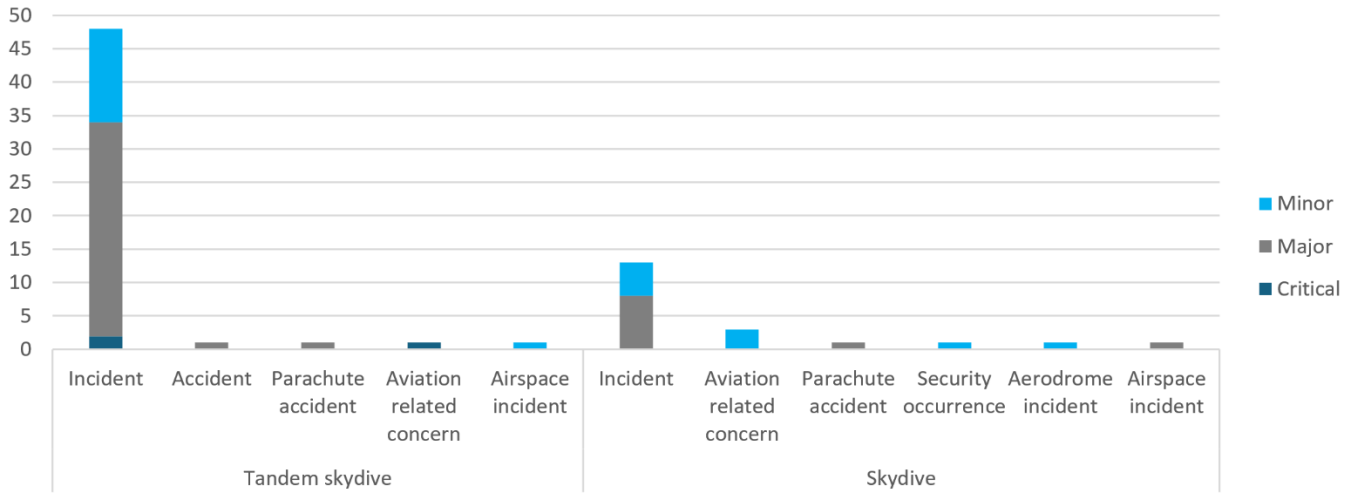
1. What keeps showing up in adventure aviation

Risk driver	Appears in
Changing weather /marginal conditions	Paraglider, microlight
Press-on decision-making / reduced awareness	Paraglider, microlight, skydive
Airspace integration (separation, comms, complexity)	Glider, microlight, gyroplane
Inconsistent practices (equipment, setup, packing)	Skydive, microlight, gyroplane
Training / tandem exposure (reliance on passenger)	Paraglider, skydive

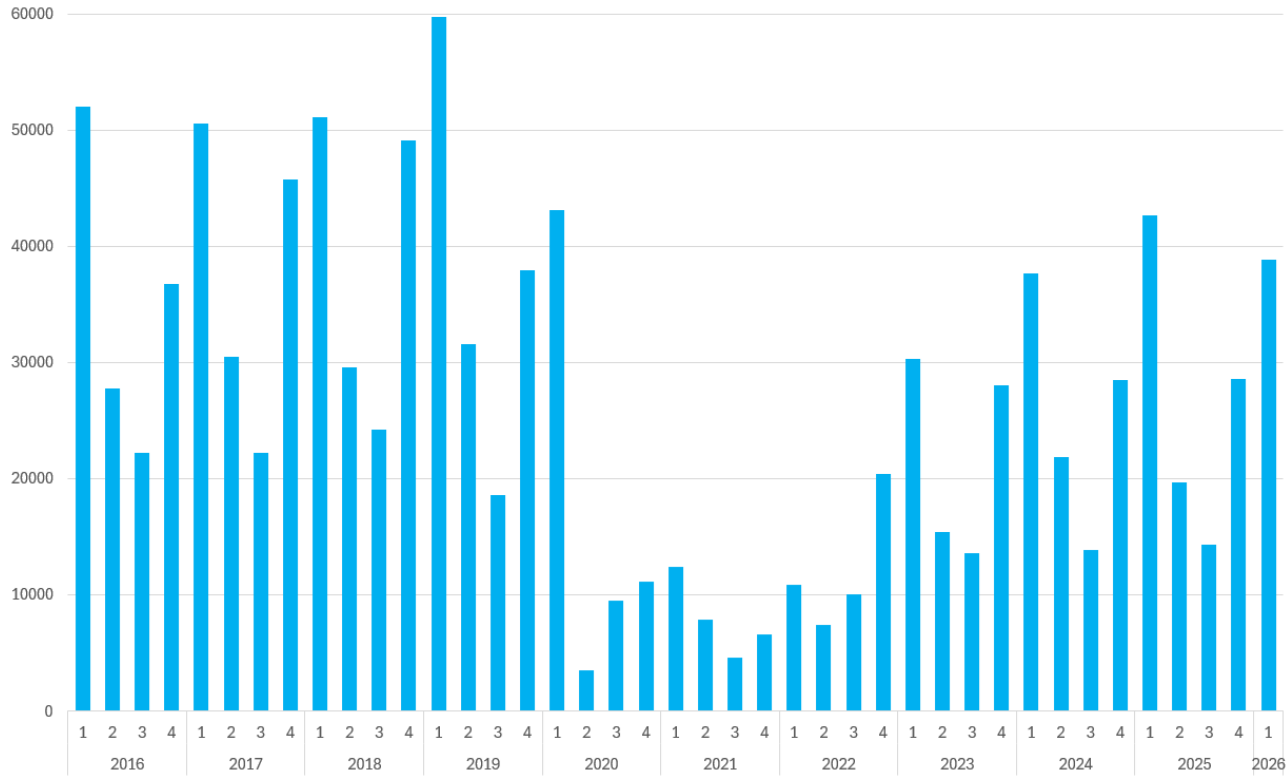
2. Tandem skydive/skydive



Graph 1: Tandem skydive/skydive occurrences



Graph 2: Tandem skydive/skydive occurrences by type



Graph 3: Total recorded skydive jumps January 2016 to March 2026

What the data shows

Skydive and tandem skydive represent the largest number of occurrences within the adventure aviation dataset. The majority of occurrences are classified as incidents (85 percent) with 66 percent of incidents being of major severity.

It's important to note that graph 3 puts the number of occurrences into perspective, showing that they are very low in comparison to the total number of jumps. For the period 1 January 2025 to 31 March 2026, the number of recorded jumps is 144,074 versus a total of 72 reported occurrences.

The data shows a consistent pattern of frequent operational incidents involving canopy deployment and behaviour, particularly:

- line twists
- tension knots
- uneven or delayed canopy inflation, and
- slider-related issues.

These events often result in emergency procedures (cutaway and reserve deployment), which are repeatedly described as effective, with safe landings and minimal injuries. This indicates a system with strong recovery capability, despite a relatively high rate of underlying technical or operational disruptions.

A large proportion of occurrences relate to packing of equipment and setting it up, including:

- loss of line tension during packing
- untidy or inconsistent packing practices

- configuration differences between canopy systems, and
- equipment wear or ageing.

Many occurrences also highlight the influence of human factors during both preparation and flight including:

- body position during exit or deployment
- delayed or ineffective response to malfunctions, and
- variation in instructor or jumper technique.

Operational decision-making is a recurring theme, particularly in relation to:

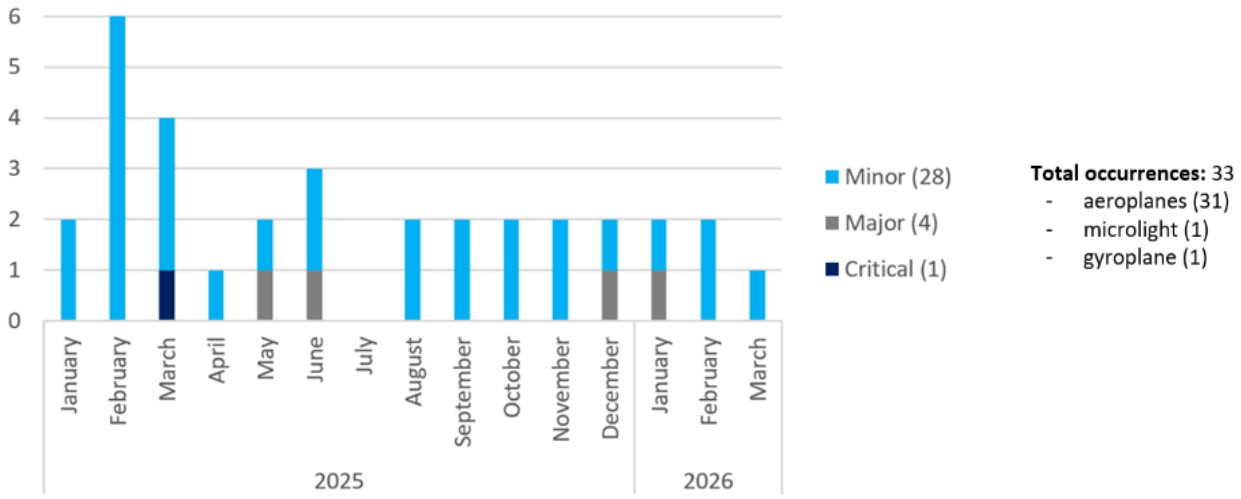
- exit timing and spot selection
- continuation of operations in marginal weather conditions, and
- canopy management and landing decisions.

Landing-phase events are also present and include:

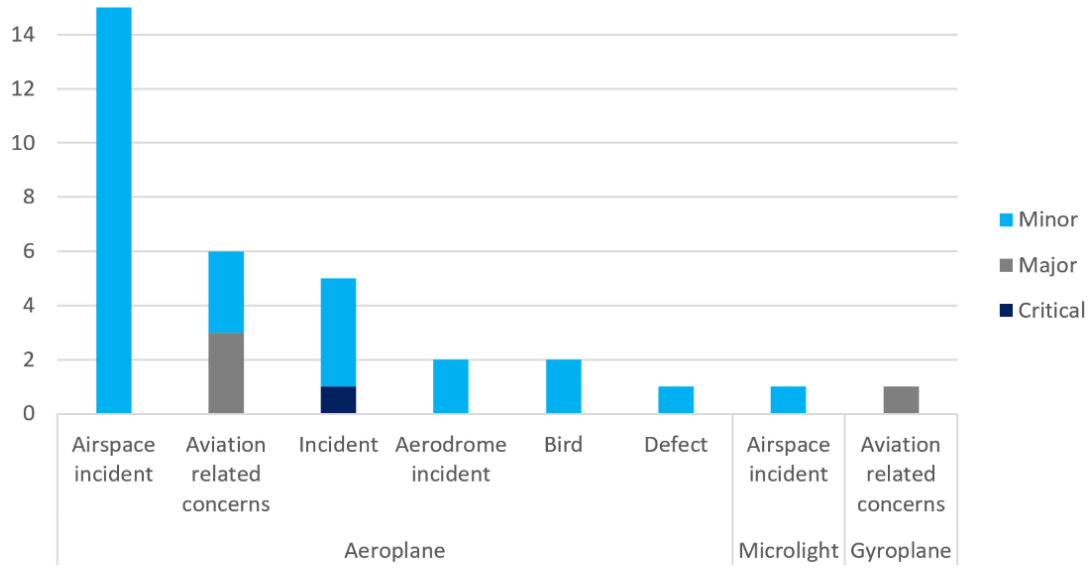
- hard or vertical landings in wind conditions
- passenger behaviour affecting landing safety, and
- off-field landings due to positioning or environmental factors.

Overall, skydive operations demonstrate a pattern of high-frequency, manageable disruptions, where well-established procedures and training lead to safe results, but where underlying variation in equipment handling, environmental conditions, and human performance remains persistent.

3. Aeroplane/other aircraft



Graph 4: Aeroplane occurrences (includes microlight and gyroplane)



Graph 5: Aeroplane occurrences by type (includes microlight and gyroplane)

What the data shows

The number of aeroplane and other aircraft occurrences in adventure aviation is low, with most events classified as of minor severity, and occasional higher-consequence occurrences.

A key feature of the dataset is the role of these aircraft in supporting parachute operations, meaning many occurrences arise at the interface between aircraft operations and skydiving activity.

Airspace related events (49 percent) are a recurring theme, including:

- entering controlled airspace without clearance
- altitude deviations above assigned levels
- interaction with active parachute drop zones, and
- coordination issues between aircraft, air traffic control and parachute operations.

Several occurrences involve aircraft operating in or near parachuting zones, including instances where:

- aircraft enter active drop zones
- parachute aircraft deviate from expected flight paths, and
- coordination or communication is incomplete or delayed.

Operational complexity is also evident during:

- climb, jump run, and descent phases
- multi-aircraft environments, and
- changes to plans in-flight (eg, landing with jumpers onboard or altered drop configurations).

Technical and mechanical events occur less frequently but include:

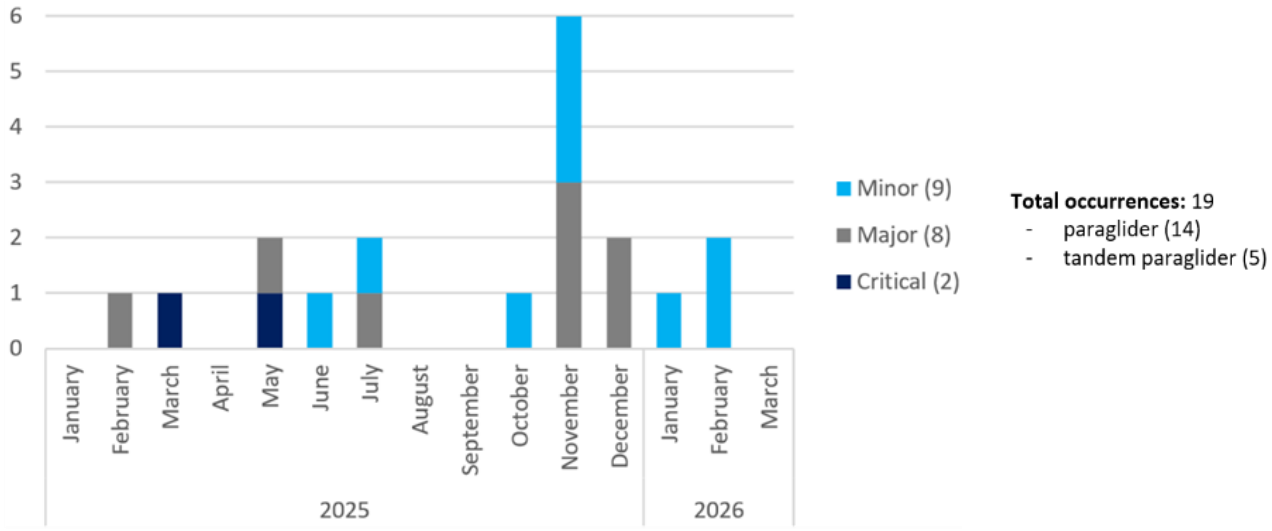
- engine or system failures
- bird strikes, and
- problems with equipment or control systems.

There are also occurrences linked to factors in organisational and safety culture, including:

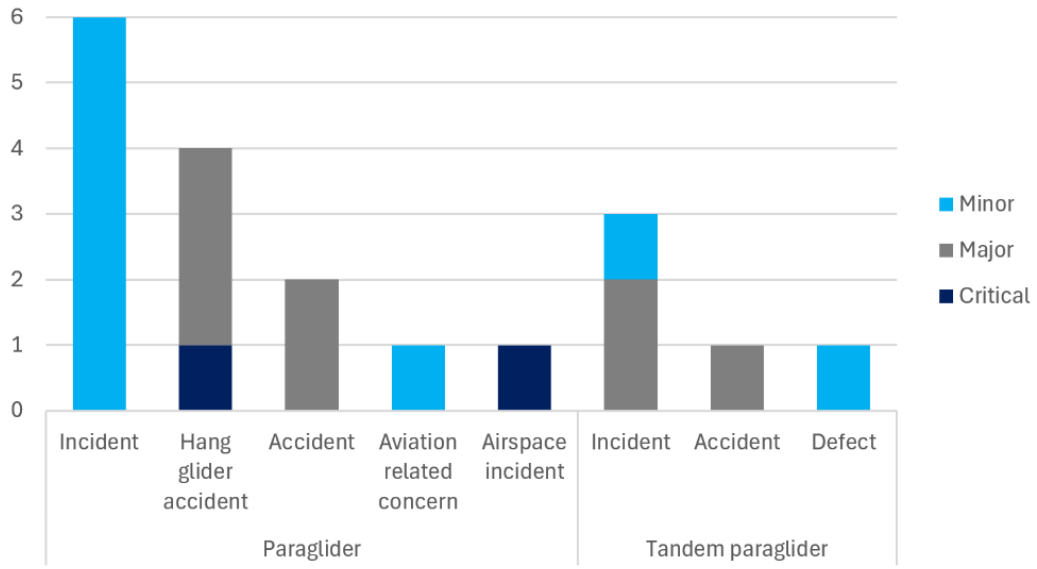
- decision-making under operational or commercial pressure
- procedural deviations, and
- concerns raised by participants or staff regarding safety practices.

Overall, aeroplane operations occurrences are low in frequency but occur in airspace where safety relies heavily on coordination, communication, and integration with other aviation activities.

4. Paraglider/tandem paraglider



Graph 6: Paraglider/tandem paraglider occurrences



Graph 7: Paraglider/tandem paraglider occurrences by type (note HGA occurrences were all paraglider accidents)

What the data shows

There are fewer paraglider and tandem paraglider occurrences in adventure aviation, but they include a higher number of injuries, particularly in accident and critical categories. The majority of occurrences are

classified as incidents (47 percent). There are also several accidents (32 percent) some of which resulted in broken vertebrae, other fractures, and an ocean landing. This shows there's a high frequency of lower-severity events, but when things go wrong, consequences escalate quickly (typical of the paragliding risk profile).

The data reflects a pattern where bad environmental conditions and low-altitude operations strongly influence outcomes, with occurrences commonly involving:

- collapses and loss of control
- misjudged launches or aborted take-offs
- hard or uncontrolled landings, and
- interactions with terrain.

Environmental conditions are a dominant theme, including:

- variable or gusty winds
- thermic and turbulent air
- challenging terrain, and
- rapidly changing conditions during flight.

Many occurrences occur during high-risk flight phases, particularly:

- launch and take-off
- low-level manoeuvring near terrain, and
- approach and landing.

Human factors are frequently noted in occurrence narratives, including:

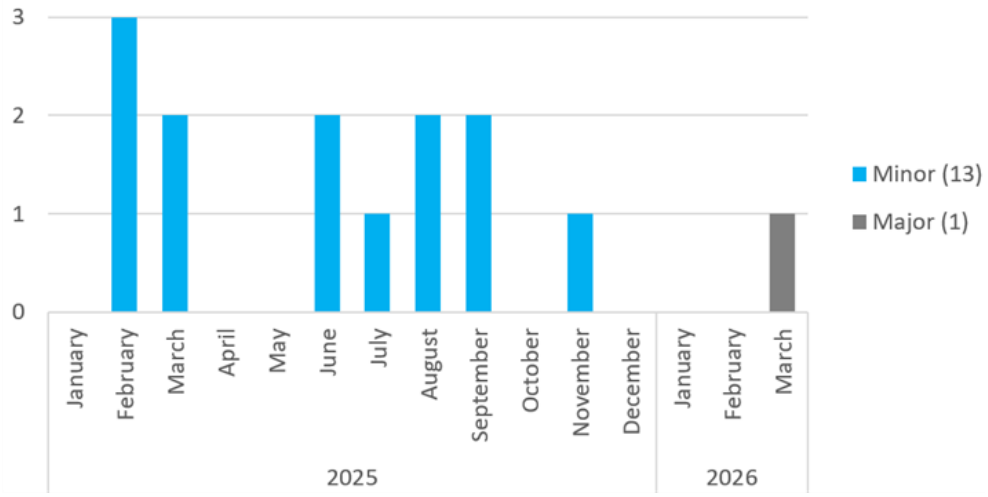
- misjudgement of conditions or site characteristics
- unfamiliarity with local flying environments
- overconfidence or willingness to continue despite warning cues, and
- task overload during critical phases of flight.

Tandem operations introduce additional complexity, particularly through:

- passenger behaviour during launch or landing, and
- communication challenges.

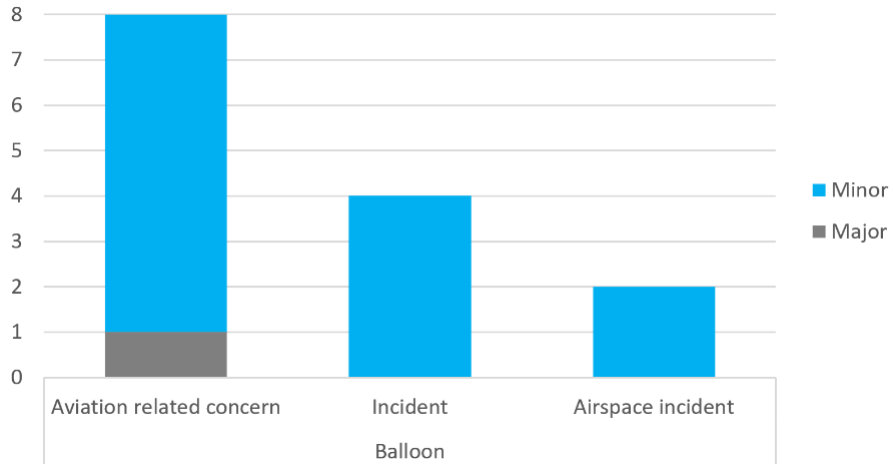
Overall, paraglider operations show a pattern of low-frequency but higher-consequence events, driven by the interaction of environmental conditions, proximity to terrain, and pilot judgement.

5. Balloon



Total occurrences: 14

Graph 8: Balloon occurrences



Graph 9: Balloon occurrences by type

What the data shows

Balloon occurrences are mostly reported as aviation-related concerns and are relatively low in number and predominantly minor in severity. Most events involved concerns about operational or public interface, rather than in-flight loss of control.

Many occurrences relate to operations at low altitude over populated or controlled areas, including:

- flying below minimum height requirements
- operations over residential areas, and
- proximity to other aircraft, infrastructure, or obstacles.

A recurring theme is interaction with people, property, and public perception, including:

- concerns from the public regarding low flying
- operations near roads, houses, or livestock, and
- complaints related to noise or perceived safety risk.

Operational challenges are also evident during:

- approach and landing phases
- selection of suitable landing areas, and
- navigating obstacles such as fences, wires, and terrain features.

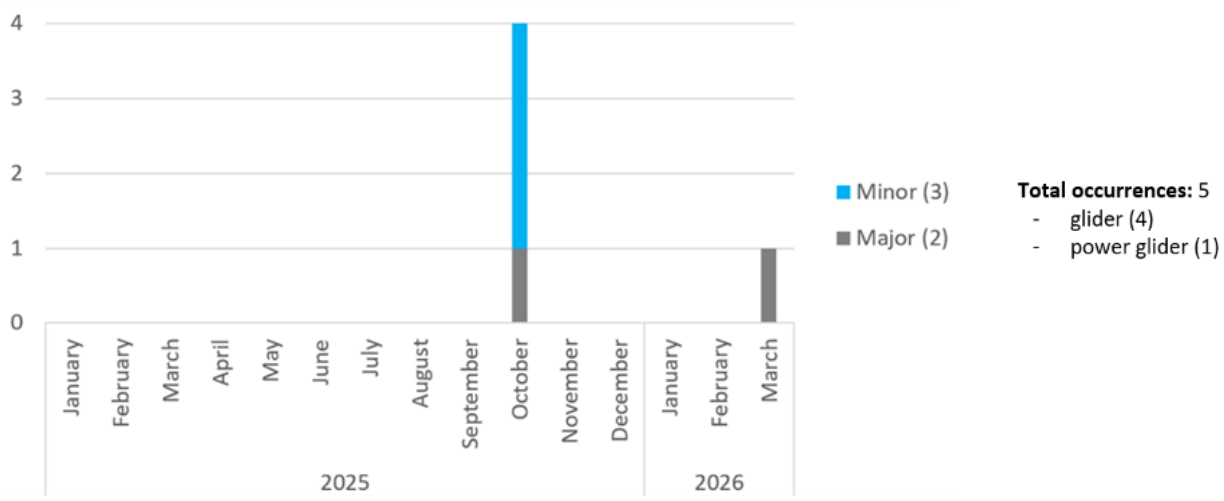
Airspace integration issues are present in some cases, including:

- limited or absent radio communication
- interaction with aerodrome traffic, and
- coordination with other aircraft in shared environments.

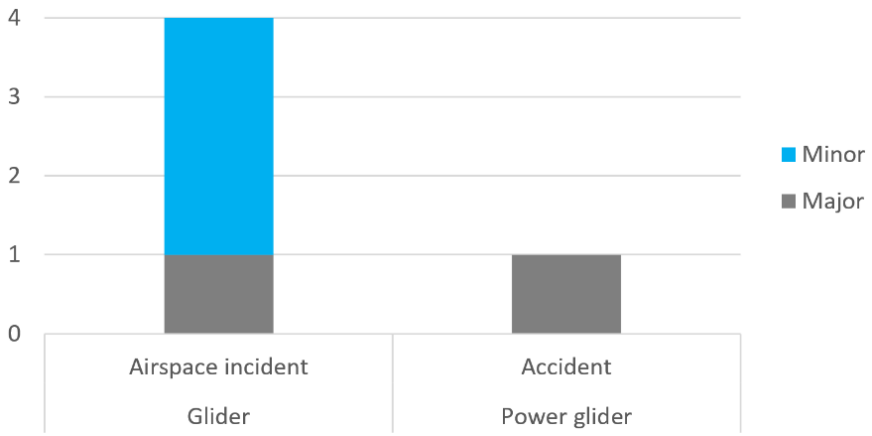
Although most events result in no injury or damage, several highlight the limited margins available during low-level operations, particularly in complex or populated environments.

Overall, balloon operations demonstrate a pattern of low consequence but publicly visible events, where safety is closely linked to operational discipline and awareness of surroundings.

6. Glider/Power glider



Graph 10: Glider/power glider occurrences



Graph 11: Glider/power glider occurrences by type

What the data shows

The number of glider and power glider occurrences in adventure aviation is low, with most events classified as minor severity. Four of the five occurrences involved airspace infringements, with the power glider being involved in an accident. Two occurrences involved conflict with parachute operations, one conflict with a drone, and one conflict in controlled airspace.

The majority of occurrences involve:

- airspace incursions or altitude deviations
- operations within or near controlled airspace without clearance, and
- interaction with parachute operations and other traffic.

Several events describe close proximity or potential conflict with other aircraft, particularly:

- parachute operations
- commercial traffic, and
- other recreational flying activity.

Operational factors contributing to these occurrences include:

- airspace awareness challenges (eg, entering an active PDA)
- variable communication with ATC, and
- decision-making in dynamic flight conditions.

There are also isolated events involving:

- approach and landing issues, including hard landings, and
- problems with equipment or instruments.

While the number of occurrences remains low, the context in which they occur, often in shared or controlled airspace environments, means they have a disproportionate significance to the sector relative to frequency.

Sample of occurrence narratives

Note: These occurrence narratives are presented largely as they were originally reported to the CAA. Identifying information has been removed, including details that could identify people, aircraft, operators, or organisations.

Skydive/tandem skydive

1. *Routine Tandem Jump until main canopy opening: Main Canopy opened off-heading, surging into 3 line twists just above the risers. I noticed the off-heading opening as it was developing and attempted to prevent this. Canopy was fully open and flying stable (but with a slight turn) around 4.5k feet with 3 twists. Airspace clear, position good. Attempted to kick/spin out of twists with PAX assistance. Alternated Kicking, Twisting both risers and using one riser for leverage + kicking. Due to the uneven risers I was rotating "Up-Hill" and unable to generate enough momentum to fully rotate out of the twist(s). At 3.5k feet I observed the situation had not improved and decided to make several more attempts to solve the situation. After several more attempts I had made no progress and was at 3.15k feet. I initiated Emergency Procedures. Normal Cutaway and Reserve Canopy deployment. Checked on Customer, stowed handles, performed canopy control checks and practice*

flare. Normal landing on PLA, no further issues. Suspected causal factors: Packing cannot be identified as the problem, the opening starts out on heading then as the canopy is inflating line twist forms, on occasion this is not preventable. Most likely cause is the slider staying up too long. Resulting Action Taken: TM tried multiple times to clear line twist with no success, carried out EP's above hard deck, landed safely on the pla with a good reserve parachute. TM was given advice on twisting the risers correctly to help get out of line twist malfunction easier.

2. *I did a skydive with my family at [redacted] yesterday. The wind was very strong and getting stronger in the afternoon. When we were watching the other skydivers land you could see them not moving forward at all when traveling in to the wind and landing straight down very hard. My instructor said we can go and I trusted him but my family member instructor who was meant to be on the same plane said they could not go because the wind is too strong. When we landed it was straight down and very hard and I fell on my back from the wind being so strong. I told my instructor I was hurt and asked why we went we went when others did not. He told me the safety officer was saying it was safe to jump and it is his decision and putting pressure on other instructors to jump even though many others stopped. The safety officer needs to be investigated for pushing it to unsafe operations. It sound like there is lots of pressure from company management to keep going to make money at the expense of people getting hurt. I am not the only one hurt on that day. I have a hurt back and legs and am returning to [redacted] early because of this. I tried speaking to the company but they only care about money.*

3. *During a routine tandem decent, regular free fall and good opening. After opening [redacted] noticed the canopy turning to the left, he corrected with right toggle input. When doing his canopy inspection he noticed a visible tear in the rib of a cell instructor carried out a control check and confirmed it was still able to be flown safely. Made the decision to land the canopy. landed safely with out incident. Apologies for the late reporting, this was missed on my part as a notifiable report. Suspected causal factors: Canopy is older with 2300+ jumps, possibly used a lot for higher wing loaded jumps that would put more stress on the canopy over time. Resulting Action Taken: Canopy was inspected by [redacted] master rigger, taken out of service and retired.*

4. *Normal tandem skydive, smooth opening, slider stayed up but came down when toggles were pumped. Tension knot present on the front left of canopy. [Redacted] said canopy was flying fine and only knew there was an issue due to visual inspection. As tension knot was on the front he was unable to attempt to clear by pumping brake. brake lines were not a factor. [Redacted] decided it was safer to go to reserve than attempt to land with the tension knot. procedures completed correctly. safe landing on PLA. Emergency procedures carried out followed by clean reserve deployment and the pair landing safely on the PLA. Tandem packing to be monitored to help improve openings.*

5. *Tandem camera jump, uneventful Freefall and parachute ride. Upon landing, the jumper initially touched down on the right leg but was pushed to the left due to wind conditions. When placing weight on the left leg, the jumper experienced knee pain. Despite the discomfort, the jumper walked back to the hangar and continued packing until the end of the workday. A few days later, due to persistent pain, the jumper sought medical attention. The doctor subsequently signed the jumper off from work for 14 days due to suspected ligament damage.*

<u>Aeroplane/other aircraft</u>

6. *ZK-[redacted] breaching the active [redacted] PDS twice in one flight. First occurrence was breaching the North-eastern corner of the PDS, the second was shortly after breaching the South-*

eastern corner. Pilots transiting this area should remain East of the main road or North and West of Shoreline VRP to remain clear. A suggestion would be to outline the PDS on the VNC, similar to danger/restricted areas as this is a high VFR traffic area.

7. *Aircraft ZK-[redacted] went through PDA while dropping parachutes in [redacted]. I was in ZK-[redacted] and heard the aircraft ZK-[redacted] rolling at [redacted] going to [redacted]. I made standard 2 mins t drop radio calls & additionally advise [redacted] that parachuting was in progress. [Redacted] went east through the PDA whilst people were in freefall and under canopy.*

8. *First load of the day at [redacted], weather conditions broken cloud and forecast strong winds, showers in the vicinity. Prior to refueling the aircraft discussions with manifest took place regarding the weight, fuel load and the consideration of a landing with everyone on board. Conditions looked suitable at the time but showed signs of deterioration. Due to the deteriorating conditions extra fuel was uplifted to allow for the flight, any holding and possible diversion plus reserves. With both factors in mind all up take off weight was 8928lbs which included 650lbs of fuel, this allowed the possibility to meet the reduced landing weight restriction of 8500lbs with fuel burnoff should a landing with everyone onbaord be required. On the flight the winds were measured to be higher than anticipated and deemed unsafe for skydiving. The decision was made to cancel the flight and land back at the [redacted] strip, at this time the aircraft was overweight for landing. [Redacted] was descended down to 3000ft to maximise fuel burn and to stay below the incoming cloud. Given the remaining fuel and the current fuel burn at that altitude it was going to take approximately 50 minutes of total holding time to meet the landing weight restriction. After approximately 15 minutes a request from the operations manager was made to land over concerns for customer experience. A landing was completed 278lbs overweight.*

9. *After start for a Part 115 passenger flight there was an electrical burning smell in the cockpit. The engine was shut down, all electrics turned off, and as a precaution the ground crew was asked to deplane the passenger from the aircraft. The rides were almost complete for the day, so the passenger was transferred to [another aircraft] for her flight.*

<u>Paraglider/tandem paraglider</u>

10. *I witnessed the near miss. A student was coming into land at [redacted] but was short of the main field. He set up to land in the paddock behind the main field but misjudged his set up and landed right on the fenceline of the paddock and [redacted]. The wing then fell behind him onto a powerpole. He unclipped and walked away with no injury. The wing was hung up on the side of the powerpole. [Redacted] was called and they sent someone to remove the wing. No damage was caused to the pole or the wing. Didn't make the main landing area due to headwind and flying in the wrong area. Poor set up for landing. Misjudgment of the amount of area he had to land, a 90 deg turn would have had him land in the grassy paddock. Possible target fixation.*

11. *Launched at [redacted] soared above [redacted] at 400m agl. Followed a pilot crossing the bay to [redacted], got flushed down in the Lee side on [redacted]. Had to land in the ocean close to the shore/on some rocks in the water. Could manage to free myself from the glider (could not recover it) and swim a few meters back to land. Climbed up the cliffs on the west side of [redacted]. Glider got ripped apart on the rocks in the water, drifted into the ocean after I detatched it. Hight to landing was good during the crossing, but the Lee trap should have been obvious to me. Most probably wouldn't have tried it on my own. Don't follow pilots you don't know in sites your not fully familiar with. Do not land in the ocean at all costs. Carry a cutoff knife. Police and local club was fully informed about the incident right after.*

12. *Top landing in lifty conditions, overflew the normal top landing area, touched down lightly on a 45 degree part of the slope (long grass -sloping to the left), weight was not fully on the ground, turned glider to the left to kill it in towards the top of the slope, was lifted as the glider spun in to the hill, touched down lightly again, both pilot and passenger fell over in the long grass as pilot was killing the glider. No impact, no dragging, no injuries, not proud of the landing or the decision making, could have ended up worse. The passenger is unknown to pilot, someone onsite he talked to and offered a flight.*

13. *I was flying along the saddle ridge of [redacted] on the lee side after flying for 1,5 hrs in challenging conditions. Haven't noticed the wind has picked up more and got gusty as it was pushing down the valley and over the saddles. I was 50m AGL when the right side of the glider collapsed more than 70%. As it recovered aggressively the left side wrapped around and created a full twist. I suspect my hand were low after loosing pressure as well as trying to catch the collapse. This has resulted the glider to lock into backfly slightly tracking along and away from the slope with 7,5m/s sink and 10-15km speed. I remember looking up and seeing the wingtips floppy the center inflated and trailing edge slightly floppy as I was flying backwards. I looked over my shoulder and had roughly 25m AGL as I was reaching for my reserve realising its not enough to work. I impacted the very steep boggy tussock on an angle that absorbed most of the energy. No injury apart from a massive scare.*

14. *I had a look at "Paragliding Map" at [date]. Wind seemed good for [date]. At [date] around 01:30 pm I was there. Alone. The waves had white caps. I had flown in such conditions in [redacted overseas country] but at an better launch pad. There was no wind on the ground. After several attempts, lying out the canopy again, getting grass twigs out etc., I got the glider up and was lifted up and found the brakelines entangled. I could not steer and after a few seconds I did collide with the uppermost part of the Ridge with my left side. Immediate severe pain in the lower back. Left side ok, hip protection at the harness. I crawled less than 10 m to the road and called and ambulance, which brought me to [redacted] Hospital. 16.12. the L1 vertebra fracture was consolidated with Titan from the neighbouring vertebra. Since then the pain is much better. Full recovery to be expected in 3-6 months, even longer. Mistakes: I did not contact local pilots. I was too keen to fly, too bold, and took not enough consequences from the strong wind, the three to four failures to launch; the smallness of the launchpad, missing possibilities to launch further down, at least I didn't see something. And it was too steep down the ridge. I am a visiting pilot from [redacted], [redacted] licence „B", the higher one. And I have a [redacted] license for paramotoring. I have a NZHGPA License Nr. [redacted]. Glider Advance Epsilon 9, biggest size. Woody Valley sitting harness. I have transcribed this as pilot is still in hospital. In arriving to the scene later after being informed I noted the wind was from South east and strong this would have had appearance on launch on coming up the face but been from a cross direction with rotor. Pilots have started taking off from the crown of the hill not gully and subsequent accidents have been higher.*

<u>Balloon</u>

15. *I was approaching [redacted] airfield from the southeast, targeting landing next to the refuelling area. As I got close (approximately 750meters away) a small aircraft taxied to that area and stopped. As that landing site was then unavailable, I had to adjust my landing location to further down the airfield, I climbed to approximately 300foot to turn left in the higher winds. Once far enough over I descended to turn right and to land on the run way. During this time the small plane relocated to the western end of the runway, as I approached the runway, over the hangers from the south, the plane started rolling and then took off. There was no impact to my landing i.e. no wash from the plane however at our closest we were less than 100meters apart. Learning: Due to adjusting the landing location during the approach and with downwind obstacles (horses next to*

the runaway) as a result, I had to prioritize flying the balloon. With hindsight, I realised I missed a radio broadcast as a result. I don't believe that this would have made any difference to the situation, there were multiple balloons operating in the area (including one that had already landed at the airfield) and the small plane would have seen us approaching from when they were at the refuelling area. In my opinion there wasn't anyone at fault in the situation, I wanted to log this for the learnings and awareness… I am happy to discuss this in more detail if that would help.

16. *Approaching landing site noticed posts stick up randomly at desired touchdown point. Balloon touched the ground prior to the intended landing paddock, then climbed over fence to paddock but caught a plain wire that had been placed 1m above fence. The wire caught the basket and broke. Balloon climbed away and landed further downwind in another selected paddock. Have landed in this paddock several times and never noticed the wire. Notified the manager and they were surprised to learn of the wire. Thought perhaps lessee had placed it there to keep horses from grazing over the fence. No damage to balloon. 2.5mm wire reconnected and strained up.*

17. *I was woken up by the sound of a hot air balloon which sounded like it was on top of my house. So I ran outside and it was very close to the roofs of houses. It was bright yellow balloon and I could see an older man driving it. I watched it head towards the Fulton Hogan tower [redacted] and it didn't get higher and from my angle the basket was within a metre of hitting part of the tower. I have - video. I then watched him go low down close to the main road [redacted]. Then lost sight of him.*

<u>Glider/power glider</u>

18. *ZK-[redacted] entered the [redacted] PDA at 2000ft when a cloud drop was in progress by ZK-[redacted]. [Redacted] was instructed to remain clear of the 2nm PDA and make a glider arrival. They then entered the PDA. [Redacted] TWR was phoned and they advised the chutes and the glider were in sight. NZ[redacted] Cloud base at the time was 3700ft.*

19. *Today (time TBA) ZK-[redacted] a single seat Schempp-Hirth Ventus 2cT powered glider had a heavy landing at the [redacted] glider aerodrome (3nm SE of [redacted]). Pilot [redacted] was uninjured however as a result of the heavy landing the gliders fuselage broke aft of the trailing edge of the wing. The glider was at the short final part of its approach at ~60kts when sink was encountered leading to what is thought to have been an aerodynamic stall. Windspeed was 5-10 kts. This info was passed to me by [redacted] the National Ops manager of [redacted] who was at the aerodrome and who also mentioned they will be investigating the calibration of the gliders airspeed indicator. Mr [redacted] has also taken photos of the glider and damage and they will report as part of their process but he [redacted] was seeking approval to move the glider off the airstrip. I ran all this past [redacted] who was in the office and who, like me, saw no merit in blocking the runway so I advised him to move the glider off. I also advised TAIC who responded they would not be investigating.*

20. *Drone sighted operating at speed below ZK-[redacted] at approximately 2000ft overhead [redacted] main beach. Considered non threatening due to distance from airfield. No disruption to aerodrome traffic. Police notified.*

21. *ZK-[redacted] was on a gliding flight from [redacted]. The acft was instructed to remain clear of the [redacted] PDA as there were parachutes descending from above at the time. [Redacted] was then observed to make a glider arrival and join to land at [redacted]. The acft called [redacted] TWR without an instruction to do so.*

What's next

Thank you for continuing to report occurrences to the CAA. The information you provide is incredibly valuable for identifying key risk areas and generating insights that help others learn, identify new controls, improve existing controls and operate more safely.

To further strengthen the usefulness of these reports, we encourage you to include complete and accurate details – such as aircraft type, model, operator information, pilot details and any analysis you've done to understand why the event occurred. Thoughtful, well-described reporting enables us to build a clearer picture of emerging risks and share more meaningful guidance back to industry.

If you have any further questions, or ideas for additional insights, please reach out to the Safety and Security Education team at education@caa.govt.nz.