




















UK Flight Safety Committee

UKFSC News #12

28 Jan 2025

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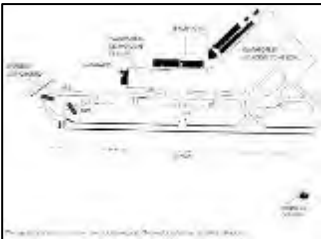
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SKYBRARY

Aviation Language

Using a Country’s Native Language for Communication with Local Crews Potentially Prevents International Crews from Achieving The Desired Level of Situational Awareness

‘On 6 October 2022, a solo student pilot departing Seville in a light aircraft was instructed to hold short of the active runway on reaching it but, without the controller noticing, entered the runway. An Airbus A320 had already been cleared to land then called that there was a light aircraft on the runway and after initially just repeating the clearance, the controller then saw it. The context for the conflict was assessed as the controller’s use of English for PA28 communications and Spanish for A320 communications and the absence of any requirement to activate controllable stop bars in visual daylight conditions.’



An Investigation was carried out by the Spanish Commission for the Investigation of Accidents and Incidents (CIAIAC) using FDR from the A320 and surveillance radar data for the airport and recorded ATC communications with both aircraft.

The Cause of the runway incursion was determined to have been “the student pilot's failure to comply with the procedures prescribed in the Standardised European Rules of the Air”.

Two Contributory Factors were formally recorded as follows:

- The fact that the controller did not change his communications to English.
- That fact that the airport stop bars were not used, as the Seville control tower Operating Manual does not stipulate their use during daylight hours in flight visual meteorological conditions.

[Learn more](#)

New articles

- [Runway Incursion](#)
- [English Language Proficiency Requirements](#)
- [Multi-language ATC Operations](#)



Ryan - stock.adobe.com

AUSTRALIAN TRANSPORT SAFETY BUREAU

DHC-8 Incorrect Flap Setting for Short Runway Take-off

What Happened

‘On 26 June 2024, a De Havilland Canada DHC-8-402 (Dash 8), was preparing to operate a QantasLink passenger flight from Horn Island to Cairns, Queensland. The flight crew identified that the take-off would be performance-limited due to the runway length at Horn Island and the high passenger and cargo weights. The crew determined that a flap setting of 15° and the bleed air system switched off was required for take-off.

During pre-flight preparation, the first officer (FO) was the pilot flying and inadvertently selected a flap setting of 5° instead of the required flap setting of 15°. The crew completed the after start checks and after start checklists in accordance with the standard operating procedures, however neither the first officer, nor the captain as pilot monitoring, detected the incorrect flap setting.

During the initial take-off run, the Dash 8 accelerated normally, however the crew noted that the aircraft’s rotation was slow and that the aircraft performance differed from their usual experience during take-off. The first officer’s application of continued back pressure to the controls during the take-off run resulted in the aircraft successfully becoming airborne slightly after the expected rotation speed. The first officer identified that the flaps were configured at a setting of 5° and immediately advised the captain. The captain instructed the first officer to continue to fly the aircraft. The first officer slightly lowered the nose of the aircraft to increase airspeed. The aircraft accelerated in response to this action and a positive rate of climb was maintained. The flight continued to Cairns without further incident.

What the ATSB Found

During preparation for take-off from Horn Island, the FO inadvertently selected the flap lever to 5° instead of the required setting of 15°. This was likely due to habitual behaviour as the flap setting of 5° was the most common take-off flap setting for other sectors in the network and was the flap setting required on the 2 sectors flown prior to the incident. Standard pre-flight checks and crosschecks were conducted, however the flight crew failed to identify the incorrect flap setting before take-off at Horn Island. This was likely due to automatic behaviour by the crew registering flap 5° to be the usual setting at take-off.

What Has Been Done as a Result

Following the occurrence, the operator implemented the following organisational and operational changes:

- Review of standard operations procedures as necessary to reduce the likelihood of erroneous flap selection and misidentification.
- Review of relevant checklists to strengthen crosschecking in accordance with the computed take-off performance data.
- Training for crew focusing on standard operating procedures and compliance.’

[ATSB Report](#)



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Photo by cottonbro studio: [pexels.com](https://www.pexels.com)

PILOTS WHO ASK WHY

The Crucial Skill of Saying No as a Pilot

‘Every pilot will face that moment at some point: the one where you have to draw the line and say no. For some it’s second nature. For others, it’s one of the hardest parts of a pilot career.

So why is this skill so essential for professional pilots? And what happens when you’re too agreeable, whether it’s in the cockpit or in day-to-day operations?’

[Read the full article here.](#)



CHIRP

ATFB 153

CHIRP Air Transport FEEDBACK Edition 153 welcomes the new Director Aviation, Nicky Smith, as she takes over the role from Steve Forward. Nicky gives her perspectives on safety management and gives a short piece about her background.

Edition 153 covers a variety of reports including fatigue, engineering management and flight over conflict areas.



Photo from the interim accident report

INTERSTATE AVIATION COMMITTEE

Loss of Control

The aircraft proceeded normally to 5000’. After flap retraction when attempting to initiate further climb the aircraft’s anti-stall system (AoA limit system) pitched the aircraft down and the pilots were unable to recover despite full nose up control inputs.

Two of the angle of attack sensors that had been replaced prior to the flight were overreading. An ADS DISAGREE message was activated.

Two months earlier on the same type a similar scenario developed following the replacement of two angle-of-attack sensors, but in this case the crew selected the reserve air data computer and completed the flight.

The safety actions taken: -

- To develop a service bulletin for the for the unambiguous fastening of the angle-of-attack sensor mounting plate to a marked specific location.
- A bulletin to flight crew on the response to incorrect data from two or more ADS channels.

[Interim Report in Russian](#)



UK AIRPROX BOARD

December UKAB INSIGHT

Assumption – the mother of all mistakes

The December edition of INSIGHT looks at an Airprox involving a PA-22 and a Tiger Moth in the circuit at Compton Abbas.

The article concentrates on the pitfalls associated with assumption and discusses what defences pilots can employ so that they don’t get caught out by an inaccurate mental model.

It also provides a few options for pilots to consider if they find themselves in an uncomfortable situation in or around the visual circuit at an uncontrolled aerodrome.

[Read the full article.](#)



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Images from the interim accident report

AVIATION AND RAILWAY ACCIDENT INVESTIGATION BOARD SOUTH KOREA

Jeju Air B737-800 Belly Landing and Runway Overrun

Muan, 29th December 2024

The interim report published on 27/1/25, states: ‘At 08:54:43, HL8088 first communicated for landing with the air traffic control tower of Muan International Airport. The tower cleared to land on runway 01. While HL8088 was approaching the runway, the tower advised the airplane at 08:57:50 to be cautious of bird activity. Both the CVR and FDR recordings stopped at 08:58:50.



After a few seconds, at 08:58:56 (time converted from CVR waveform), HL8088 made an emergency declaration (Mayday x 3) for a bird strike during a go-around. As HL8088 was flying over the left side of the runway 01, it turned right and approached runway 19 to land on it after aligning with the runway centerline. The airplane belly-landed without its landing gear deployed, overran the runway, and crashed into the embankment, including the installed localizers, bursting into flames.

This accident resulted in the fatalities of 4 crew members and 175 passengers, while 2 crew members were seriously injured.

After the crash into the embankment, fire and a partial explosion occurred. Both engines were buried in the embankment's soil mound, and the fore fuselage scattered up to 30-200 meters from the embankment. The empennage flipped and fell beyond the embankment, partly burning.

Flight data recorder (FDR) and cockpit voice recorder (CVR) were installed in HL8088. However, both recordings stopped at 08:58:50 on December 29, 2024. The airplane impacted with the embankment at 09:02:57, meaning the last

00:04:07 recordings were missing. The airplane speed and pressure altitude when the recorders stopped were 161 kts and 498 ft, respectively. Figure 2 shows the flight path of HL8088 from its takeoff to where its flight recording stopped.

The pilots identified a group of birds while approaching runway 01, and a security camera filmed HL8088 coming close to a group of birds during a go-around. Both engines were examined, and feathers and bird blood stains were found on each. The samples were sent to specialized organizations for DNA analysis, and a domestic organization identified them as belonging to Baikal Teals.

The Aviation and Railway Accident Investigation Board (ARAIB) will tear down the engines, examine components in depth, analyze CVR/FDR and ATC data, and investigate the embankment, localizers, and bird strike evidence. These all-out investigation activities aim to determine the accurate cause of the accident.

In addition, issues deemed necessary for safety or any other improvements will be reviewed and are expected to lead to urgent safety recommendations.’

Interim Report



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Photo by Jeffry S.S;
-pexels.com

NATIONAL TRANSPORTATION SAFETY BOARD
B737 Turbulence Encounter

‘The captain asked the cabin crew to sit down for about 10 minutes as they transited an area of predicted moderate turbulence about 80 miles prior to the top of descent, during which the turbulence was light chop. During the descent, at an altitude of about 12,000 ft, the aircraft experienced what the captain described as 2-3 seconds of moderate turbulence as the airplane flew through a cirrus cloud. After landing, the C flight attendant told the captain that during the turbulence, both of her feet left the floor momentarily, and that she landed awkwardly on her feet She was later diagnosed with a fractured left tibia. A convective SIGMET was in effect for an area surrounding the accident, warning of either existing or expected thunderstorms. Convective SIGMETS imply the possibility of severe or greater turbulence. There were no AIRMETS in effect, and no PIREPS.’

[NTSB Report.](#)



OPSGROUP

FIRE on the NAT!
Where to go in an emergency?

‘If you’re in big trouble on the NAT (like an engine on fire, for example), where can you go?

Turns out there’s quite a bit of complexity to this. Some airports don’t have amazing levels of fire cover, some are closed at night, and some have weird setups where you have to pay them in advance to make sure they stay open in case you need them.’

[Read more.](#)



Photo from the accident report

AIRCRAFT ACCIDENT AND INCIDENT INVESTIGATION BRANCH TANZANIA

ATR 42 - 500 Aircraft Crashed in Lake Victoria

ATR 42 - 500 aircraft crashed in Lake Victoria while approaching runway 31 of Bukoba Airport. During the approach it encountered heavy rain and thunderstorms with lightning as well as significant crosswind and turbulence. During the final approach, several nose down inputs on the control column increased the descent rate of the aircraft. The EGPWS SINK RATE-SINK RATE alert triggered 15 seconds before the accident. Then the EGPWS PULL-UP warning triggered, followed by flight crew's nose up input on control column, around 2 seconds before the aircraft struck the water surface of Lake Victoria about 500 meters short of runway 31 threshold. The impact with the water caused significant damage to the aircraft fuselage followed by water entering the cabin and flight deck.

The AAIB Tanzania concluded that conducting an unstable final approach in poor weather conditions that could not allow clear visual contact with the ground was a major factor in this accident. The decision of the Pilot in Command to negotiate his way through the narrow weather window in order to reach the runway, the high crew workload caused by the presence of thunderstorms, the variable cross wind, rain and turbulence as well as the absence of air traffic services at Bukoba airport were contributory factors.

The F/O twice advised the PIC to divert to Mwanza, but the PIC chose to continue. Towards the end of the flight, when the EGPWS SINK RATE warning was triggered the F/O shouted to the PIC “pull up” without response.

There are 8 recommendations: 1. TCAA to establish PBN approaches for commercial flights at VFR airports, 2. TCAA to establish Air Traffic Control at Bukoba. 3. Precision Air Services (PAS) comply with weather minima and SOPs. 4. PAS to sue weather from official sources. 5. Tanzania Airport Authority to add water rescue capability to Bukoba RFFS. 6. The Ministry of Health to ensure doctors are qualified to conduct autopsies in accordance with ICAO standards. 7. PAS implement Flight Data Monitoring to support SOPs. 8. Air Navigation Service Provider at Mwanza airport should amend the relevant procedures to include provisions to transmit critical weather information to aircraft that has already tuned their radios to the unmanned frequency (118.2 MHz).

[AAIBT Report](#)



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UK CAA PUBLICATION

UK MPD 2025-001-E: BRP Rotax GmbH & Co KG Rotax 912i, 915i and 916i engines: Engine / Electrical Power – Internal Generator – Inspection / Replacement of Oil Spray Nozzle.

UK CAA Mandatory Permit Directive

[View UK MPD 2025-001-E](#)

UK CAA PUBLICATION

EASA EAD 2025-0023-E: Pipistrel Vertical Solutions d.o.o. Virus SW 121 aeroplanes: Flight Controls – Flaperon Bellcrank Bolt – Inspection

EASA Emergency Airworthiness Directive This AD supersedes EASA EAD 2023-0079-E

[View EASA EAD 2025-0023-E](#)

UK CAA PUBLICATION

ORS4 No.1618: Flight Data Recorders (FDR) and Cockpit Voice Recorders (CVR) – Non-Part 21 Public Transport Helicopters

The purpose of this Exemption is to provide alleviation for Non-Part 21 helicopters when conducting Public Transport operations with a MTOW of between 2,730 kg and 3,175 kg from the requirement to carry a cockpit voice recorder, and those issued with a Certificate of Airworthiness first issued on or before 31 July 1999 and a MTOW over 3175 kg but not exceeding 7000 kg from the requirement to carry a flight data recorder. It is not applicable to helicopters operated under a Police Air Operator's Certificate. It is issued to align Public Transport operations equipment requirements with the equipment requirements of Commercial Air Transport operations and achieve a level playing field for operators.

[View ORS4 No.1618](#)

EASA

i-Conspicuity — Interoperability of Electronic Conspicuity Systems for General Aviation

Automatic Dependent Surveillance – Light Coalition - A common standard for General Aviation conspicuity

EASA is promoting its ADS-L Coalition project that is a coalition of conspicuity manufacturers, with the support of EASA, that ensures that all conspicuity devices, whether licensed or not, can talk to each other.

[i-Conspicuity interoperability](#)

[ADS-L See and Be Seen](#)



EASA EUROPEAN PLAN FOR AVIATION SAFETY

EPAS Volumes II and III Updated

EPAS Volume III 'Safety Risk Portfolios' provides comprehensive documentation of the safety issues affecting the European aviation system. The 2025 update includes new risks in the commercial Air Transport, Airworthiness and Balloon domains: -

Commercial Air Transport:

- Ambiguity in operational requirements and lack of authority oversight for non-revenue flights, and
- Controller-pilot data link communication (CPDLC) miscommunication.

Airworthiness

- Oxygen-fed fire in the flight deck.

Balloons

- Pre-flight planning and preparation
- System reliability and ageing structures
- Use of non-certified parts in critical balloon structure/equipment

EPAS Volume II 'EPAS Actions' detail the actions related to the strategic priorities in Volume I and the risks in Volume II. The 2025 update includes the following new actions: -

Systemic safety and resilience

- °Regular update of Reg. (EU) 2023/2117 (repository of civil-aviation-related information);
- °Regular update of Reg. (EU) 2023/203 and 2022/1645 (Part-IS) and associated AMC & GM;

Rotorcraft

- °Continued integrity verification programme (CIVP);

Aerodromes and ground handling

- °Protection of aerodrome surroundings;
- °Support the implementation of the ground handling regulation

New technologies and operational concepts

- °Regular update of the use of airspace and requirements on aircraft equipment;

Environmental protection

- °Environmental protection requirements for products not covered by ICAO Annex 16;

[European Plan for Aviation Safety \(EPAS\) 2025](#)



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Recent Accidents & Incidents from the Air Safety Network Wikibase

Date	Type	Event	Location
19-Jan-25	A320	Disembarking passenger, cardiorespiratory arrest, fell down the stairs.	SJP/SBSR
24-Jan-25	A320	FL380, cabin smoke, diverted	Gulf of Botnia
23-Jan-25	A320	RTO bird strike	Ushuaia
26-Jan-25	A321	Diverted due activation of the oil level indicator.	GSV/UWSG
20-Jan-25	A321	Tow bar snapped, icy conditions, tug struck aircraft	Cleveland
19-Jan-25	A330	FL380, cabin fumes, diverted.	W of Pormpuraaw
25-Jan-25	A330	RTO due engine surge	Chiang Mai
20-Jan-25	A350	ATB, cabin smoke	Boston
25-Jan-25	AN24	RTO due engine failure & RW Excursion	Nelkan
21-Jan-25	AN26	RW Excursion, landing with 'technical problem'.	Kongolo
24-Jan-25	ATR72	ATB Windscreen cracked	Pointe-à-Pitre
19-Jan-25	B200	Lateral RW Excursion in snow	Bedford, MA
18-Jan-25	B200	Take-off aligned with RW edge lights, diverted	Austin, TX
20-Jan-25	B737-8	Multiple blown tyres while landing	SVD/TVSA
24-Jan-25	B737-8	ATB, smoke in cockpit	Bucharest
19-Jan-25	B737-5	ATB, engine failure	Kinshasa
24-Jan-25	B737-8	ATB, electrical smell in cabin	Florida Keys
24-Jan-25	B737-8	Diverted due technical problem	Astrakhan Oblast
24-Jan-25	B787-8	FL360, sudden altitude loss	over Daloa
21-Jan-25	B787-9	Engine failure during pushback	Santiago
20-Jan-25	BD100	ATB, engine failure	Nassau
25-Jan-25	Global	Windscreen cracked.	Near Samara
22-Jan-25	C208B	Lateral RW Excursion in snow, glycol on the windshield reduced visibility.	South Bend, IN
20-Jan-25	C402	Landed on road. Engine issue after take-off.	Bowdle, SD
23-Jan-25	Typhoon	Canopy jettisoned after bird strike	North Sea
20-Jan-25	F100	Tyre failure during landing	Tehran
20-Jan-25	H800XP	Nose landing gear failure after diverting	Minneapolis
24-Jan-25	LET410	RW excursion after landing at Wamaza	Wamaza
20-Jan-25	F35	ATB due bird strike.	North Wales
22-Jan-25	PC12	Nose gear collapsed, after landing	Grand Rapids, MI
21-Jan-25	PC6	RW Excursion, overrun.	Maripasoula
19-Jan-25	DHC6	Diverted due smoke in cockpit.	Sint Maarten



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Safety Conference Calendar

Year	Month	Day(s)	Org	Event	Location	Notes
2025	Feb	4 th 5 th	EASA	EASA Fatigue Risk Management Conference	AESA, Spain	Hybrid
2025	Feb	18 th	FSF	Advancing Aviation Safety: Integrating Mental Health into Operational Excellence	Online	Webinar
2025	Mar	11 th 12 th	NTSB	Automation In Transportation: Lessons For Safe Implementation	Washington DC	In person meeting
2025	Mar	12 th	UKFSC	470 th SIE	TBC	
2025	Mar	TBC	Airbus	Airbus Safety Conference	TBC	
2025	Mar	17 th – 19 th	FRMS Forum	FRMS Forum Annual Conference	Santiago, Chile	
2025	Mar	19 th – 20 th	RAeS	RAeS Flight Operations Conference 2025: Single Pilot Operations - Logical Progression or a Step Too Far?	Hamilton Place, London	
2025	Mar	24 th – 28 th	CANSO	Global Safety Conference	Christchurch, New Zealand	
2025	Mar Apr	31 st – 1 st	IATA	34th Safety Issue Review Meeting	Montreal, Canada	
2025	Mar Apr	31 st – 2 nd	UKFSC	FSO Course	Gatwick	
2025	Apr	2 nd – 3 rd	ERA	Safety Group	TBC	
2025	Apr	7 th – 9 th	ACSF	ACSF Safety Symposium	Embry Riddle, Daytona Beach, FL	Business aviation
2025	Apr	7 th – 9 th	FoF	Flight Operations Forum Norway 2025 – Communicate for Safety	Oslo airport	
2025	Apr	28 th -30 th	UKFSC	FSO Course	Gatwick	
2025	May	6 th – 7 th	FSF	70th Business Aviation Safety Summit	Charlotte, North Carolina	
2025	Jun	5 th – 6 th	FSF	Safety Forum 2025 Theme: People in the Centre of Aviation Safety	Eurocontrol, Brussels	
2025	Jun	24 th	UKFSC	471 st SIE	TBC	
2025	Aug	18 th – 20 th	UKFSC	FSO Course	Gatwick	
2025	Sep	10 th	UKFSC	472 nd SIE	TBC	
2025	Sep	15 th – 17 th	UKFSC	FSO Course	Gatwick	
2025	Sep/Oct	29 th – 4 th	ISASI	ISASI 2025 - Soaring to New Heights: A World of Innovation	Denver, Colorado	
2025	Oct	6 th – 7 th	SAE	Defence Aviation Safety Conference	London	
2025	Oct	14 th -16 th	IATA	World Safety and Operations Conference	Xiamen, China	
2025	Nov	4 th – 6 th	FSF	78th International Aviation Safety Summit	Lisbon, Portugal	
2025	Nov	10 th – 12 th	UKFSC	FSO Course	Gatwick	
2025	Dec	2 nd	UKFSC	473 rd SIE	TBC	