



UK Flight Safety Committee

# UKFSC News #16

25 Feb 2025





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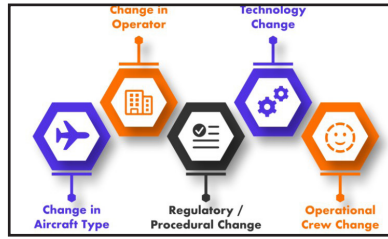
**ATSB**

**Super Puma Loss Of Control**



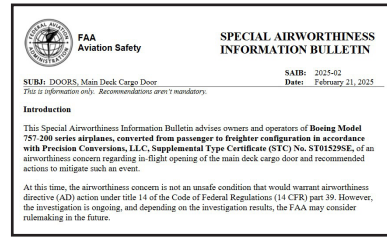
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### SKYBRARY

## Managing Multiple Failures Will Stretch Even The Most Experienced Pilots And Should Be Practiced In The Simulator

By Björn Wylezich Stock.adobe.com



‘On 20 December 2012, a PW4168A-engined Airbus A330-200 was climbing through FL220 after departing Phuket at night when sudden uncontained left engine failure occurred.

Engine shutdown and initiation of a return was followed by consequential loss of the green and then blue hydraulic systems. Shortly after this, a relatively uneventful landing followed with only minor damage but “without pilot assessment or knowledge of the safety margin”. As the findings of the Investigation raised still-relevant concerns about the way this multiple failure scenario was handled.’

### [A332, NW of Phuket Thailand](#)

### Related Links

### [Uncontained Engine Failure](#)

### [Emergency and Abnormal Checklist](#)



Photo from the ATSB accident report

### AUSTRALIAN TRANSPORT SAFETY BUREAU

## SA227 Hydraulics System Failure

During a non-scheduled air transport flight the crew experienced a complete loss of pressure in the hydraulic system. Without the hydraulic system, the flaps, nose wheel steering, and landing gear were not functional, however limited braking was available from a an accumulator. The captain conducted a flapless landing and after stopping on the taxiway for a short moment, opted to continue the taxi to the operator’s hangar, mistakenly believing that the brakes were functioning. In close proximity to the operator’s hangar, the crew applied the brakes to stop the aircraft while on a slight slope, but they were ineffective and the aircraft collided with the hangar.

### Contributing factors

A crack in a hydraulic line resulted in a loss of hydraulic pressure. Following the hydraulic system failure, the captain was required to take-on both the pilot flying and pilot monitoring roles. The first officer’s inexperience limited their ability to contribute to managing the failure. After stopping

on the taxiway, the captain mistakenly assumed the brakes were functioning. Unable to locate or contact the tow tug and influenced by self-imposed pressure, continued the taxi.

### Safety action by the operator

- The flight crew received refresher training in human factors, standard operating procedures, workload management and decision-making. Additionally, the captain has completed remedial training on decision-making.
- The captain has completed a series of simulator exercises to confirm all procedures are followed in accordance with the QRH and company standards.
- During their fleet meeting, all fleet pilots were made aware of the incident and the lessons learnt to prevent re-occurrence.
- All fleet pilots have completed theory training and examination of the hydraulic system.
- Skippers Aviation is carrying out a review of maintenance practices for tube repairs and replacements for the fleet.

### [Report](#)

### ROYAL AERONAUTICAL SOCIETY

## RAeS Lecture: ESA Director General’s Address

10 March 2025 19:00 - 20:00

Insights into the latest developments in the space industry and its key challenges. The lecture will be followed by an audience Q&A.

### [Registration](#)

### EUROCONTROL

## RTAB Podcast - Digital iNM

RTAB podcast episode with Tony Licu, shares insights into iNM - the integrated Network Management programme set to modernise EUROCONTROL’s systems by 2030.

### [Listen](#)

### EUROCONTROL HINDSIGHT

## People in Control? Staying in the loop...Lessons learned from HindSight 36

5th of March 2025 14:00-15:30 CET

With Dr. Steve Shorrocks, Senior Team Leader – Human Factors

### [Registration](#)





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NORWEGIAN SAFETY INVESTIGATION AUTHORITY

A320 Lithium Battery Fire in the Cabin, 11 June 2022



At top of descent to Flesland, the cabin crew was alerted by passengers about a fire in the forward part of the cabin. A passenger’s cell phone had overheated and caught fire.

The cabin crew members immediately initiated the procedure for fighting lithium-ion battery (LIB) fires, and equipped themselves with water, hand held BCF fire extinguishers, fire proof gloves and breathing equipment. Simultaneously, the flight crew was informed about the situation, and declared an emergency («MAYDAY»).

The cell phone was first cooled by water, which caused the fire and smoke to stop. The phone was secured in a metal container and placed in an aft lavatory. The container was filled with water and monitored for the reminder of the flight. The crew members on board the Wizz Air flight handled the situation quickly and in a very good way. They had relevant equipment available, and followed the necessary procedures to cool down the cell phone battery, and to keep it under control until the aircraft had landed.

Protective gloves are important in order to handle hot or burning batteries. Thus, the NSIA recommends that all operators equip the cabin and the cockpit with easily accessible fire protective gloves in addition to relevant TR and LIB fire equipment kits. It is also important that crew regularly perform TR handling procedure training.

[NSIA Report.](#)



By icholakov Stock.adobe.com

NATIONAL TRANSPORTATION SAFETY BOARD

Learjet Rejected Take-off & Runway Overrun

‘The pilot-in-command (PIC) reported hearing a “boom” during the takeoff just before reaching VI and a second “boom” just as he called out VI. The second-in-command (SIC), who was the pilot flying, called to abort the takeoff. Both suspected they had blown tires. They attempted to slow the airplane, but there was no braking action. The drag chute was deployed but the airplane continued off the end of the runway, traveled through the runway end lights, and into the grass. During the accident sequence, the drag chute separated from the airplane and was located on the runway. Examination of the airplane after the accident revealed that the left main landing gear tyre had ruptured and pieces of the tyre and the left brake system assembly were

found along the runway. The airplane sustained substantial damage to the left wing during the accident.

The airplane’s maintenance manual recommended that the tire pressures be checked before the first flight of every day. The tire pressure was not checked on the day of the accident, therefore, it could not be determined whether or not the tyres were appropriately inflated at the time of the accident. According to the operator, the drag chute most recent 6-month inspection was complied with on October 26, 2022.’

The NTSB concluded the probable cause as a left main landing gear tyre rupture during takeoff, which resulted in a runway overrun.

[NTSB Report.](#)

CAA PUBLICATIONS

SN-2025/002: Department for Transport Security Advice to Air Operators

The purpose of this Safety Notice (SN) is to remind or alert UK aircraft operators to the international security threat and risk information available from the Department for Transport (DfT).

[View SN-2025/002](#)

ORS4 No.1620: Carriage of Aerosols without a Subsidiary Hazard on Board an Aircraft

General Exemption authorising aircraft operators who do not have fuel heaters, to carry Aerosols, UN1950, Division 2.1 without a subsidiary hazard as anti-icing additive. Supersedes ORS4 No.1569

[View ORS4 No.1620](#)

SN-2025/003: Part 21 Aircraft with Ballistic Parachute Recovery Systems (BPRS) Fitted

This Safety Notice is to advise owners of Part 21 Aircraft with BPRS Fitted that they may wish to install placards described in CAP 482.

[View SN-2025/003](#)



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Photo By Navacepe Stock.adobe.com



AUSTRALIAN TRANSPORT SAFETY BUREAU

Loss Of Control & Collision With Terrain - AS332 Super Puma

On 22 November 2024, at about 0955, while cruising at about 3,500 ft above mean sea level, the pilot noted a high frequency vibration through the airframe that was also apparent to the passenger. The pilot lowered the collective control and began a descent, data showed the helicopter was descending at about 1,500 ft/min with an indicated airspeed of about 115 kt.

The pilot reported that, during the descent, they heard a loud thud, which was immediately followed by an uncommanded yaw to the left. To control the yaw, the

pilot established an autorotation then indicated that they reduced the throttles to idle, however, inadvertently reduced the no 2 engine throttle beyond the idle gate position resulting in the engine shutting down.

With the reduction in power, the uncommanded yaw ceased, and the pilot initiated a straight-in approach towards open fields. On approaching the ground, the pilot reported that, during the final flare with reduced airspeed, application of the collective control to cushion the landing resulted in the helicopter yawing again. The helicopter landed heavily, initially impacting terrain in an upright attitude but facing in the opposite direction of flight, before rolling onto its right side. The emergency locator transmitter was activated in the impact and there was no post-impact fire. The pilot and passenger survived the impact but were seriously injured. The passenger, who was seated in the forward cabin, succumbed to their injuries. The helicopter was destroyed.

Airbus Helicopters published safety related information, Safety Information Notice 4082-S-64 on 29 November 2024 that highlighted tail rotor assembly maintenance tasks, specific to inspection and lubrication requirements.

•Alert Service Bulletin ASB AS332-64-20-003 on 23 December 2024 that specified an inspection for defects of the splined sleeve radius area of the control plate mount flange. [Report.](#)

AUSTRALIAN TRANSPORT SAFETY BUREAU

Smoke In Aircraft And Descent Below Lowest Safe Altitude, 15 Aug 2024



Photo from the ATSB report

After departure from Perth, the crew noted high-temperature air and light smoke emanating from flight deck air vents. The crew commenced the ‘smoke in aircraft’ checklist but did not complete it. The first officer did not don an oxygen mask and the left bleed air system was not selected ‘off’. Subsequently, the left wing overheat light illuminated. The crew then actioned the ‘wheel well and wing overheat’ checklist, but elected not to extend the landing gear. During the return to Perth, the aircraft deviated both above and below the assigned altitude including a descent to 639 ft below MSA. They completed the ILS approach and landed without further incident.

The ATSB found that a failure within the left air cycle machine resulted in smoke entering the cabin. Items on the ‘smoke in aircraft’ checklist were not completed. Consequently, the smoke ingress into the cabin continued and the left air conditioning duct overheated, and the wing

overheat light illuminated. The first officer’s decision not to don an oxygen mask increased their risk of impairment or incapacitation. The decision not to extend the landing gear, as required by the checklist, ignored the possibility of a brake fire or wheel well overheat.

The workload associated with the in-flight response to the smoke in the cockpit and wing overheat adversely affected the flight crew’s performance, leading to errors in flight path adherence, checklist completion and decision making.

The first officer readback an air traffic control altitude instruction as 2,000 ft AMSL instead of 2,800 ft AMSL. The controller correct the error. Following a query from the crew, this was later corrected. After the assigned altitude had been confirmed the aircraft descended below the MSA. When advised of the deviation by ATC, the required ‘safety alert’ wording was not used.

Following the occurrence, the operator conducted a refresher training course for flight crew on emergency response briefings and a theory examination for flight crew on bleed air, pneumatics, pressurisation and fire warning systems. Practical training was held for flight crew on revised emergency procedures and the use of the crew oxygen system. The operator also changed the flight crew training program to include a revised Line Oriented Flight Training (LOFT) program including more comprehensive oxygen system training and a presentation on the Metroliner 23 oxygen system. [Final Report.](#)





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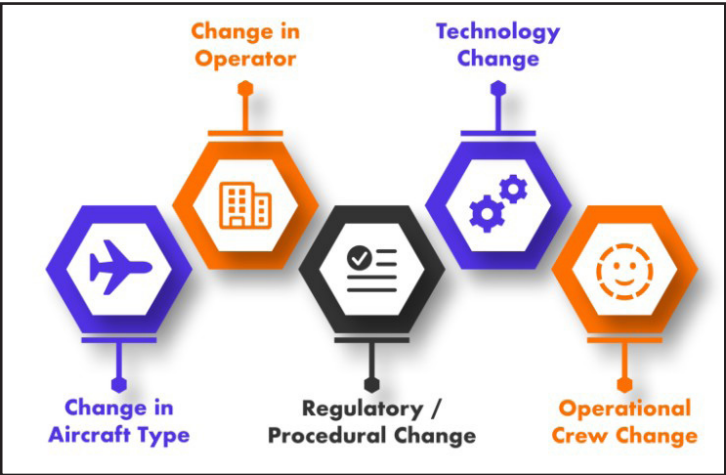



Image from pilotswhoaskwhy.com

PILOTS WHO ASK WHY

A Pilot’s Guide to Dealing with Change

In aviation (and life), change really is the only constant. New technology, updated regulations, evolving procedures, and operator take-overs can make our jobs feel like they’re always changing. So what are the best strategies for dealing with change?

[Read more.](#)



FAA  
Aviation Safety

SPECIAL AIRWORTHINESS  
INFORMATION BULLETIN

SUBJ: DOORS, Main Deck Cargo Door  
This is information only. Recommendations aren't mandatory.

SAIB: 2025-02  
Date: February 21, 2025

FAA SAIB

B757 Main Cargo Door In-flight Opening

This Special Airworthiness Information Bulletin advises owners and operators of Boeing Model 757-200 series airplanes, converted from passenger to freighter configuration in accordance with Precision Conversions, LLC, Supplemental Type Certificate (STC) No. ST01529SE, of an airworthiness concern regarding in-flight opening of the main deck cargo door and recommended actions to mitigate such an event. At this time, the airworthiness concern is not an unsafe condition that would warrant airworthiness directive. However, the investigation is ongoing, and depending on the investigation results, the FAA may consider rulemaking in the future. [FAA SAIB 2025-02](#)

CAA SKYWISE

Publication of Change Notification Form SRGI430 Issue II

[SRGI430 Change Notification Form Issue II](#) has now been published on the CAA website. Issue II has additional guidance added in relation to the completion of section 9b which states the following:

Ensure that the transition phase of this change has been considered and that any potential or required system/ equipment outages that may be necessary during this period are included within this notification. Service providers are to ensure that the [current version of the SRGI430 form](#) is used.

SW2025/028

CAA SKYWISE

Cargo Compartment Safety Risk Assessment

Regulatory changes to UK Regulation (EU) No. 965/2012 (The Air Operations Regulation) for adoption of new ICAO Annex 6 requirements in the UK, which will establish the requirements, means of compliance and guidance for operators to adequately mitigate risks introduced by unknown entities in the supply chain and to mitigate the consequences of a potential fire hazard due to the presence of incorrectly identified and classified items offered for transport.

[Consultation on Changes to UK Regulation \(EU\) No. 965/2012 with regards to the Specific Cargo Compartment Safety Risk Assessment](#)

[Consultation document](#)

SW2025/030

CAA SKYWISE

Revised UKCAA-TCCA Maintenance Arrangement

A revised version of the [Technical Arrangement on Maintenance between UKCAA and Transport Canada \(TCCA\)](#) was signed on 14th February 2025.

The revised version includes additional procedures for facilities outside the UK and updated application forms. Moreover, a procedure for authority-to-authority SIS visits has been added and minor editorial changes were incorporated.

SW2025/029

CAA SKYWISE

Airspace Safety: Flying in the North West

Restricted Area EGR323 North West Transit Corridor (NWTC) has replaced the Manchester Low Level Route.

To operate within this restricted area pilots must:

- fly an aircraft with a Maximum Certified Take-Off Mass of 40,000 KG or less
- maintain a minimum in flight visibility of 5 KM
- use the Manchester or Liverpool QNH (altimeter) setting
- fly below 1500 feet AMSL
- keep the indicated airspeed below 140 KTS

Detailed information on the NWTC boundaries and operational requirements is included in the UK Aeronautical Information Circular [AIC Y 004/2025](#).

We have updated the Airspace & Safety Initiative guidance and advice for pilots [Flying in the North West](#) including a new guide to [Restricted Area EGR323 NWTC](#).

SW2025/031



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Recent Accidents & Incidents from the Air Safety Network Wikibase

Date	Type	Event	Location
<a href="#">17-Feb-25</a>	AW119	Starboard door's window ejection system was inadvertently activated	Altamira
<a href="#">20-Feb-25</a>	AW119	Police, when attempting to evade ground fire they collided with power lines.	Jardim Balneário
<a href="#">18-Feb-25</a>	A320	ATB. Bird strike.	Lahore
<a href="#">19-Feb-25</a>	A320	Missed approaches at dest. and alt. Low fuel emergency declared and diverted.	Parnaíba-Santos
<a href="#">22-Feb-25</a>	A321	Smoke was detected in the cabin. Declared emergency and diverted.	Lisbon
<a href="#">20-Feb-25</a>	A321	ATB. Bird strike.	Rio de Janeiro
<a href="#">23-Feb-25</a>	A321	ATB. Engine issues.	Xian-Xianyang
<a href="#">17-Feb-25</a>	A321	ATB. Bird strike.	Fortaleza-Pinto
<a href="#">22-Feb-25</a>	A330	Odour in the cabin. Diverted.	NW of Ireland
<a href="#">22-Feb-25</a>	A350	ATB, smoke and fumes in the flight deck.	Los Angeles
<a href="#">20-Feb-25</a>	AN2	No.1 engine failure. Diverted.	Krasnoyarks
<a href="#">20-Feb-25</a>	Bell 505	Struck a powerline and crashed on ice.	S of Ririe, ID
<a href="#">18-Feb-25</a>	B737-8	GCOL. Wingtip touched the roof of a container during taxi.	Tallinn-Lennart Meri
<a href="#">22-Feb-25</a>	B737-700	ATB. Bird strike.	Cochabamba
<a href="#">23-Feb-25</a>	B747-400	ATB. Engine failure.	Hong Kong
<a href="#">23-Feb-25</a>	B777-200	Engine failure. Diverted.	Norwegian Sea
<a href="#">23-Feb-25</a>	DHC8	Engine failure.	Fuvahmulah Island
<a href="#">22-Feb-25</a>	DHC8	ATB. Bird strike.	Yuzhno-Sakhalinsk
<a href="#">21-Feb-25</a>	DHC8	Turbulence. Two passengers suffered minor injuries.	Bergen
<a href="#">21-Feb-25</a>	DHC8	ATB. Tyre failure.	Tamanrasset-Aguemar
<a href="#">17-Feb-25</a>	C525	Diverted. Bird strike on departure.	Sarasota-Bradenton
<a href="#">17-Feb-25</a>	EC135	Helicopter was impacted by an unknown object, damaging two rotor blades.	Hospital Heliport, PA
<a href="#">20-Feb-25</a>	Kazan	Hard landing after reporting loss of rotor pitch control.	Stavropol
<a href="#">19-Feb-25</a>	NH90	Crashed during a night training exercise in a wooded area	Sierra de Cameros
<a href="#">18-Feb-25</a>	R22	Crashed during an emergency landing in a field	Sankt Augustin
<a href="#">21-Feb-25</a>	SI00	ATB. Gear did not retract.	Noyabrsk
<a href="#">20-Feb-25</a>	SA227	RTO. Due to brake failure after initiating the take-off. Hit runway lights.	Denver
<a href="#">18-Feb-25</a>	YAK40	ATB. Engine failure.	Vologda



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Safety Conference Calendar

Year	Month	Day(s)	Org	Event	Location	Notes
2025	Feb	18th	FSF	<a href="#">Advancing Aviation Safety: Integrating Mental Health into Operational Excellence</a>	Online	Webinar
2025	Mar	11 <sup>th</sup> - 12 <sup>th</sup>	NTSB	<a href="#">Automation In Transportation: Lessons For Safe Implementation</a>	Washington DC	In person meeting
2025	Mar	12 <sup>th</sup>	UKFSC	470 <sup>th</sup> SIE	TBC	
2025	Mar	17 <sup>th</sup> – 20 <sup>th</sup>	Airbus	29 <sup>th</sup> Airbus Safety Conference	Amsterdam	
2025	Mar	17 <sup>th</sup> – 19 <sup>th</sup>	FRMS Forum	<a href="#">FRMS Forum Annual Conference</a>	Santiago, Chile	
2025	Mar	19 <sup>th</sup> – 20 <sup>th</sup>	RAeS	<a href="#">RAeS Flight Operations Conference 2025: Single Pilot Operations - Logical Progression or a Step Too Far?</a>	Hamilton Place, London	
2025	Mar	24 <sup>th</sup> – 28 <sup>th</sup>	CANSO	<a href="#">Global Safety Conference</a>	Christchurch, NZ	
2025	Mar Apr	31 <sup>st</sup> – 1 <sup>st</sup>	IATA	<a href="#">34<sup>th</sup> Safety Issue Review Meeting</a>	Montreal, Canada	
2025	Mar Apr	31 <sup>st</sup> – 2 <sup>nd</sup>	UKFSC	<a href="#">FSO Course</a>	Gatwick	
2025	Apr	2 <sup>nd</sup> – 3 <sup>rd</sup>	ERA	<a href="#">Safety Group</a>	TBC	
2025	Apr	7 <sup>th</sup> – 9 <sup>th</sup>	ACSF	<a href="#">ACSF Safety Symposium</a>	Embry Riddle, Daytona Beach, FL	Business aviation
2025	Apr	7 <sup>th</sup> – 9 <sup>th</sup>	FoF	<a href="#">Flight Operations Forum Norway 2025 – Communicate for Safety</a>	Oslo airport	
2025	Apr	28 <sup>th</sup> -30 <sup>th</sup>	UKFSC	<a href="#">FSO Course</a>	Gatwick	
2025	May	6 <sup>th</sup> – 7 <sup>th</sup>	FSF	<a href="#">70th Business Aviation Safety Summit</a>	Charlotte, North Carolina	
2025	Jun	5 <sup>th</sup> – 6 <sup>th</sup>	FSF	<a href="#">Safety Forum 2025 Theme: People in the Centre of Aviation Safety</a>	Eurocontrol, Brussels	
2025	Jun	24 <sup>th</sup>	UKFSC	471 <sup>st</sup> SIE	TBC	
2025	Aug	18 <sup>th</sup> – 20 <sup>th</sup>	UKFSC	<a href="#">FSO Course</a>	Gatwick	
2025	Sep	10 <sup>th</sup>	UKFSC	472 <sup>nd</sup> SIE	TBC	
2025	Sep	15 <sup>th</sup> – 17 <sup>th</sup>	UKFSC	<a href="#">FSO Course</a>	Gatwick	
2025	Sep/Oct	29 <sup>th</sup> – 4 <sup>th</sup>	ISASI	<a href="#">ISASI 2025 - Soaring to New Heights:A World of Innovation</a>	Denver, Colorado	
2025	Oct	6 <sup>th</sup> – 7 <sup>th</sup>	SAE	<a href="#">Defence Aviation Safety Conference</a>	London	
2025	Oct	14 <sup>th</sup> -16 <sup>th</sup>	IATA	<a href="#">World Safety and Operations Conference</a>	Xiamen, China	
2025	Nov	4 <sup>th</sup> – 6 <sup>th</sup>	FSF	<a href="#">78th International Aviation Safety Summit</a>	Lisbon, Portugal	
2025	Nov	10 <sup>th</sup> – 12 <sup>th</sup>	UKFSC	<a href="#">FSO Course</a>	Gatwick	
2025	Nov	11 <sup>th</sup> – 13 <sup>th</sup>	Bombardier	<a href="#">29<sup>th</sup> Bombardier Safety Standdown</a>	Wichita, Kansas	
2025	Dec	2 <sup>nd</sup>	UKFSC	473 <sup>rd</sup> SIE	TBC	