



UK Flight Safety Committee

UKFSC News #22

22 Apr 2025



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SKYBRARY

Fan Blade Failure Results In Significant Engine Damage And An Associated Fire Which Could Not Be Fully Extinguished

On 20 February 2021, an aircraft was climbing through 12,500 feet after departing Denver when a sudden right engine fan blade failure occurred leading to an engine fire which could not be fully extinguished until after landing. The Investigation found that the aircraft operator's blade inspection process had been inadequate and that the engine manufacturer's prescribed blade inspection intervals were insufficient with both contributing directly to the in-service failure. It found that the consequences of the failure were worsened by inadequate design and testing of both the engine inlet and the main gearbox support structure.

[Learn more.](#)

Related articles

[Uncontained Engine Failure](#)

[Fire in the Air](#)

[In-Flight Fire: Guidance for Flight Crews](#)



AIRBUS

Use of Rudder

The use of rudder by the flight crew on Airbus aircraft is limited to the takeoff and landing roll, crosswind landings, or to counteract the yaw effect caused by an engine failure until the rudder is trimmed. Several events have been reported where the flight crew used rudder inputs after encountering turbulence, causing unnecessary trajectory deviations and loads on the aircraft structure.

This article describes such an event and explains the two types of rudder design used on Airbus aircraft. It also provides recommendations to the flight crew on the use of rudder and emphasises the importance of reporting lateral loads events after an occurrence. It also provides guidance to maintenance personnel to ensure necessary inspections are performed following a reported high load event.

The article describes a high bank angle on an A320 at 31000' that was corrected with rudder and side stick resulting in left and right inputs until the aircraft was stabilised with wings level.

A LOAD<15> report was generated due to high vertical loads. The affected A320 aircraft was however not fitted with a Flight Data Interface and Management Unit (FDIMU) capable of generating LOAD<15> reports detecting high lateral loads.

The event was reported as turbulence and the 'Stop Rudder Inpt' warnings were not reported. As a result the lateral load inspection was not carried out before the aircraft returned to service.

[Airbus Safety First Article](#)

TRANSPORT CANADA

Unannounced Loss Of Ground Lift Dump Spoilers Due To Faulty Throttle Quadrant Assembly - BDI00

The purpose of this [Civil Aviation Safety Alert \(2025-03\)](#) is to raise awareness of recent failures of the ground spoiler system on the BD-100-caused by faulty TQA and details of the repair to correct the faults.

CAA

Ground Handling Regulation Workshops

The UK Civil Aviation Authority are hosting three in person workshops in London, Edinburgh and Manchester, to help get the industry get ready for the proposed regulation for Ground Handling.

[Register here.](#)

EASA

Nuisance Alerts from Distress Tracking Systems

The recent introduction of ELT(DT) in different aircraft types resulted in a significant increase of nuisance alerts. They can result from weaknesses in the design or from inappropriate handling.

[EASA SIB 2025-02](#)

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Cerib - stock.adobe.com

AIR ACCIDENT INVESTIGATION BRANCH

A320 Rejected Go-around & Long Landing at Corfu

Synopsis

Following a stable approach flown by the co-pilot, the aircraft drifted high on short finals leading to a deeper than expected landing. The commander took control and applied full power to initiate a baulked landing go-around before realising the co-pilot had engaged reverse thrust when the mainwheels touched down. The Airbus A320 Flight Crew Techniques Manual (FCTM) directs pilots ‘must not initiate a go-around after the selection of thrust reversers.’ Having unwittingly commenced a go-around after reverse thrust selection, the commander experienced startle and surprise. This led to hesitation in deciding whether to continue or reject the go-around. During this period of startle and surprise the commander cycled the thrust levers between full power (TOGA), maximum reverse thrust (REV MAX) and back to TOGA before finally reselecting REV MAX and maximum manual braking to reject the go-around.

The aircraft came to a halt approximately 340 m before the end of the runway.

After precautionary maintenance action for a possible heavy landing, the aircraft was released back to service.

Operator’s Safety Actions

1. To liaise with CFU on the siting of the Runway 34 PAPI lights and TDZ aiming point markings and to enquire whether these could be repositioned 300 m from the threshold, ‘as per EASA regulation.’
2. To review the CFU airport risk assessment and re-assess whether sufficient mitigations are in place to manage the runway excursion risk associated with the non-standard position of the aiming point markers on Runway 34.
3. To review the company’s baulked landing procedure.

4. To share details of the event with its pilot community through the medium of safety publications.

Manufacturer’s safety communications

The aircraft manufacturer’s ‘contribution’ report to the investigation contained links to three resources relating to the handling and risks associated with go-arounds after thrust reverser selection. The first resource was an article highlighting the ‘risk of non-availability of maximum thrust on one or more engines, if the associated reversers do not stow.’ The second was an article highlighting that ‘the SOP for landing states that as soon as the flight crew selects reverse thrust, they must perform a full-stop landing’ and that ‘in service data shows that there is still a risk exposure with flight crews deciding to perform a go-around after the thrust reversers were selected.’ The third resource was a video focusing on go-arounds, which included a reminder about the risk associated with a go-around after reversers selection.

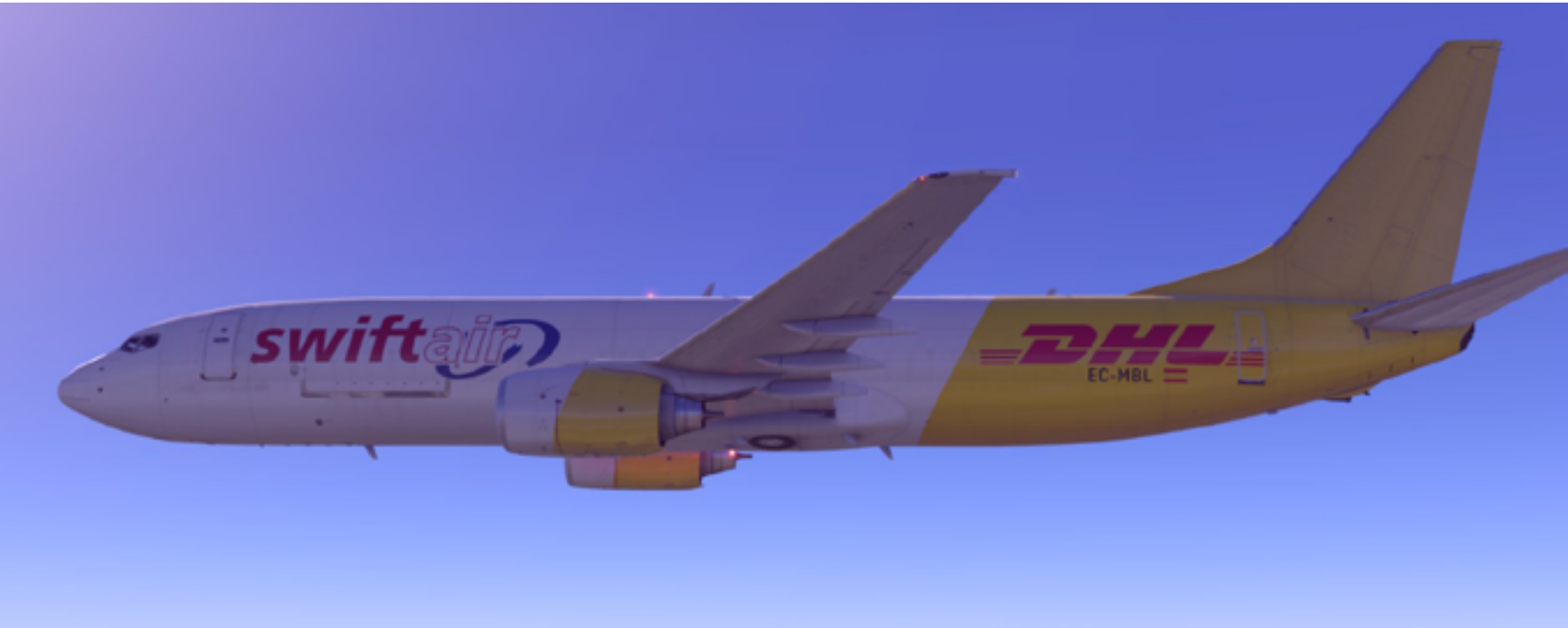
Conclusion

After a stabilised approach, a protracted flare resulted in the aircraft touching down around the end of the TDZ. Each pilot had a different appreciation of where the touchdown occurred, leading to startle and surprise for both parties when the other’s actions were not as expected. While this confusion introduced hesitation and uncertainty into the decision-making process, the pilots’ mental models re-aligned when the lack of perceivable acceleration caused them each to question the viability of continuing with the go-around. Almost contemporaneously both pilots called “stop” while initiating maximum braking and the aircraft came to a full stop within the runway length remaining ahead. [AAIB Report](#)

UK CAA AD

AD G-2025-0002: IPECO Type 3A063 flight crew seats: Equipment / Furnishings – Pilot & Co-Pilot Seats – Inspection / Modification UK CAA Airworthiness Directive. [View UK AD G-2025-0002](#)

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MINISTRY OF JUSTICE OF THE REPUBLIC OF LITHUANIA TRANSPORT ACCIDENT AND INCIDENT INVESTIGATION DIVISION

B737 Crashed on Approach

The cargo aircraft had a crew of two pilots and two passengers. At 03:28 hrs the Boeing 737-400SF impacted the ground short of runway RW19 on approach to Vilnius. The aircraft was destroyed. The captain was fatally injured, and the co-pilot and two passengers were seriously injured.

Thr first officer was the pilot flying. During the approach the captian is heard on the CVR confirming that the engine anti-ice is selected on. However, the investigation determined that the engine ant-ice switches were in the off position and the hydraulic system B engine and electric driven pumps were in the off position. The CVR records the flap requests and sounds that resemble the flap selection lever being moved.

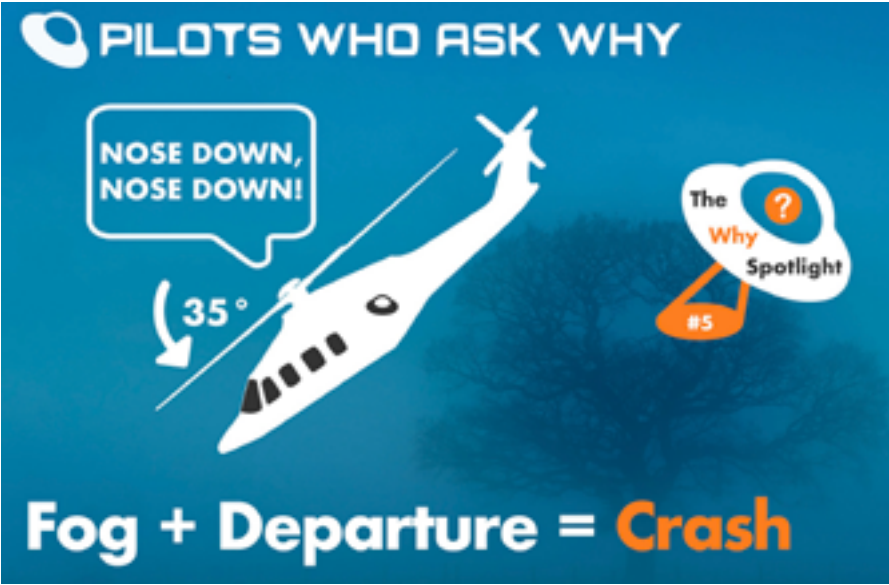
At 03:26:58 hrs VACC Vilnius approach air traffic controller contacted the crew and stated for “Postman one eight delta, four miles from touchdown, contact tower, one one eight two zero five”. According to the CVR the captain read back the incorrect frquency. The aircraft was not on

approach or tower from that point on. The captain made two more attempts to contact VACC Vilnius aerodrome air traffic controller on the incorrect frequency.

At 03:27:42 hrs the captain stated that the runway is in sight and the co-pilot should further reduce speed. This happened simultaneously with the captain recognizing that he selected the wrong frequency.

At 03:27:56 hrs the co-pilot recognized that flaps are retracted at approximately 350’ agl and 150kt. Immediately after, the stick shaker activated and a “Sink Rate, Pull Up” warning was triggered by the enhanced ground proximity warning system (EGPWS). At 03:28:02 hrs the crew called for go around. The auto throttle was set to GoAround (GA) mode and the engines accelerated to above 90% NI at impact. At 03:28:07 hrs a “too low – terrain” warning was triggered by the EGPWS. One second later the aircraft impacted into the ground.

[Interim Report](#)



PILOTS WHO ASK WHY

Fatal AW139 Crash after Departure in Fog at Night | The Why Spotlight #5

We have two pilots in an AW139 helicopter, about to fly from a private site to Coventry in the U.K.

The plan? A vertical departure.

The result? Total loss of the aircraft and everyone on board – less than a minute after takeoff. So how does that happen?

Not from an engine failure. Not from an instrument malfunction, but from something a bit more insidious.

[Learn more.](#)



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AIR ACCIDENT INVESTIGATION BRANCH

A320 Take-off From an incorrect Intersection in Toulouse

During pre-flight preparations, both pilots completed a takeoff performance calculation from intersection N2 of Runway 32R at Toulouse-Blagnac Airport in France. During taxi, the aircraft was cleared to line up and take off from intersection N2 with 2,300 m takeoff distance available. However, the crew entered the runway via the N4 intersection, reducing the takeoff distance available by approximately 500 m. The Tower Controller did not monitor the aircraft visually and did not notice the error. The aircraft rotated with 500 m of runway to go and passed the upwind end of the runway at a height of 180 ft. The operator, Toulouse ATC and the Direction des Services de la Navigation Aérienne (DSNA) implemented safety actions to strengthen their respective procedures to prevent reoccurrence.

During the turnaround the crew carried out a performance validation of critical data and a takeoff data crosscheck, following which they conducted a departure briefing. They discussed the taxi routing and noted that it was short and uncomplicated. However, they did not discuss the location of the N2 intersection and it was not visible from stand V10. The operator provided a ‘Threat Matrix’ to assist crews in identifying potential threats, but it did not include intersection departures as an example of a potential threat. The turnaround took 38 minutes. The weather was reported as CAVOK.

During taxi the co-pilot informed Tower that they would be “ready for departure upon reaching n2”. Tower replied, “bonjour from n2 2,300 m cleared for line up take off 32R wind 310 degrees 12kt”. As the co-pilot read back the takeoff clearance the aircraft was approaching the N4 intersection where the commander turned the aircraft right, towards the holding point N4 for Runway 32R.

Analysis conducted by the DSNA (ATC) and the operator revealed several interconnected factors that led to the crew initiating takeoff from an incorrect intersection. These factors can be broadly categorized into three main areas: 1. High Workload and expeditious mindset. 2. Limited attentional capacity and suboptimal situational awareness. 3. Confirmation bias. The report describes how these factors lead to the event and lists the safety actions taken by the operator and the ANSP.

Final Report

CAA

CAA Call for Insights - AI in Aerospace

The CAA’s [Strategy for Regulating AI in Aerospace](#) aims to enable the sector to benefit from this transformative technology.

They are inviting stakeholders to [provide their insights](#) on the AI use cases being explored across the aerospace sector, to help shape our regulatory requirements for the safe deployment of AI and advanced automation in aerospace.

In addition to the above, they have also [published a guide](#) which explains how they continue to protect consumers as aviation adopts AI.

CAA SKYWISE

Update of UK.SC.VTOL to Issue 2.

The Civil Aviation Authority is consulting on the update of the Special Condition - UK.SC.VTOL to Issue 2.

[Give the CAA your views.](#)

SW2025/066

CAA SKYWISE

Test and Evaluation activities report - UAS

[Test and Evaluation Annual Report \(CAP3099\)](#) covers the activities carried out by the Test and Evaluation team in the last year. These activities are related to CAA-driven data and intelligence gathering, facilitation and support of Test and Evaluation activities and enabling industry testing.

SW2025/068

CAA SKYWISE

Guidance on Cyber Safety Objectives for Specific Category Operations [CAP 3098](#)

As part of the introduction of the Specific Operation Risk Assessment (SORA) framework for Remote Piloted Air Systems (RPAS) operations in the specific category, we have considered the Cyber Safety Extension which was published as part of JARUS SORA 2.5 and produced [this guidance](#) for operators.

SW2025/069



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ATSB

Unnecessary Step In Standard Operating Procedures Leads To Incorrect Mode Selection Prior To E190 Low-Speed State After Take-Off

Prior to conducting the Before-start checklist, the left seat pilot (captain) was required to set the aircraft’s speed mode selector, with flight management system (FMS) mode recommended. While the crew’s intention was to depart in FMS speed mode, undetected by either flight crew, this step was omitted, and the speed selection remained in manual mode.

As the aircraft was climbing through 1,200 ft, vertical flight level change (VFLCH) mode engaged in the FMS. Once in VFLCH, the flight director (FD) commenced targeting the manual target speed which, at that time, was 125 kt.

Over the next 20 seconds, the aircraft’s speed gradually reduced and the pitch gradually increased to target the manual speed. Detecting that the aircraft was not accelerating, the PM assessed there was too much drag on the

aircraft and retracted one stage of flap. The flap retraction resulted in a visual low airspeed cockpit alert.

Shortly afterwards, the crew detected the speed mode was incorrectly set, and changed the speed mode to FMS mode, at which time the aircraft commenced accelerating to the correct target airspeed.

The ATSB determined that the left seat pilot (captain) unintentionally left the speed selection in manual mode instead of flight management system mode with no manual speed set.

The report details the SOP changes and training implemented to prevent this from occurring again.

[ATSB Report](#)

NTSB

Address Noncompliant Evacuation Slide Components on Boeing 727, 737 & 757 Airplanes



The National Transportation Safety Board (NTSB) is providing the following information to urge Boeing and the Federal Aviation Administration (FAA) to take action on the safety recommendations in this report addressing the failure of an evacuation slide to deploy normally during an emergency evacuation.

We identified this issue during our ongoing investigation of an emergency landing involving FedEx flight 1376, a Boeing 757-236, in Chattanooga, Tennessee. The NTSB is issuing three safety recommendations to Boeing and four safety recommendations to the FAA. Additional actions may be recommended as the investigation proceeds.

[Aviation Investigation Report 25-02](#)



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ATSB

Midair collision involving Two Eurocopter EC130s, Gold Coast, Queensland, 2/1/23

The accident occurred a week after the operator started using two EC130 B4 helicopters for scenic flights without a change management process. The ATSB identified the following: -

- Communication Failure: An inbound call from VH-XH9 did not register with VH-XKQ’s pilot due to radio faults.
- Visibility Issues: Limited visibility for VH-XKQ’s pilot due to restrictions and angles of closure.
- Separation Management: Both pilots had to manage separation from vessels and other traffic points.
- Collision: Midair collision occurred due to limited visibility, competing priorities, and incorrect understanding of clear airspace.
- Operator Changes: Changes to location, facilities, and helicopters undermined risk controls and created conflict points.
- Safety Management: Operator’s safety management system failed to manage aviation safety risk effectively.
- Procedural Flaws: Procedures for scenic flights introduced variability in pilot decision-making.
- Incorrect Restraint: Passengers were incorrectly restrained, affecting injury outcomes.
- Safety Device Integration: Regulations required lifejackets and seatbelts, but their integration was not tested, leading to incorrect fitment.

Sea World Helicopters (SWH) Actions:

- Reviewed processes with reference to other high-intensity operations.
- Updated job hazard analysis for scenic flights.
- Introduced new position ‘Pad Boss’ for traffic advisory.
- Added air traffic systems to helicopter avionics.
- Increased communication protocols, including a second call on final approach.
- Enhanced aircraft visibility with high-intensity strobe lighting and high-visibility paint on rotor blades.
- Mandatory human factors awareness training for staff.
- Briefing videos and crew training on seatbelt fitment.

Civil Aviation Safety Authority (CASA) Actions:

- Conducted a review of airspace around Southport, publishing results in March 2025.
- Updated guidelines for heliports to include flight path interaction considerations.
- Updated advisory circulars to include information on multipoint restraints and lifejackets.

Australian Transport Safety Bureau Actions:

Recognized safety actions by SWH to reduce reliance on unalerted see-and-avoid, but also recommended:

- Consider design of conflict points to eliminate or control them.
- Develop safety management system objectives focused on aviation safety risk.
- Improve change management processes to identify and maintain risk controls.
- Clarify change management procedures for introducing additional helicopters.

Safety Advisory Notices:

- Issued notices on correct use of passenger restraints and the combined use of lifejackets and seatbelts.
- Called for research on the correct method of wearing lifejackets with multipoint seatbelts.

The investigation report contains 28 safety factors that provide lessons to flight crews, operators, and other organisations. Overall, the most fundamental lesson is that changes that appear to improve safety can have unintended consequences. Without application of change management processes, it cannot be reasonably determined that a change will not undermine existing aviation safety. Consequently, there is a need for effective implementation of safety management systems with well-defined safety objectives and effective engagement with aviation safety risk.

ATSB Report

SKYBRARY

Excessive Brake Use May Lead To Malfunction And Fire



On 8 November 2022, an aircraft experienced radio altimeter failure during descent into Sydney. The crew were unaware this would prevent use of reverse pitch after touchdown and the consequent implications for brake use and temperature on the long taxi in. The brakes slowly became less effective and failed and caught fire as the aircraft reached its gate. A successful emergency evacuation followed and the airport fire service extinguished the brake fires. It was concluded that the aircraft operator had provided insufficient guidance on both radio altimeter failure and the reversion of both engines to manual control.

Learn More



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Recent Accidents & Incidents from the Air Safety Network Wikibase Page 1 of 2

| Date | Type | Event | Location |
|---------------------------|-----------|---|-------------------|
| 18-Apr-25 | A319 | Diverted due to a bird strike on departure. | Florence-Peretola |
| 16-Apr-25 | A320 | The crew reported smoke in the cockpit on approach. | Porto Francisco |
| 14-Apr-25 | A320 | ATB due to depressurization. | Mineralnye Vody |
| 17-Apr-25 | A320 | ATB, engine issues immediately after take-off. | Manila |
| 02-Apr-25 | A320 | Diverted after an electrical problem and cockpit smoke. | Ajaccio |
| 19-Apr-25 | A320 | GCOL,An airport vehicle collided with the nose. | Bengaluru |
| 16-Apr-25 | A321 | Diverted, after an odour of smoke was detected in the flight deck. | over Iowa |
| 21-Apr-25 | A321 | ATB after the crew reported a possible hydraulic issue. | Boston-Logan |
| 15-Apr-25 | A321 | Hard landing, nose wheel damaged, ingested in the go-around, engine fire, failure. Held, did a single engine approach to a go around and then landed. | TJSJ |
| 16-Apr-25 | A330-200 | GCOL.While taxiing to stand left wing collided with a lamp post | Sebha Airport |
| 09-Apr-25 | A330-300 | On approach struck birds leading to engine damage. | Aruba |
| 21-Apr-25 | A330-300 | Engine fire during pushback/engine start.An evacuation was carried out. | Orlando |
| 16-Apr-25 | A350-1000 | ATB, a burning smell in the front end of the rear cabin section. | over Namibia |
| 04-Apr-25 | A350-900 | Suffered a bird strike on landing, causing damage to the Radome | Buenos Aires |
| 15-Apr-25 | ATR72 | Tail strike while trying to land in gusting wind conditions | Guernsey |
| 18-Apr-25 | Beech390 | RWEXC. Runway overrun after landing | Scottsdale |
| 07-Apr-25 | Beech200 | The nose landing gear was partially deployed and collapsed on landing. | Yellowknife |
| 11-Apr-25 | Beech200 | Maintenance flight, lost its fuselage panel fitted with the left passenger door on take-off. | Lanseria |
| 14-Apr-25 | Bell 206B | Engine issues and performed an autorotation, landing hard | near Amboy |
| 06-Apr-25 | Bell 206L | Crashed after firefighting bucket struck the tail | Daegu |
| 10-Apr-25 | Bell 206L | Destroyed following an inflight breakup.The main rotor, with part of the transmission attached, and parts of the tail were seen to fall separately. | Hudson River |
| 14-Apr-25 | B737 Max8 | Post-flight inspection revealed damage to the right-wing leading edge due to a possible bird strike. | Panama City |
| 03-Apr-25 | B737 Max9 | Suffered a blown tire during take-off, continued to destination. Damage was found to the left the engine. | Atlanta |
| 02-Apr-25 | B737 Max9 | Substantial damage to the underside of the fuselage and left engine. It is unclear if the damage occurred during take-off or landing | Mexico City |
| 05-Apr-25 | B737-400 | Fell off a jack while undergoing routine line maintenance.Three maintenance workers were injured. | Johannesburg |
| 03-Apr-25 | B737-700 | Diverted due fire in the cabin, reported galley oven smoke. | over Virginia |
| 19-Apr-25 | B737-700 | ATB after the instruments of the first officer went dark at FL350. | Near Federal |
| 17-Apr-25 | B737-700 | ATB due an engine fire. | near Houston |
| 15-Apr-25 | B737-800 | ATB after suffering an engine failure | Los Angeles |
| 13-Apr-25 | B737-800 | No. 2 engine surges after a rabbit was ingested on take-off. | Denver |
| 09-Apr-25 | B737-800 | Diverted due a bird strike on departure. EMC declared. | Rotterdam |
| 07-Apr-25 | B737-800 | RTO, night, lined up and rolled on the left runway edge. | Tokyo |
| 05-Apr-25 | B737-800 | In the go-around lost about 500 feet during the climb out, before regaining altitude. | Cairo |
| 02-Apr-25 | B737-800 | ATB, fumes in the flight deck after departure. | Portland |



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Recent Accidents & Incidents from the Air Safety Network Wikibase Page 2 of 2

| Date | Type | Event | Location |
|---------------------------|-----------|--|---------------------|
| 10-Apr-25 | B737-800 | Diverted after a passenger’s iPad tablet suffered a thermal runaway. | N Portugal |
| 08-Apr-25 | B737-800 | Lost a panel of the lower fuselage during flight. | Gwangju-Jeju |
| 16-Apr-25 | B737-800 | A wheel detached on landing. | Tanjung |
| 16-Apr-25 | B737-800 | One of its tyres separated from the aircraft during landing | Raja Haji |
| 09-Apr-25 | B767-300 | ATB, cracked windscreen while en-route at FL390. | Enroute |
| 10-Apr-25 | B777-300 | Diverted due to smoke in the cabin. Inspection after landing revealed no evidence of smoke or fire. | South of Japan |
| 16-Apr-25 | B787-9 | Diverted when a crack developed in a cockpit window at FL340. | South of Jeju |
| 16-Apr-25 | CRJ900 | Ingested a bird in one of the engines | Wausau-Central |
| 10-Apr-25 | CRJ900 | GCOL with a company ERJ175 | Ronald Reagan |
| 02-Apr-25 | DHC8-400 | Crew entered incorrect data into the FMS and subsequently during approach, the aircraft descended below the lowest safe altitude. | Cairns |
| 15-Apr-25 | C208B | RW EXC, runway excursion after landing. | Paguir Airstrip |
| 17-Apr-25 | C208B | Hijacked with a knife, diverted. Hijacker shot by a passenger. | near Corozal |
| 12-Apr-25 | C560XL | Substantial damage when it was involved in a landing accident | Crossville |
| 15-Apr-25 | Falcon 20 | Diverted, lost the no.2 engine cowling at FL350. | SW Pennsylvania |
| 08-Apr-25 | DHC8-300 | Evacuated on the stand after arrival at TRD, when smoke was observed coming from one of the engines. | Trondheim-Værnes |
| 08-Apr-25 | ERJ145 | ATB, struck a bird on departure. | Harrisburg |
| 10-Apr-25 | ERJ145 | GCOL. Collided with a company CRJ900. | Ronald Reagan |
| 06-Apr-25 | EC135 | Ambulance flight ditched after loud abnormal noise and directional control issues. | Nagasaki |
| 10-Apr-25 | SA227 | RWEXC. Runway excursion after landing | North Little Rock |
| 10-Apr-25 | GV | RWEXC. Runway excursion during landing | Cabo San Lucas |
| 11-Apr-25 | H 800XPi | RWEXC. Overran runway after landing and overturned after passing the first steel fence and then the brick perimeter wall. | Fès-Saïss |
| 07-Apr-25 | H 800XP | RWEXC.A runway excursion during a touch and go, the fuselage and right wing sustained structural damage. | São José dos Campos |
| 06-Apr-25 | H-23D | Hiller H-23D experienced an engine failure and crashed | Rockledge |
| 13-Apr-25 | HA420 | RWEXC. Lateral runway excursion veered to the right while landing. | Nagoya |
| 09-Apr-25 | HA420 | RWEXC.Veered off the left side of runway 05 while landing. | Naples |
| 07-Apr-25 | HA420 | RWEXC. Overran runway 05 after landing ended up in the water of Coos Bay. | North Bend |
| 09-Apr-25 | Lear31A | ATB, departing from runway 32 when the cabin door opened. | Naples |
| 04-Apr-25 | Lear45 | A left generator fire during startup.The fire was extinguished by ground crew. | Wichita |
| 06-Apr-25 | DC9 | During fuelling, an apparent failed vent led to over pressurization of the fuel lines, blowing out the overwing cap and punching a hole in the wing. | Austin-Bergstrom |
| 12-Apr-25 | MU2B | The NTSB reported that the aircraft crashed at a high rate of descent in a flat agricultural field following a missed approach | Copake, NY |
| 03-Apr-25 | R44 | During the initial climb out to around 300m altitude the engine failed forcing the pilot to conduct an autorotation | Pirenópolis |
| 17-Apr-25 | R44 | Crashed shortly after take-off under unknown circumstances. | Moorabbin |



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Safety Conference Calendar

| Year | Month | Day(s) | Org | Event | Location | Notes |
|------|---------|-------------------------------------|------------|--|---------------------------|---------|
| 2025 | Apr | 29 th | EASA | Summer Safety Launch Webinar | Online | |
| 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 | May | 15 th | EASA | Cabin Safety Webinar | Live from Oslo | NEW |
| 2025 | May | 20 th - 22 nd | EBAA | EBACE | Geneva | NEW |
| 2025 | May | 22 nd – 23 rd | EASA | PNT Resilience Workshop | Cologne | |
| 2025 | May | 29 th | EASA | Safety Culture | Live from Dublin | NEW |
| 2025 | Jun | 5 th – 6 th | FSF | Safety Forum 2025 Theme: People in the Centre of Aviation Safety | Eurocontrol, Brussels | |
| 2025 | Jun | 10 th - 12 th | EASA | EASA-FAA International Aviation Safety Conference | Cologne | On site |
| 2025 | Jun | 25 th - 26 th | EASA | Part-IS Implementation Workshop | Cologne | Hybrid |
| 2025 | Jun | 24 th | UKFSC | 471 st SIE | TBC | |
| 2025 | Aug | 18 th – 20 th | UKFSC | FSO Course | Gatwick | |
| 2025 | Aug | 27 th – 28 th | EASA | Artificial Intelligence in Aviation | Cologne | Hybrid |
| 2025 | Sep | 10 th | UKFSC | 472 nd SIE | TBC | |
| 2025 | Sep | 10 th - 11 th | AAPA | Asia Pacific Aviation Safety Seminar 2025 | Manila | NEW |
| 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 | Nov | 11 th – 13 th | Bombardier | 29th Bombardier Safety Standdown | Wichita, Kansas | |
| 2025 | Dec | 2 nd | UKFSC | 473 rd SIE | TBC | |