UK Flight Safety Committee

UKFSC News #24

13 May 2025

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Issue #24

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UKFSC NEWS

The latest news from the flight safety world

Issue #24

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NTSB PRELIMINARY REPORT

Bell 206 In-flight Break Up

On April 10, 2025, about 1515 eastern daylight time, a Bell 206L-4 helicopter, N216MH, was destroyed when it was involved in an accident near Jersey City, New Jersey.

The helicopter flew a teardrop pattern south of the Statue of Liberty, then proceeded north along the east side of the Hudson River adjacent to Manhattan, past the George Washington Bridge, where it performed a u-turn, then headed south along the New Jersey side of the river.

Several witnesses described hearing several loud "bangs" emanating from the helicopter before it broke up and descended into the river. Surveillance video (with accompanying audio) captured the helicopter traveling south before it suddenly separated into three major sections: fuselage (including the engine), main rotor system (including both main rotor blades, transmission and roof-beam structure), and the tail boom (including the tail rotor).

The investigation is ongoing.

NTSB Preliminary Report

Image Markus Mainka - stock.adobe.com

AIR ACCIDENT INVESTIGATION BRANCH

B777 RTO Above V1, London Gatwick

During takeoff, the co-pilot began retarding the thrust levers at airspeed V1 , instead of removing his hand from them. After momentarily advancing them again, he initiated the rejected takeoff (RTO) procedure around 2 KIAS later. The RTO was performed effectively and the aircraft stopped some distance before the end of the runway surface.

The V1 call-out was a normal prompt for the co-pilot to move his left hand during the takeoff roll, while preparing to pull back on the control column with his right hand. However, he unintentionally pulled his left hand back instead. The resulting 'action sequence' resembled the RTO or landing manoeuvres, rather than a normal takeoff. There was no obvious reason for him being primed to do that – for example, he had not recently changed aircraft seat or type, or practiced landings or RTOs in a simulator – and he could not identify a reason for it on the day.

Preventing action slips is an ongoing challenge for operators and crew. This operator had published guidance on methodical control selections, and has promoted the human factors topic of 'focus' in training and briefing material. The report considers why even experienced pilots may benefit from mentally rehearsing the takeoff roll and other routine procedures, especially after returning from time off.

The report considers the complex nature of the takeoff roll and why mental rehearsal of motor actions may benefit pilots, particularly after time off from flying. It discusses the industry-wide challenge of preventing action slips.

AAIB Report

FAA SPECIAL AIRWORTHINESS INFORMATION BULLETIN

Engine Fuel and Control - Semi-Synthetic Jet Fuel

Jet fuel made from the listed components that meet ASTM International Standard D7566 are acceptable for use on certificated aircraft if re-identified as D1655 fuel.

SAIB: NE-11-56R5 May 8, 2025

CAA SKYWISE

Request for feedback on the proposed definition of Complex Motor-Powered Aircraft

The CAA is proposing an amendment to the CMPA definition and thresholds, they invite stake holders **to give their views.**

SW2025/091

EASA SAFETY INFORMATION BULLETIN

ADS-B Out, Mode S and Mode C Transponder Systems: Ground Testing

Mode C, Mode S, ADS-B Out capable Transponder Ground Testing Guidance.

SIB No.: 2011-15R3

Issued: 08 May 2025

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SKYBRARY

Mountain Waves: Guidance for Controllers

Mountain Waves are oscillations to the lee side (downwind) of high ground resulting from the disturbance in the horizontal air flow caused by the high ground.

The wavelength and amplitude of the oscillations depends on many factors including the height of the high ground relative to surrounding terrain, the wind speed and the instability of the atmosphere.

Formation of Mountain Waves can occur in the following conditions:

Wind direction within 30 degrees of the perpendicular to the ridge of high ground and no change in direction over a significant height band.

Wind speeds at the crest of the ridge in excess of 15 kt, increasing with height.

A temperature inversion just above the hill or mountain barrier.

Controller response

When notified of mountain wave activity, try to accommodate pilots' requests for later descents over the mountain chain in question.

Consider allowing aircraft to climb or descend quickly from regions with the most significant turbulence as far away from known mountain ridges as possible.

Photo by: https://www.pexels.com/photo/snowcapped-mountains-during-sunset-10450948/

A pilot report of a mountain wave is a special or non-routine aircraft observation. It needs to be disseminated to the local MET office in accordance with local procedures and to other pilots likely to be affected.

Mountain Waves

Photo: OliverFoerstner - stock.adobe.com

AIRCRAFT ACCIDENT INVESTIGATION BUREAU INDIA

A320 Aborted Take-off on a Taxiway in Goa

After being cleared by ATC to taxi to the holding point of RWY28 via TWY 'A5', the aircraft received LINEUP and then Take-off clearance from ATC. The aircraft lined up on TWY 'A' parallel to RWY28 and commenced take-off. ATC instructed the crew to abort the take-off . The maximum aircraft speed was 124 kt. There were no other aircraft, vehicle or personnel on TWY 'A'.

Causes & Contributing Factors

The issuance of "Take-off clearance" early, on TWY 'E', likely caused the crew's cognitive focus to shift entirely toward executing the take-off, diminishing their situational awareness, resulting in expectation bias, thus preventing recognition of the visual cues. The take-off clearance was issued by ATC and the Before Take-off Checks completed by on taxiway 'E' near the taxiway intersection. The flight crew did not taxi via TWY 'A5' before lining up. The airport is not equipped with an Advanced Surface Movement Guidance and Control System (A-SMGCS). The PM was busy head down trying to login to the EFB.

Recommendations

To avoid the EFB screen going into sleep mode, optimize screen settings. Crew should cross-check their position using the AMM (Aircraft Moving Map) functionality of the EFB. AAI review MATS 1 para 7.9.3.4 to add a procedure to issue take-off clearance to departing aircraft not before the aircraft enters a designated taxi route that leads to the holding point. AAI should consider installing Advanced Surface Movement Guidance and Control Systems (A-SMGCS).

AAIB India Final Report

FAA AD

DC9 & MD80 Series Aircraft Elevator Jammed Trailing Edge Down

The NPRM was prompted by the discovery of jammed elevators during takeoff. In the NPRM, the FAA proposed to require revising the "Certificate Limitations" section of the existing AFM to include a procedure to confirm elevator surfaces are not jammed in the TED position. The FAA is issuing this AD to address jammed elevators, which if not addressed, could result in the inability of the airplane to rotate at rotation speed VR, and lead to a rejected takeoff and high-speed runway excursion.

The FAA considers this AD to be an interim action. Boeing is developing a design change to address the unsafe condition. If final action is later identified, the FAA might consider further rule making.

AD 2025-09-11

Image by Claus Norgaard from https://pixabay.com/

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Photo by Jeffry S.S.: https://www.pexels.com

RNSA SIA-ICELAND

B777 Turbulence & Rapid Descent

Flight TK0018 encountered severe turbulence at FL350 north of the glacier Langjökull in Iceland. The investigation revealed that the turbulence was caused by high-altitude mountain waves, which led to an upset condition in the flight. The flight crew's response to the turbulence exacerbated the situation, as the aircraft responded to all their inputs.

Satellite images and weather data indicated that high-altitude mountain waves had been present over Iceland for many hours before the incident. However, there were no SIGMETs (Significant Meteorological Information) warning of these severe conditions prior to the incident.

Four minutes after the upset condition, SIGMET M01 was issued, warning of high-altitude severe mountain waves over Iceland, but it did not cover the area where the incident occurred. About 40 minutes later, the Icelandic MET Office issued SIGMET M02, which enlarged the mountain wave area and notified that severe mountain waves had been observed within the area.

During the 80-second upset condition, the flight crew made several rapid, sharp control column inputs and large thrust changes, resulting in four stick shaker situations. They struggled to control the aircraft's lateral and vertical paths simultaneously.

The autopilot and auto-throttle were engaged leading up to the turbulence encounter, but large control column inputs caused the autopilot to disconnect. A force-fight ensued between the First Officer (Pilot Flying) and the Captain (Pilot Monitoring), with opposite control column inputs causing the columns to break out from each other. The crew reacted to changing conditions without deactivating the auto-throttle, leading to a struggle for control between the pilots and the auto-throttle.

Causes & Contributing factors

The causes of the event were an encounter with severe turbulence, a breakdown in Crew Resource Management and Loss of Situational Awareness. There were four contributing factors:

1. SIGMET for high-altitude severe mountain waves had not been issued prior to the incident.
2. The Captain (PM) did not follow procedure by using the phrase "I have control" (used by the operator), when he tried to take over the controls.
3. Inappropriate control inputs during the aircraft upset.
4. The auto-throttle remained engaged and speedbrakes remained deployed during the aircraft upset.

Safety Actions

The Captain (PM) and the First Officer (PF) completed the Airplane Upset Prevention and Recovery Training.

The operator made internet connection for Electronic Flight Bag available for crew to track changes in flight conditions.

The operator updated its flight monitoring program, improving two-way communications between IOCC and flight crews. Variable weather conditions, e now reach flight crews instantaneously from the EWAS system via ACARS, including the dispatch phase. Areas that are of concern can be sent more effectively and viewed in graphical format.

The Icelandic Met office set out a list of goals for improvement.

The report makes three recommendations to the Icelandic Met Office and one to Turkish Airlines to re-evaluate their CRM training, to emphasize the importance of each pilot's role in flying the aircraft.

SIA Iceland Report

UK CAA PUBLICATION

ORS9 CAA Decision No.47: Decision adopting and amending Acceptable Means of Compliance (AMC) and Guidance Material (GM) to Regulations (EU) No. 1178/2011, 965/2012 and 139/2014

This Decision is adopts and amends to Acceptable Means of Compliance (AMC) and Guidance Material (GM) to Regulations (EU) No. 1178/2011, 965/2012 and 139/2014 in respect of, among other items, new and updated requirements for mandatory crew training and checking requirements for air operators, all weather operations and fuel planning considerations.

View ORS9 CAA Decision No.47

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Image: Markus Mainka - stock.adobe.com

AIRCRAFT ACCIDENT INVESTIGATION BUREAU INDIA

B737 Severe Turbulence & Passenger Injuries

In descent for Durgapur, the aircraft informed Kolkata Radar that it was maintaining a Heading of 065 due to weather. Expecting weather and turbulence, the PIC advised the passengers to remain seated for the next 15 minutes over PA and this was followed by an advice to cabin crew to remain seated till the expected rough weather is cleared. The seatbelt signs were ON. The cabin crew who were in process of securing the cabin were near 8th row and returned to their seats. The cabin crew made an announcement over PA for the passengers to remain seated and wear seat belts. Announcements to remain seated were repeated by PIC and cabin crew. The aircraft encountered severe turbulence. Many passengers, not wearing seat belts, were thrown from their seats and suffered injuries.

Probable Causes Of The Accident

The accident was caused by the poor CRM and decision making on the part of the crew to penetrate bad weather and not maintain specified separation from turbulence prone weather.

Due to insufficient time for securing cabin, the cabin crew could not ascertain if all passengers had seat belts on.

Passenger not complying with seat belt instructions led to avoidable injuries as aircraft encountered severe turbulence.

Safety Recommendations

The operator should ensure that procedure for recurring defect monitoring and control is followed in letter and spirit. This is a reference to 60 deferred defects in weather radar over a period of 6 months.

The DGCA, Airport Operators and Airlines should conduct seatbelt awareness campaigns amongst passengers.

The DGCA should ensure that its officers follow the procedure laid in APM for obtaining clearance from AAIB during de-registration of aircraft. The airline sent the aircraft back to the lessor before the AAIB had completed their investigation and without their permission.

AAIB India Final Report

NTSB

Cirrus SF50 Abnormal Runway Contact

Image by gordzam - stock.adobe.com

The pilot reported that during take-off, they heard an unrecognisable sound and decided to abort the take-off roll. They applied the brakes and pulled the throttle simultaneously. As a result, the airplane briefly lifted off the ground before returning to the runway on its nose, gear which collapsed. Procedures include a caution: "the airplane might rotate and lift off the ground if the thrust lever is abruptly brought to IDLE prior to brake application."

A post accident review of flight data revealed that the landing gear lever was in the UP position during the take-off roll when one of the weight on wheel (WOW) sensors showed it airborne. A few seconds later, the WOW sensor reactivated and the airplane settled on the nose gear. The nose gear was in the transitory and unlocked position at that time and collapsed. When the aircraft stopped, the landing gear lever was placed in the DOWN position. The data also showed that the airplane remained on the runway surface during the take-off and abort.

The pilot reported no failures or malfunctions with the airplane that would have precluded normal operation.

Probable Cause

The pilot's improper landing gear selection during the take-off roll and failure to maintain airplane control during a rejected take-off, which resulted in abnormal contact with the runway and a collapse of the nose landing gear.

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Image from the BEA report

BEA FRANCE

Mid Air Collision EC155 & Nord 1203

The pilots of both aircraft were on a head-on flight path, with a high relative speed of around 280 kt (520 km/h or 145 m/s) at the same flight altitude, flying through Albertville valley in uncontrolled airspace. Although they were monitoring the same radio frequency, the pilots were not aware of the other aircraft on the opposing route. The helicopter pilot visually detected the aeroplane just before the collision and initiated an emergency evasive manoeuvre, by turning right and descending. The pilot of the aeroplane only saw the helicopter during the evasive manoeuvre, and did not have time to react to modify his flight path.

The helicopter pilot's evasive manoeuvre prevented a head-on collision, but the separation between the two aircraft as they passed was not sufficient to prevent contact between the helicopter's main rotor blades and the aeroplane. Both aircraft were damaged, but remained controllable, and the pilots managed to land, in a field for the helicopter and at Albertville aerodrome for the plane.

Contributing factor

The limits of the "see-and-avoid" principle, accentuated by the two aircraft being on a head on path with a high relative speed.

Safety lessons

Several mid-air collisions or near-collisions have occurred in recent years. In October 2020, a midair collision between a DR400 and a Pioneer 300 was investigated by the BEA. The investigation showed that the current safety principles on which collision avoidance is based, namely the "see-and-avoid" rule, do not prevent mid-air collisions. The development and generalisation of electronic conspicuity systems could meet the collision avoidance objectives, provided that these systems are fully interoperable.

EASA responded favourably to the BEA's recommendation in June 2023, and the subject was included in EASA's 2024 annual safety review. The actions identified included: regulatory changes in order to have on-board alert systems on aircraft weighing less than 5,700 kg or with fewer than 19 passengers; demonstration and feasibility of the interoperability of alert and information systems; promoting the installation and use of these systems on all EASA-certified aircraft.

BEA Report

CAA SKYWISE

HS 748: Revocation of Type Certificate

The UK CAA is issuing UK.CN.00009 **Notification of Type Certificate Revocation for the HS 748** (EASA.A.397 Issue 2). This is as a result of the TC holder's (BAE Systems) intention to surrender the Type Certificate. The Effective Date of Revocation is 01 July 2025.

SW2025/095

CAA SKYWISE

Survey For Manufacturers And Suppliers Of Aeronautical Ground Infrastructure Applications

The UK CAA is seeking industry input to help shape the future of ground-based airspace surveillance and communication infrastructure to support beyond visual line of sight (BVLOS) operations under the Future of Flight action plan and in accord with the CAA's Airspace Modernisation Strategy.

The CAA has published a survey that will help formulate future policy and regulation in this area.

SW2025/096

CAA SKYWISE

Review of UAS Regulations Consultation Reply

In 2023, the DfT sponsored the CAA to review the regulation of UAS in the UK. As part of this review, the CAA published the "Review of UK UAS Regulations consultation" on 22nd November 2023. This consultation set out proposals to simplify regulation, deliver greater education for UAS users, improve safety and security, and support the UAS sector transition to new regulations.

The CAA read, reviewed and engaged with all responses to the consultation. We reconsidered each of our proposals, in collaboration with the DfT, Home Office and police. **This consultation reply document sets out the CAA's final policy recommendations.**

SW2025/093

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Screenshot from 5 News YouTube Channel

NATIONAL TRANSPORTATION SAFETY BOARD

Beech 400 Runway Excursion after Flight Control System Malfunction/Failure

During the take-off the pilot pulled the aeroplane's control yoke aft to rotate and the airplane lifted off the runway as normal. The nose of the airplane dropped, and the pilot applied additional back pressure on the yoke. The pilot reported he felt a "snap" followed by a lack of tension on the control yoke. The airplane pitched down and settled back on the runway. The pilot applied maximum braking and full thrust reverse; however, the airplane continued off the end of the runway. The pilot applied left rudder and brake to turn the airplane to avoid contacting a gas station. The landing gear collapsed during the turn, which resulted in substantial damage to the right wing when it struck the ground.

A post accident examination of the airplane revealed the elevator control cable was fractured at a pulley bracket near the aft portion of the fuselage where the cable transitioned from a horizontal to a vertical orientation. A metallurgical examination found nearly all the wires of the cable had rubbing damage to varying extents around the sides of the wires near the fracture.

The upper guard pin exhibited wear, scratch marks, and gouges. The pulley contained several isolated wire fragments. The damage on the cable, upper guard pin on the pulley, and the pulley assembly was consistent with the cable having been improperly routed on the wrong side of the upper guard pin. Over time, the cable likely rubbed against the upper guard pin until the cable was sufficiently damaged to produce failure under normal operating loads. A review of the maintenance logbook entries found that the elevator cable was replaced about a year before the accident and that the airplane flew about 316.5 hours before the cable separated.

Probable Cause

The NTSB determined the probable cause to be:

Improper rigging of the elevator cable over the upper guard pin, which resulted in a cable separation and loss of elevator control.

NTSB Report

EASA

Helicopter Vortex Ring State Experimental Research

Image by Hermann Kollinger from Pixabay

The EASA's VRS research project aims to improve understanding of the Vortex Ring State (VRS) in helicopters, a dangerous flight condition where the rotor's wake recirculates back into the rotor, causing a loss of lift. The research involves experimental flight tests on two different helicopter types, instrumenting them with sensors to measure flight and system parameters in real-time. The primary goals are to determine the onset conditions of VRS, compare the effectiveness of conventional and Vuichard recovery maneuvers, and assess the impact of various factors like vertical speed and torque.

HelicopterVortex Ring State Experimental Research

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Recent Accidents & Incidents from the Air Safety Network Wikibase

Date	Type	Event	Location
11-May-25	A321	THY Turkish Airlines	Prague-Vaclav
06-May-25	MB.339A	Three aircraft of the Frecce Tricolori display team were involved in a mid-air collision during an airshow	Pantelleria
06-May-25	AS350B	Crashed from low altitude at low speed during training	Vöslau Airfield
07-May-25	A320	RWEXC. Right gear on grass during landing in a thunderstorm.	Ho Chi Minh City
09-May-25	A320	ATB due to a hydraulic fault after departure.	NW of Trivandrum
05-May-25	A321	GCOL. Struck and damaged by mobile airstairs.	Chisinau
06-May-25	A321	Diverted to Havana due to an engine failure.	José Martí, de La Habana
09-May-25	A330-200	Emergency landing at SXM after a smoke alert in the cargo hold while on approach.	Near Sint Maarten
06-May-25	A350-900	Landed at LAX with a blown tyre.	Los Angeles
06-May-25	BAe Hawk	The nose landing gear of the BAe Hawk Mk 208 collapsed after the aircraft bounced during landing.	Alor Setar-Sultan Abdul Halim
09-May-25	Bell 212	Crashed into the Maduru Oya Reservoir shortly after it took off from a helipad	Maduru Oya Reservoir
08-May-25	Bell 407	Crashed in a wooded area and fell into a deep gorge	Gangnani, Uttarakhand
06-May-25	B737-800	RTO, fire occurred in the braking system of the left-hand main gear.	Mandalay
06-May-25	B77-300	Diverted due to smoke in the cabin while en route.	near Delhi
06-May-25	B777F	Diverted due to reported smoke in the cockpit.	Near Mount Morris
07-May-25	F18	Crashed in Rovaniemi practicing for an air show.	Rovaniemi Airport
06-May-25	F18	Crashed into the sea as a result of a failed landing attempt on the USS Harry. S. Truman.	USS Harry S. Truman
06-May-25	DHC6	Sustained hail damage during flight.	Near Boulder City
09-May-25	DHC8	Diverted due to a failure of one of the hydraulic systems.	Terceira-Lajes
06-May-25	DHC8	ATB due to a blown tyre on the right main landing gear during take-off.	Calgary
06-May-25	AS350B	Contacted a lamp post next to a street, and impacted the ground from a height of 5-6 metres	Carona, BG

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Safety Conference Calendar

Year	Month	Day(s)	Org	Event	Location	Notes
2025	May	15th	EASA	Cabin Safety Webinar	Live from Oslo	
2025	May	20th - 22nd	EBAA	EBACE	Geneva	
2025	May	22nd – 23rd	EASA	PNT Resilience Workshop	Cologne	
2025	May	29th	EASA	Safety Culture	Live from Dublin	
2025	Jun	5th – 6th	FSF	Safety Forum 2025 - People at the Centre	Eurocontrol, Brussels	
2025	Jun	10th - 12th	EASA	EASA-FAA International Aviation Safety Conference	Cologne	On site
2025	Jun	25th - 26th	EASA	Part-IS Implementation Workshop	Cologne	Hybrid
2025	Jun	24th	UKFSC	471st SIE	Dublin	
2025	Jul	7th - 9th	UKFSC	FSO Course	Gatwick	
2025	Aug	18th – 20th	UKFSC	FSO Course	Gatwick	
2025	Aug	27th – 28th	EASA	Artificial Intelligence in Aviation	Cologne	Hybrid
2025	Sep	10th	UKFSC	472nd SIE	TBC	
2025	Sep	10th - 11th	AAPA	Asia Pacific Aviation Safety Seminar 2025	Manila	
2025	Sep	15th – 17th	UKFSC	FSO Course	Gatwick	
2025	Sep/Oct	29th – 4th	ISASI	ISASI 2025 - Soaring to New Heights: A World of Innovation	Denver, Colorado	
2025	Oct	6th – 7th	SAE	Defence Aviation Safety Conference	London	
2025	Oct	14th -16th	IATA	World Safety and Operations Conference	Xiamen, China	
2025	Nov	4th – 6th	FSF	78th International Aviation Safety Summit	Lisbon, Portugal	
2025	Nov	10th – 12th	UKFSC	FSO Course	Gatwick	
2025	Nov	11th – 13th	Bombar-dier	29th Bombardier Safety Standdown	Wichita, Kansas	
2025	Nov	19th	RIN	4th Annual UK PNT Leadership Seminar	London	
2025	Dec	2nd	UKFSC	473rd SIE	TBC	