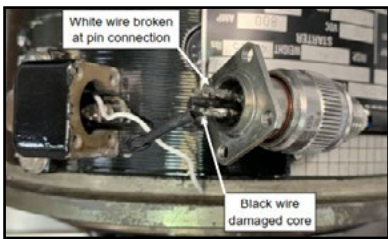




UK Flight Safety Committee

UKFSC News #25

20 May 2025



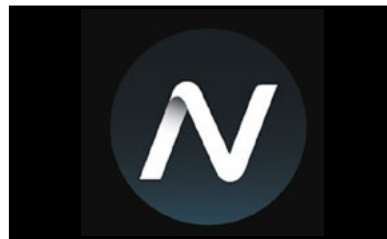
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CAA SKYWISE

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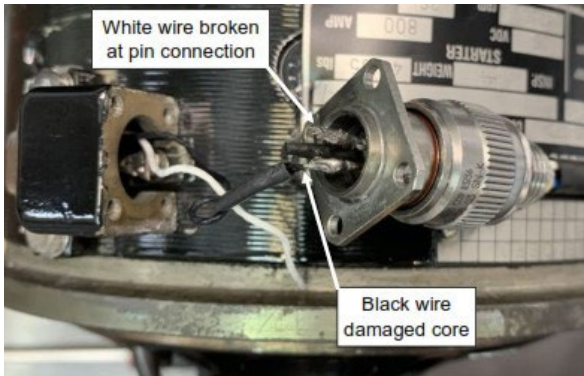
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SKYBRARY

Wiring Defect Caused Loss of Primary Flight Instruments

On 17 January 2023, an aircraft in the final stages of a CAT 2 ILS night approach to East Midlands experienced a significant electrical malfunction which disabled one set of primary flight instruments and triggered multiple system status indication failures. These included false system warnings and radio communications problems. The approach was discontinued, a MAYDAY declared and a successful manually-flown diversion to Birmingham was then made. The cause of the electrical malfunction was found to be a wiring defect which was considered to have probably been caused by the incorrect use of mechanical wire stripping tools during third party maintenance.

[Learn More](#)

Related articles

[Aircraft Electrical Systems](#)

[Component Maintenance Manual](#)

[Electrical Problems: Guidance for Controllers](#)



Image Photo by Andrew Cutajar: <https://www.pexels.com/>

CIVIL AVIATION ACCIDENT AND INCIDENT INVESTIGATION COMMISSION SPAIN

Pilot Incapacitation While Alone on the Flight Deck

While en-route at 10:31 UTC, the captain (Pilot Monitoring) left the flight deck for the lavatory, leaving the co-pilot (Pilot Flying) in control. The captain noted the co-pilot appeared alert and capable. Upon returning at 10:39 UTC, the captain was unable to re-enter the flight deck using the standard procedure and made multiple attempts, including an intercom call. Eventually, the co-pilot manually opened the door just before the emergency access code timer expired.

The captain resumed control at 10:42 UTC and observed the co-pilot was pale, sweating, and behaving abnormally. Cabin crew and a doctor on-board provided first aid, suspecting a heart condition. The captain diverted the flight to Madrid.

The investigation established the cause of the co-pilot's incapacitation was the manifestation of a symptom of a condition that had not previously been detected either by the pilot himself or during the aeronautical medical examination.

This incident has highlighted the benefit of another authorised person on the flight deck when one of the two pilots leaves for physiological or operational reasons. If another authorised person had been present on the flight deck, they could have identified the co-pilot's incapacitation, alerted the rest of the crew and opened the flight deck security door so that the captain could swiftly take control of the aircraft. See [EASA SIB No 2016-09 Minimum Cockpit Occupancy](#).

REC 02/25: It is recommended that operators review this event so that they may take it into account and reassess, from an operational safety and security point of view, the risks associated with one pilot remaining alone on the flight deck when the other pilot leaves for physiological or operational reasons.

[CAAIIIC Report](#)

NATS ALTITUDE #41

Airport Digitisation

Digital transformation: smarter flight management, real-time operational insights, and seamless passenger experiences driven by advanced technologies.

[NATS Altitude 41 YouTube](#)

JET 2

Jet2FlightPath Fully Funded Pilot Training

No barriers. No limits. Just opportunity!

Designed for talented individuals who have dreamt of taking to the skies but never had the opportunity. _

[Jet2FlightPath](#)

CRANFIELD UNIVERSITY

DiscoverYour Future - Open Days

Cranfield Campus Open Day 21 May 2025, 0930-1530

[Register](#)

Virtual Open Day 4 June 2025

[Register](#)



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NASA CALLBACK #544

A Maintenance Legacy

Aviation Maintenance Technicians (AMTs) bear the solemn responsibility of keeping our aircraft safe and airworthy, and on occasion, they assume additional duties during the course of a flight. Operating in what is commonly considered the most hazardous work environment, AMTs guard their own safety and that of co-workers, crewmembers, and passengers. Inquisitive and innovative, AMTs often quell threats and hazards before they become incidents and accidents.

In May, we often remember Charles E. “Charlie” Taylor, the Wright Brothers’ legendary bicycle mechanic, who turned engine mechanic and became the country’s first real AMT. Charlie was born on May 24, 1868 in Cerro Gordo, Illinois. His life is an iconic American story. In his tradition, ASRS honors and thanks all AMTs for their expertise and professionalism in maintaining America’s aircraft.

This month, CALLBACK offers selected incidents that demonstrate significant impact, positive or negative, that AMTs can have on all flights. AMTs work tirelessly to mitigate or eliminate real and potential threats. Explore the narratives as you identify the issues and the actions taken by the AMTs involved.

[CALLBACK 544 May 2025](#)



Image by Michael Kastelic from Pixabay

NATIONAL TRANSPORTATION SAFETY BOARD

Pilot Incapacitation Due to Loss of Cabin Pressure

A pilot and three passengers departed on a cross-country flight. After climbing through 26,600 ft, the pilot stopped responding to ATC. The aircraft continued on autopilot, reaching 34,000 ft and flying its planned route, even overflying its destination. About two hours after takeoff, it entered a spiraling descent and crashed.

Two minutes before the descent, U.S. Air Force pilots intercepted the aircraft. They observed no structural damage, smoke, or deployed oxygen masks. One person was seen slumped in the pilot seat, with no visible movement from others.

Investigators concluded that the pilot likely became incapacitated during the climb, and the autopilot maintained the flight path until control was lost. The pilot had some cardiovascular risk factors, but no evidence of recent misuse of medication.

Maintenance records revealed serious issues: overdue inspections, a missing pilot oxygen mask, and low supplementary oxygen levels. These deficiencies meant oxygen would not have been available in the event of cabin depressurization.

The most probable cause of incapacitation was hypoxia due to a loss of cabin pressurization. Whether the depressurization was rapid or gradual couldn’t be determined, but gradual loss is particularly dangerous because it can impair awareness before corrective action is possible.

Probable Cause: Pilot incapacitation due to loss of cabin pressure for undetermined reasons. Contributing to the accident was the pilot’s and owner/operator’s decision to operate without supplemental oxygen.

[NTSB Report](#)

FAA AD

Boeing 787-8, 787-9, and 787-10 Water Leakage from the Potable Water System into the Electronics Equipment (EE) Bays

This AD was prompted by reports of water leakage from the potable water system due to improperly installed waterline couplings, and water leaking into the electronics equipment (EE) bays from above the floor in the main cabin, resulting in water on the equipment in the EE bays. A water leak from an improperly installed potable water system coupling, or main cabin water source, if not addressed, could cause the equipment in the EE bays to become wet, resulting in an electrical short and potential loss of system functions essential for safe flight.

[AD 2025-09-12](#)



Image by István from Pixabay



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BUREAU D'ENQUETES ET D'ANALYSES

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

C525 Failure of Barometric Chain, Undetected Altitude Deviation & TAWS ‘PULL UP’

The aircraft departed Limoges-Bellegarde airport at 17:55 bound for Paris-Le Bourget airport. On flying through the transition altitude, the pilots detected an inconsistency between the altitude values indicated on their PFDs.

When the aircraft was established at FL 180 according to the information displayed on the captain’s PFD, the crew informed air traffic control that they had a problem with the altimeters. The crew asked ATC to confirm their level was FL180. The controller informed the crew that they were at FL 180. The controllers altitude data was from the aircraft.

Subsequently, the processing of the failure led the crew to consider that the altitude indicated on the co-pilot’s PFD was incorrect. The crew then selected ADC 1 as the altimetry source for both PFDs.

At around 18:30, the crew began their descent. Five minutes later, when the crew thought they were level at FL 90 and tried to contact CDG control, the aeroplane’s GNSS altitude was actually around 3,000 ft, and the aeroplane was descending with a vertical speed of around -270 ft/min.

In their statement, the crew indicated that a TAWS PULL UP TERRAIN alert was triggered a few minutes later. The aircraft, which was supposed to be at FL 90, was at a GNSS altitude of 1,200 ft, i.e. a height of 700 ft, and descending.

The captain disconnected the autopilot, increased power and flew using visual references and landed at Le Bourget.

The first elements of the investigation confirm once again that an altimetry problem is a singular and real threat to air safety, particularly for aircraft equipped only with two independent anemo-barometric systems.

This type of in-flight malfunction is likely to simultaneously:

- generate a trajectory deviation in the vertical plane which

can be the cause of a dangerous approach between aircraft or of an aircraft with the ground;

- deprive pilots and air traffic controllers of the elements allowing them to have full awareness of the real situation;
- compromise the effectiveness of the recovery barriers that ACAS systems constitute on the side of the ship, and STCA or MSAW on the air traffic control side.

Three similar serious incidents have already been the subject of BEA safety investigations and resulted in several safety recommendations. As of the date of publication of this report, some recommendations have led to action (several of which are still ongoing), while others have not been followed up. Valljet, Textron, DSN, DSAC, FAA and EASA had already been involved in some of these investigations.

This serious incident shows that the resources available to crews and air traffic controllers may be insufficient to enable them to manage appropriately in the event of doubt about an aircraft’s altitude.

The initial elements collected during the investigation into the F-HJAV, as well as this report, have been shared with the bodies mentioned above so that they can reassess, in light of this new serious incident, the adequacy of the decisions or measures already taken.

The safety investigation will pay particular attention to the following elements:

- the failure of the F-HJAV anemo-barometric system;
- training and procedures for crews and air traffic controllers;
- consideration by the various parties concerned of previous safety events and the corresponding safety recommendations.

[BEA Interim Report in French](#)

UK CAA SAFETY NOTICE 2025 - 007

UK Part-145 Appendix IV Conditions for the Use of Staff Not Qualified in Accordance with UK Part-66

With immediate effect from the publishing date of this Safety Notice, the maintenance organisations located outside the UK holding a UK Part-145 approval and Part-CAMO and PartCAO organisations contracting UK Part-145 approved maintenance organisations located outside the UK are to confirm and assure themselves that the certifying staff and support staff holding a licence or an authorisation issued under their national legislation are in compliance with the requirements of Appendix IV to UK Part-145.

[SN2025007](#)

Contents



Image: pilotswhoaskwhy.com

PILOTS WHO ASK WHY

The Most Dangerous Crew Member on Board: Your Ego

Ego is that one crew member that doesn't wear a uniform, doesn't speak during the brief, and isn't on the checklist.
But it's definitely there: influencing decisions, shutting down questions, and overriding good judgement.
Safety critical errors are made every day because "ego" knew better, or at least it thought it did!
We talk a lot about threats and errors in aviation, but how

often do we really talk about ourselves as the main threat?
Talking about our ego isn't about judgement or blame, it's about awareness. Because ego can be one of the most dangerous forces in the cockpit, but the hardest one to detect.
This one might be a little confronting!
Let's take a look - [Continue Reading](#)

EUROPEAN SAFETY PROMOTION NETWORK – ROTORCRAFT (ESPN-R)

Helicopter Hoist Operation PCDS Personnel Carrying Device System Guide



The European Safety Promotion Network – Rotorcraft (ESPN-R) is a collaboration between EASA, National Authorities, and the Rotorcraft Community, which works together to provide non-binding best practice information to support safe operations. The ESPN-R Hoist Safety Promotion working group would like to support the growing Helicopter Hoist Operations market (HEMS, offshore wind energy, etc.) and address potentially operational safety risks and an increasing number of occurrences, by creating an equipment guide in order to

increase safety in hoist operations of all types.
Equipment Manufacturer, Helicopter OEM's (Original Equipment Manufacturers), operators and Training Organizations have been associated with this initiative to define clearly PCDS recommendations
This ESPN-R PCDS guide is compatible with the ESPN-R hoist operator training guide and pilot training guide.
[ESPN R Hoist PCDS Guide](#)



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Image by Dimitris Vetsikas from Pixabay

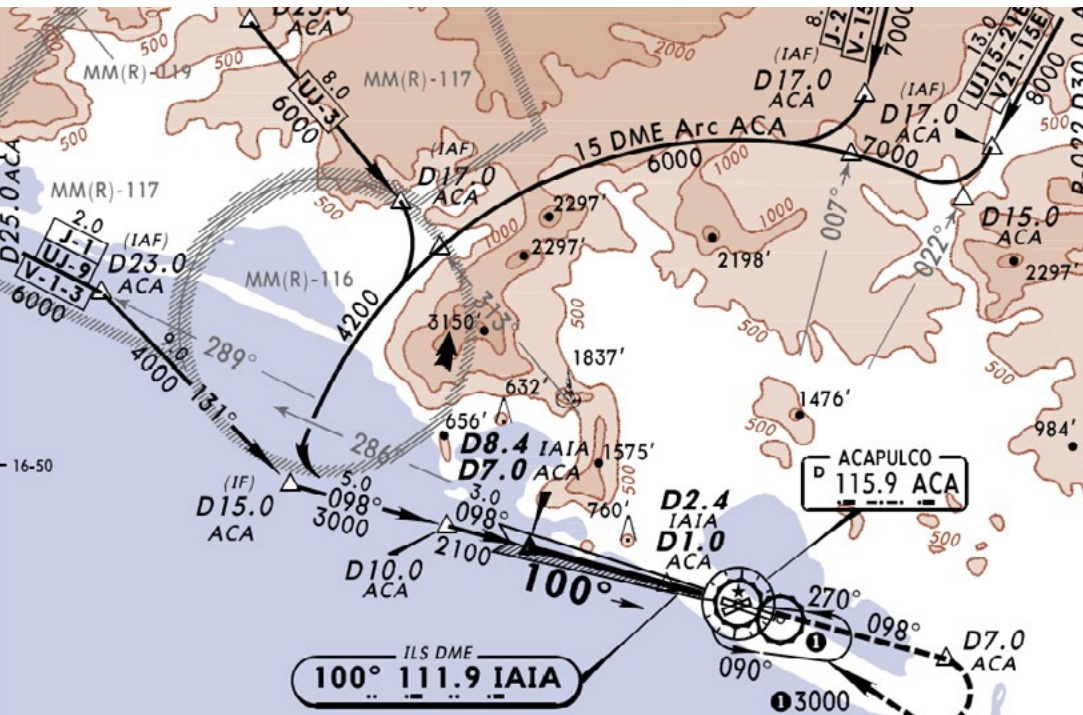


OPS GROUP

Greek Summer Ops Lowdown

‘All Greek islands will be extremely busy this summer. Athens too. Very few slots are made available to bizav flights, overnight parking is scarce, even quick turn arounds are extremely difficult in some cases. At Level 3 airports, your filed flight plan must match the confirmed slot time within ±15 minutes, otherwise it will be suspended. Watch out for extra fees at LGMK/Mykonos, LGKR/Corfu and LGKO/Kos. Consider drop-and-go’s, with parking at airports on the Greek mainland, Cyprus, or Turkey.’

Ops Group Greek Summer Ops Lowdown



https://recursosdeaviacion.com/wp-content/uploads/2020/05/introduction-to-jeppesen-navigation-charts.pdf

EASA WEBINAR

RNP Visual with Prescribed Track: What You Should Know

Wednesday, 28 May 2025 11:00 - 12:30 BST

The operational safety online event is part of the Summer Safety Campaign 2025 of the European Union Aviation Safety Agency (EASA). Join EASA, the DGAC France, Airbus, Lufthansa, Iberia, Austrian Airlines, and Easyjet to discuss the key aspects of Required Navigation performance Visual with Prescribed Track (VPT), covering the practical implementation and oversight of this novel technological innovation that will enhance the conduct of circling and visual approaches and who is expected that will substitute in due course the RNAV visuals, and RNP visuals.

[Register](#)

CAA SKYWISE

ECCAIRS2 - System Update Announcement

The CAA has upgraded their occurrence reporting system from ECCAIRS to ECCAIRS 2—a web-based tool that enhances how they collect and manage safety reports. This helps adopt the latest taxonomy releases and works more efficiently. The CAA kindly ask for your patience and understanding as our team adjusts to the new platform. The CAA are working hard to ensure a smooth transition, and your continued support means a great deal. Thank you for bearing with us during this upgrade.

[SVW2025/098](#)

CAA SKYWISE

REMINDER: Carbon Monoxide Safety in General Aviation

From 1 January 2025, operators of specified piston engine aircraft are required to have a functioning active carbon monoxide detector on board when operating with passengers who do not hold a recognised pilot qualification – see SD-2024/001 for further details. The CAA [Safety Sense Leaflet](#) provides guidance to GA pilots on how they can protect themselves and their passengers from CO by employing effective prevention via maintenance and detection methods.

For further guidance, please visit the CAA [safety page on carbon monoxide](#) on the CAA website. [SW2025/099](#)

CAA SKYWISE

Publication of CAP722L first edition

The CAA has published [CAP722L](#), setting out the requirements for a UAS Operator wishing to make any modifications to their operations after obtaining an Operational Authorisation (OA) through the UK SORA process. They cover which type of modification require a technical change to an OA. [SW2025/105](#)



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[Image by jannoon028 on Freepik](https://www.freepik.com/free-photo/seat-belt-airplane_1018559.htm)

UKFSC

Seat Belt Extenders

From FSC inputs this remains an issue that the ease of online purchasing exacerbates. Here are all of your views.

The motivation of passengers buying their own is, in the main, to not draw attention to themselves when in the cabin, which is understandable, if misguided. Also to be self sufficient. Cabin crew are sensitive to this self-consciousness when a passenger requests an extension seat belt.

Airlines report having seen an increase in passengers bringing fake belts on board.

The issue has recently been discussed at the Cabin Liaison Safety Group.

Several airlines are running or about to run campaigns or advice in crew notices to raise awareness and vigilance among their crews.

Operators of smaller business aircraft report the challenge of seating plus size passengers in relation to emergency exits.

The question of liability was raised. One would expect that provided there is an explicit policy not to allow the use of a passengers own belt the choice to do so would be considered ‘misadventure’? We will seek a legal opinion.

One operator has reported that uncertified extension seat belts have been discovered during maintenance. Given the integrity of their supply chain the only remaining explanation is that passengers are swapping their ‘fake’ belt for an airline supplied original. It is impracticable for the cabin crew to perform a detailed inspection every time they are returned.

Most airlines prohibit the use of extenders next to emergency exits. The extension belt could be a trip hazard if used adjacent to an emergency exit. This obviates the need to assess whether the plus size individual would be able to open and use any particular exit.

Identifying fake belts during cabin secure checks is challenging because they are the same colour.

Most Airlines use Type A seat belts, but some, such as South West use Type B. The belts on sale online appear to be Type A. Compatibility is not guaranteed.

The online sales pitch includes claims of certified products quoting standards. These are automotive standards and ISO standards not aviation standards.

Seat belts are not the only non-approved or certified parts brought on board.

The safety issues include whether the seat belt will break under stress. If it not a certified product it is not certain if it will maintain its integrity during acceleration, deceleration or turbulence. Will it unlatch or jam, preventing it from being unlatched in an evacuation.

A selection of airline website policies follow.

Aer Lingus

Seatbelt extensions are available on all our aircraft. They can’t be pre-booked but if you need one, just let a member of cabin crew know when you’re boarding. Passengers requiring a seatbelt extension unfortunately won’t be able to sit at an exit row.

easyJet

Our cabin crew will be able to provide you with an extension seat belt if you are of a large build. Please make sure you speak to a member of our crew when on board so they can bring you the seat belt, as you are only allowed to use the belts supplied on board.

Alaska Airlines

Passengers needing extra coverage may ask the flight attendant for a seatbelt extension, which adds 25 inches to the seatbelt length. Only seatbelt extensions provided by the specific aircraft operator may be used on-board. Seat belt extensions are prohibited: in Exit Rows.

United

You can ask a flight attendant for a seatbelt extender once you board your flight. You aren’t allowed to bring your own.

Contents

Recent Accidents & Incidents from the Air Safety Network Wikibase

Date	Type	Event	Location
14-May-25	AS350B	Made an emergency landing due warning light.	Nagoya
15-May-25	SA315B	Rolled over in an accident during an aerial application flight.	Roxana de Guapiles
17-May-25	A320	Diverted. FL360 left engine failure.	Zakovryashino
15-May-25	A320	ATB due bird strike incident just after take-off	Narita
12-May-25	A320	RH engine issue in descent, held, squawked emergency and landed.	Mentese
15-May-25	A321	ATB cabin pressure problem	Heathrow
12-May-25	A330-300	Unable to vacate the runway due to a green hydraulic leak	Prague
12-May-25	A340-300	ATB due failure of engine no.2 while en-route at FL350 over the Atlantic Ocean	Nantucket
13-May-25	AN24	ATB due failure of the right generator	Irkutsk
16-May-25	ATR72	ATB due No. 1 engine cowling opened.	Kaohsiung
15-May-25	BELL UH-1H	Mechanical failure and forced landing in a field	La Fortuna ranch
17-May-25	B737 MAX8	Fire right main gear brakes when landing. Disembarked safely after the fire extinguished.	Galeão International
16-May-25	B737-800	Diverted after the crew reported a hydraulic issue.	Nashville
17-May-25	B737-800	ATB due smoke in the cabin.	Innsbruck-Kranebitten
16-May-25	B737-900	ATB due to a malfunctioning speed indicator, possibly caused by a pitot tube issue.	Salt Lake City
13-May-25	B757-200	EMC DST,ATB due to a loss of pressurization.	Türkmenabat
17-May-25	B777-300ER	ARB due an engine issue, consistent with an engine stall.	Amsterdam-Schiphol
17-May-25	B787-8	ATB. It is believed the aircraft suffered a loss of pressurization..	Heathrow
16-May-25	CRJ900	ATB due to the failure of their autopilots.	Munich
15-May-25	CL415	Emergency landing after fuselage was damaged after striking a ‘shallow reef’.	Porto Vecchio
16-May-25	CIRRUS SF50	Multiple aircraft were damaged when an EF5 tornado struck London-Corbin Airport	London-Corbin
16-May-25	DHC8	Lost a wheel on take off continued to Dhaka.	Cox’s Bazar
11-May-25	E195	ATB, en route at FL390 south of Paris when the crew reported severe electrical problems.	France
12-May-25	ERJ145	GCOL. Involved in a ground collision incident according to NTSB.	Bimini
13-May-25	EERJ175	Struck a fuel truck while being pushed-back from gate.	Chicago-O’Hare
17-May-25	AS350B	Arriving for casualty, tail rotor malfunction, emergency landing.	Kedarnath Temple
16-May-25	EC135	Multiple aircraft were damaged when an EF5 tornado struck London-Corbin Airport	London-Corbin
16-May-25	EC135	Multiple aircraft were damaged when an EF5 tornado struck London-Corbin Airport	London-Corbin
16-May-25	Fokker 50	Lateral RW EXC. Sustained substantial damage when it veered off runway 27 after landing	Bocas Del Toro
13-May-25	C130	Taxiway EXC.Veered off the taxiway into a ditch	Latacunga-Cotopaxi
15-May-25	R44	Reported technical malfunction ditched	Manta
17-May-25	R44	Two Robinson R44 Raven I’s, flying in formation, collided in mid-air and crashed	Eura
17-May-25	R44	Two Robinson R44 Raven I’s, flying in formation, collided in mid-air and crashed	Eura
17-May-25	R66	Hard landing in a field	Islavskoye
13-May-25	S-70B-8	Made an emergency landing at sea due to technical malfunction.	Antalya



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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	22 nd – 23rd	EASA	PNT Resilience Workshop	Cologne	
2025	May	29th	EASA	Safety Culture	Live from Dublin	
2025	Jun	5 th – 6 th	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	24 th	UKFSC	471 st SIE	Dublin	
2025	Jul	7th - 9th	UKFSC	FSO Course	Gatwick	
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	10th - 11th	AAPA	Asia Pacific Aviation Safety Seminar 2025	Manila	
2025	Sep	15 th – 17 th	UKFSC	FSO Course	Gatwick	
2025	Sep/Oct	29 th – 4th	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	Nov	19th	RIN	4th Annual UK PNT Leadership Seminar	London	
2025	Dec	2 nd	UKFSC	473 rd SIE	TBC	