UK Flight Safety Committee

UKFSC News #26

27 May 2025

Tuesday May 27, 2025

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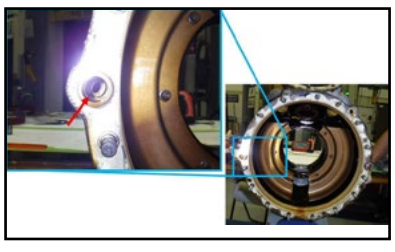

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UKFSC NEWS

The latest news from the flight safety world

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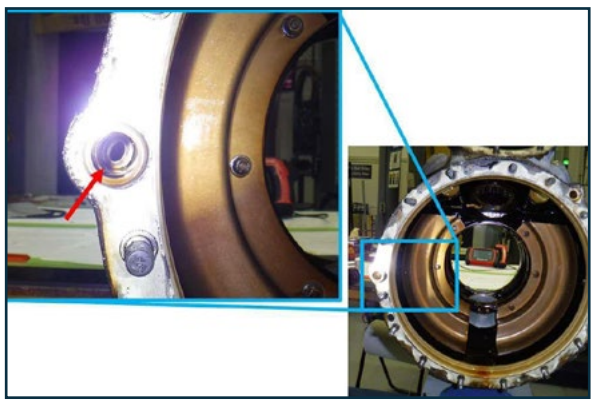

SKYBRARY

FOD Causes Loss Of Oil Pressure And Overheating Of The Helicopter Main Gearbox

On 25 September 2020, a helicopter returning from an offshore platform was in descent approximately 40nm from destination Stavanger when main gear box low pressure and left engine oil temperature cautions were annunciated. The affected engine was reduced to idle and a MAYDAY declared. A further related alert prompted descent to 200 feet and sixteen minutes after the initial malfunction, a normal landing was completed at Stavanger. A significant oil leak found in the main gear box was attributed to oil flow reduction and consequent overheating caused by a loose washer inadvertently left inside the gearbox during routine maintenance.

Learn More

Related articles

Foreign Object Debris (FOD)

Continuing Airworthiness

Health and Usage Monitoring System (HUMS)

Image from the AAIB report

AIR ACCIDENT INVESTIGATION BRANCH

EC135B Four Rotor Blades Break Off on Helideck

The helicopters rotor blades snapped off in high wind during an unscheduled stop on an oil rig helideck due to a Tail Gear Box Chip warning.

A failure of the rotor brake meant it was not possible to stop the rotors fully to apply the main rotor blade tie down straps. There was also difficulty mooring the helicopter to the helideck. It is considered vertical air flow caused by the 'cliff edge' effect (Airbus SIN 3947-S-00) of an accommodation block on the platform exacerbated the rotor blade sailing, causing four blades to break and detach from the helicopter. One blade nearly struck a person trying to strap the helicopter to the helideck. The investigation identified several operational shortcomings, a failure of the rotor brake and faults on the flight recorder.

An opportunity to identify the failure of the rotor brake prior to departure was missed which became a significant factor in the sequence of events leading to the blade failures.

The report refers to CAP 437 - Standards for offshore helicopter landing areas specifically the sections on the environmental effect on wind and guidance on tie down points and straps.

A 2015 inaccurate rig anemometer remained extant.

Six AAIB recommendations to EASA, FAA, Acron Aviation, LOGIC and Airbus Helicopters.

The AAIB acknowledged actions taken by the Helideck Certification Agency and operator to record rotor brake performance on every engine shutdown.

AAIB Report

EASA WEBINAR

1st EASA Ground Handling Implementation Webinar

17 JUNE 2025 1200 - 1400 CET

Preparation for the EU Ground Handling safety regulations applicable from 27 March 2028.

More Information & Registration

OPS GROUP

Watch Out For APU Fines at Le Bourget

If you're heading into LFPB it's a good time to remind yourself of the strict rules for APU usage lest you fall victim to some potentially large fines.

Read More

EASA WEBINAR RECORDING

EASA Summer Safety Cabin Safety

This video is the recording of the Cabin Safety session of the EASA Summer Campaign 2025 that was filmed in Oslo on Thu 15 May.

YouTube Together4Safety

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VUICHARD RECOVERY AVIATION SAFETY FOUNDATION

How To Avoid A Main Rotor Collision With Obstacles

This collision with trees occurred last Friday 23rd May as the helicopter was lifting off from a car accident site.
The main rotors struck the trees and the helicopter hard landed on the road.

YouTube Spot On International News Channel

Image from, Spot On News International YouTube Channel

According to the Vuichard Recovery Aviation Safety Foundation a frequent cause of helicopter accidents is the collision of the main rotor with obstacles.

Many of these collisions are due to an optical illusion by the pilot. This is impressively demonstrated in this safety video.

YouTube How to Avoid Rotor Collisions with Obstacles

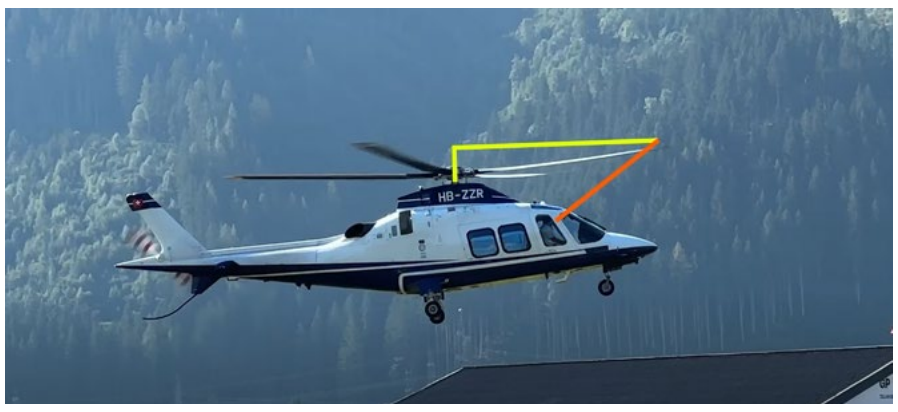

Photo from NTSB report

NTSB

B737 Left MLG Collapse

This accident occurred when the left main landing gear (MLG) of an Alaska Airlines Boeing 737 - 800 collapsed during landing. Post accident examination revealed that the aft trunnion pin in the left MLG failed during landing due to a fatigue fracture. The fracture initiated from a small intergranular region below the external chromium electroplated layer. The fatigue crack, which had propagated to a depth of 0.144 inches, was large enough to cause the remaining material to fracture in tensile or upward-bending overstress during landing, resulting in the collapse of the left MLG.

Flight data showed that, the MLG touched down, and the nose gear about 1 second later. The maximum vertical acceleration was 1.71 G. The touchdown had a “firm jolt feeling,” and the airplane was “pulling reasonably hard” to the left.

The aircraft stopped on the taxiway, the captain observed that the airplane was resting on its left engine.

The NTSB probable cause was maintenance personnel’s excessive grinding of the left main landing gear’s aft trunnion pin during machining, which imparted heat damage to the base metal and led to the fatigue cracking that caused the pin to fracture during landing.

NTSB Report

AIB DENMARK

B737 Left Wing Collided With Stairs

The aircraft approached the stand using the Docking guidance System. The left hand wing outer leading edge collided with a movable passenger stair, which had been left in a red hatched prohibited parking area.

The impact caused the passenger stair to overturn, as the aircraft continued to its designated parking position at parking stand A27. The accident occurred in daylight VMC.

The collision caused skin damage to the LH wing leading edge slat and a skin puncture of the lower skin fuel inspection panel.

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Image from the official report

AUSTRALIAN DEFENCE AVIATION SAFETY INVESTIGATION

MRH90 Spatial Disorientation Leading to Controlled Flight Into Terrain

Examination of the wreckage did not indicate and existing damage to the airframe and all major systems and flight controls were operating normally. The degree of damage is indicative of the last flight data recordings of 135KIAS and a 5200fpm descent rate, suggesting that the aircraft impacted the water at high speed. Damage to the main rotor components revealed that the rotor blades were turning at high speed, wit the engines operational and driving the rotors at the time of impact.

SAFTE-FAST estimated that the aircraft commander had an Effectiveness score of 73% at the time of the accident (2230).

73% is equivalent to 19-21 hours of wakefulness, a 37% increase in reaction time and blood alcohol level above 0.05%.

SAFETE- FAST estimated that the aircraft commander was 4.5 times more likely to experience a lapse in attention that would be expected during an average day in a well rested person. Effectiveness scores below 77% are considered to be a fatigue risk.

SAFTE-FAST estimated that the Co Pilot had an Effectiveness score of 77.5% at the time of the accident, equivalent to approximately 18.5 hours of wakefulness, a 29% increase in reaction time and blood alcohol below 0.05%. They were 3.6 times more likely to experience a lapse in attention than would be expected during an average day in a well rested person.

The investigation concluded that the primary cause of the accident was an unrecognised loss of spatial orientation, commonly referred to as spatial disorientation. This leads the pilot to take actions that are relative to their misperceived orientation and without awareness that the aircraft is in an abnormal state. Due to the low operating altitude of the formation and aircraft high rate of descent, the investigation concluded that the pilots did not have sufficient time after experiencing the unrecognised spatial disorientation event to rebuild an accurate mental model of the aircraft's orientation, and apply 'unusual attitude' recovery techniques prior to impact.

Contributory factors

Varying visibility an overcast and showery conditions where the horizon was more than likely not discernible. Task focus on maintaining formation using night vision devices. Closed cabin doors to protect the pilots from the environment which restricted the air-crewmen's ability to contribute to the pilot's situational awareness.

Systemic influences reduced the effectiveness of risk controls, regulation, approvals, training and oversight for aero medical factors, aviation fatigue management, human performance and spatial disorientation.

The army faced significant challenges to mitigate the safety and airworthiness risks arising from complex operations during a period of modernisation and platform transitions. The demands on key personnel responsible for aviation safety exceeded workforce capacity, likely degrading safety, quality and risk management systems.

Report Enclosures Factsheet

UK CAA AIRWORTHINESS DIRECTIVE

UK AD G-2025-0003: BAe 146 and AVRO 146-RJ: Time Limits / Maintenance Checks – Airworthiness Limitations Section Amendment

UK CAA Airworthiness Directive. This supersedes UK AD G-2021-0011.

View UK AD G-2025-0003

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Image by F. Muhammad from Pixabay

NTSB

B717 Cabin & Cockpit Smoke on Take-off, Engine Shutdown, Evacuation

On February 24, 2025, a Delta Boeing 717-200, experienced smoke in both the cabin and cockpit during takeoff from Atlanta Hartsfield-Jackson. The flight had 99 people on board. Two passengers sustained minor injuries during the emergency evacuation that followed the aircraft's safe return and landing.

Flight attendants first noticed smoke during the takeoff roll—forward attendants saw it near the L1 door, while the aft attendant observed it coming from all vents. Attempts to alert the cockpit via emergency call and interphone were initially unsuccessful. After takeoff, the lead flight attendant knocked on the cockpit door and made a public announcement to calm passengers. A non-revenue flight attendant proactively moved to the exit row to assist if needed.

In the cockpit, the pilots noticed smoke near the rear floor and donned oxygen masks. The first officer declared an emergency and began the smoke checklist after a forward lavatory smoke alert. Communication with the cabin crew was partially successful—pilots could hear the crew but not vice versa. Eventually, the lead FA received confirmation that the aircraft was returning to ATL.

A low oil pressure warning for the right engine prompted the crew to shut it down. Due to limited visibility from smoke and oxygen masks, the captain opted for a different runway with better guidance. After landing, the aircraft stopped on the runway, and the captain ordered an evacuation upon seeing heavy cabin smoke.

Evacuation was conducted through three doors and overwing exits. The non-revenue FA managed the overwing emergency exits evacuation. She remained on the wing with some passengers who were unable to jump from the wing or slide down the trailing edge of the wing. The wing flaps were extended to 25° prior to the evacuation in accordance with the checklist. She coordinated with the other three FAs there were no remaining risks inside or outside the cabin, the passengers remaining on both wings could reenter the cabin and evacuate using the 3 usable deployed doors slides. Post-incident inspection revealed the right engine oil reservoir was nearly empty. The investigation is ongoing.

NTSB Preliminary Report

PILOTS WHO ASK WHY

The Threats of Bird Strikes and How to Mitigate Them

Photo by Adrian Frentescu: https://www.pexels.com/

From broken windscreens, shattered helmet visors, holes in rotor blades, to complete loss of engine power and having to ditch into the Hudson: Bird strikes have been a threat since the start of aviation.

The stats show trends that suggest a significant increase in amount of bird strikes as time goes on.

There is a lot of misinformation related to bird behaviour and bird strikes. On top of this, training for flight crew rarely features bird strike related exercises.

So what are the most common bird strike myths that need debunking? What are the main threats of bird strikes, how can we mitigate them, and what can be done to safely get an aircraft on the ground after a bird strike?' Read More

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https://news.flyfrontier.com/images--video/

NTSB

A321 Hard Landing and Go-around

On April 15, 2025, a Frontier Airlines, Airbus A321 sustained nose wheel and engine damage during an attempted landing at Puerto Rico. The 235 passengers and crew on board were uninjured.

The FO recalled that during the approach, she brought the thrust levers back to idle at 20 ft RA while the RETARD aural alert sounded. The captain recalled that the landing flare began normally but became high at about 15 ft RA. The FO stated that around 15 ft RA, the captain noted that the aircraft was too high, so she corrected with a shallow descent and then a gradual flare. As the aircraft was about to touch down, the captain called for a go-around. The captain stated that he believed the aircraft was "running out of flying speed quickly, as the throttles were retarded and the pitch attitude was increasing" so he assumed control. He recalled that the airplane was slightly nose down with the thrust at the takeoff/go-around (TOGA) setting when the airplane then touched down firmly.

The captain stated that during the go-around, they heard a loud bang coming from under the fuselage and the FO called out that an engine failure was displayed on the electronic centralized aircraft monitor (ECAM) display.

The air traffic control tower (ATCT) controller reported an engine fire, but according to the flight crew, they only had an indication of an engine failure. Unsure of the damage sustained, the captain asked for a foreign object debris (FOD) sweep of the runway and a description of any debris found. Some metal and tire debris were found on the runway.

The captain stated that he flew a low pass by the ATCT to see if the controllers could determine if all three landing gear appeared to be down. The ATCT controller reported that the landing gear was intact,

After landing the passengers were disembarked using airstairs after confirmation of no engine fire

The data revealed that the airplane initially touched down on all three landing gear with a maximum recorded vertical acceleration of about 2.2g. This value is above the hard landing threshold of 1.8g per Frontier Airlines aircraft maintenance manual (AMM) Chapter 5 limitations.

A post incident inspection of the airplane revealed that the nose landing gear (NLG) left wheel and tyre had separated from its axle and departed after the initial hard landing. Metal fragments from the wheel assembly appear to have been ingested by the number one (left) engine and damage was found on the engine's inlet cowl liner, thrust reverser, fan blades, and guide vanes. The left inboard trailing edge flaps were also damaged.

In January 2021, an article titled "A Focus on the Landing Flare" was published by Airbus in their Safety First magazine. A Focus on the Landing Flare.

NTSB Preliminary Report

EASA CONSULTATION

Landing Distance on Smooth Wet Runways

In contrast to CS 25.109 (accelerate stop distance), CS 25.125 requires landing distances to be determined on a dry runway only. There is no requirement in CS 25 to determine wet runway landing distances.

This SC is applicable to CS25 for applicants willing to provide landing distances on wet runways to be published in the "Performances" section of the AFM that can be used for dispatch considerations only for those operations without specified landing distance operational factors.

Based on Flight Test Harmonization Working Group conclusions addressing landing distances on wet runways.

Certification Consultation

EUROCONTROL WEBINAR

Understanding Culture and Conversation In Organisations

24th of June 2025 14:30-16:30 CET

This webinar will be bringing together two different speakers that will approach the topic of organisational culture and conversation from different perspectives:

Prof. Tom Reader on New approaches to investigating safety culture: Recent developments in AI and digital data are revolutionising how academics and practitioners study safety culture.

Prof. Elizabeth Stokoe on Every word matters: Conversation analysis focuses on how different words, phrases, and grammar - as well as non-lexical and embodied resources - all combine to shape what happens next in our social interactions.

Registration

ATSB

Accidents Involving Visual Flight Rules Pilots In Instrument Meteorological Conditions

Weather-related general aviation accidents remain one of the most significant causes for concern in aviation safety; the often-fatal outcomes of these accidents are usually all the more tragic because they are avoidable.

ATSB Report

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Source: Photo provided by FAA. From the NTSB report.

NTSB

B717 Landed with the Nose Gear Retracted

Delta Air Lines flight 1092 was about 2,000 ft above ground level (AGL) when the flight crew lowered the landing gear handle and observed the nose wheel unsafe condition light illuminate. The unsafe condition was confirmed, and a go-around was initiated to troubleshoot and complete the applicable checklists. Multiple normal and manual landing gear extension attempts were made to no avail, and the flight crew conducted an emergency nose gear up landing. After completing the shutdown and evacuation checklists and verifying the area was safe, an evacuation was performed through the forward entry doors utilizing the emergency slides.

A post accident examination revealed that the nose landing gear upper lock link failed from a fatigue fracture. Fatigue cracks initiated along scratch features which were observed on the lower surface at the parting line of the forged aluminum alloy component. The appearance of the scratch features was consistent with tool marks such as from filing or grinding operations. These scratch features likely acted as stress concentration areas for crack initiation. Once the fatigue cracks had propagated through approximately one-third of the material cross section, the upper lock link fractured in tensile or upward-bending overstress.

Visible crack arrest marks indicated the overstress fracture may have occurred over several load cycles.

NTSB probable cause: A fatigue fracture of the upper lock link that initiated along scratch features on the lower surface at the parting line of the forged aluminum component. Contributing to the accident was the overhaul facilities noncompliance with Service Bulletin 717-32-002.

As a result of the investigation Boeing performed the following safety actions:

o Notified operators of the Boeing 717 airplanes of this accident

Recommended that Boeing 717 operators perform a high frequency eddy current inspection of all in-service nose landing gear upper lock links in addition to any spares in inventory.

o Requested the results of the high frequency eddy current inspections from the operators.

o Revised the Boeing 717 Overhaul Manual 32-21-2, in July 2024, to require that at the next and subsequent overhauls upper lock links be stripped of paint, the parting plane area be fluorescent-penetrant inspected for surface imperfections (scratches, nicks, and toolmarks), and high frequency eddy current inspections be performed on top and bottom sides of the link to check for existing cracks.

o Initiated a new Alert Service Bulletin 717-32A0043, effective for all 717 airplanes, to recommend an on-aircraft initial and repetitive high frequency eddy current inspections on in-service upper lock links.

As a result of the investigation Delta Air Line performed the following safety actions:

o Completed an inspection of all upper lock links installed on their fleet of Boeing 717 airplanes and all spare lock links in their inventory with no reported crack findings.

As a result of the investigation the remaining operators of Boeing 717 airplanes performed the following safety actions:

o Completed a fleet inspection of Boeing 717 airplanes upper lock links in January 2024 with no reported crack findings.

NTSB Preliminary Report

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Photo from the BEA report

BEA FRANCE

B737-400 Windshear, Long Landing, Runway Overrun On Landing

On the night of 23 to 24 September 2022, the crew of the Boeing 737-400 were carrying out a mail flight between Paris - Charles de Gaulle and Montpellier. The captain, in the left seat, was the Pilot Monitoring (PM), and the co-pilot, in the right seat, was the Pilot Flying (PF).

After having prepared and carried out the briefing for an ILS approach to runway 30R, the runway in use changed. They then prepared a VOR-DME approach to runway 12L. There was no briefing for the new approach.

A storm cell was approaching the airport from the south-west. During the approach, the crew's awareness of the presence of this cell was low despite available information.

On short final, the crew changed roles. The co-pilot, now the PM, did not carry out their monitoring tasks.

When flying over the threshold, the aeroplane encountered windshear characterised by a sudden reduction in the tailwind. The crew did not detect this or perceive its impact on the flight parameters. In particular, they did not observe that the aeroplane had exceeded the touchdown zone without coming into contact with the ground.

The aeroplane touched down on the runway beyond the touchdown zone, 1,500m from the threshold of runway 12L. It overran the runway and finished its run in Or lake.

Contributing factors

Lack of monitoring by the PM; no lights in the touchdown zone; the environmental conditions (dark night, heavy rain); failure to consider the threat of a storm close by; the PF focusing on holding the approach path in changing wind conditions at night with no touchdown zone lighting; focus on the runway change; bias from information that the weather was improving; inappropriate use of weather radar; no new briefing after the runway change; no Threat and Error Management (TEM) in the briefing.

Safety Lessons

Importance of briefing: The accident illustrates the necessity of not starting an approach without the crew taking the time to discuss it.

Missed approach: One of the objectives of having a stable approach is to ensure that the crew have available cognitive resources to deal with unforeseen circumstances. On short final with an aeroplane with a relatively high energy level, without active monitoring. Passing through the windshear zone was then the factor that made the landing impossible. The crew probably no longer had the cognitive resources to identify this additional threat.

Swapping PF/PM roles: The signals that led the captain to propose swapping roles could probably have led him to reconsider pursuing the approach. Even though the crew had conferred about swapping roles, it had not been anticipated by the co-pilot, and this may have created a surprise effect that prevented him from marshalling his resources to take on the monitoring task. The standard callout when swapping PF/PM roles, in line with industry recommendations, focuses solely on the PF role. This accident highlights the fact that it did not provide a sufficient stimulus to bring the PM out of the surprise effect. In this respect, it might be beneficial to assess whether adding the transfer of the monitoring role to the callout of the transfer of controls (for example "I have controls, you monitor").

The ICAO Global Reporting Format for runway surface conditions: ICAO had anticipated certain risks associated with this change, such as the risk associated with meteorological situations in which runway conditions change rapidly. Users still need to perfect their command of the GRF and more particularly its application in marginal situations, and assimilate the inherent limitations in such situations.

The report includes multiple safety actions taken by the aircraft operator, the airport operator and the ANSP.

BEA Report

Contents

Recent Accidents & Incidents from the Air Safety Network Wikibase

Date	Type	Event	Location
18-May-25	A220	Taxiway excursion.	New Haven-Tweed
20-May-25	A319	ATB due to smoke in the cockpit.	Near Berlin
22-May-25	A320	Suffered a tail strike after the flight crew had initiated a go-around.	Paderborn
23-May-25	A321	ATB due to an engine failure shortly after take-off. Possible gear issue after gear bolt found on runway.	Near Amsterdam
21-May-25	A321	Sustained damage to the nose Radome after encountering a hailstorm	Near Pathankot
24-May-25	A321	Diverted due to an indication of a possible malfunctions of the right-hand engine.	SE of Hong Kong
24-May-25	A330-300	RWEXC. Veered off the side of runway 10 while backtracking.	Bayda-Al Abraq
20-May-25	A330-300	ATB due to a bird strike during take-off.	Dhaka-Shahjalal
20-May-25	A330-300	Diverted due to vibrations in the No. 2 engine	Tyndinsky
23-May-25	H145	Air ambulance responding to a car accident, the rotor struck a roadside tree branch causing a "hard landing" on the road. https://YouTube/FH2bxHbbthA	Nothum
21-May-25	MK30	An Amazon delivery drone force landed on the front lawn of a residence	Tolleson
22-May-25	AN24B	Diverted due failure of the right artificial horizon.	Khabarovsk Novy
25-May-25	ATR72	ATB, engine failure shortly after take-off. YouTube video	Birmingham
24-May-25	Bell 212	Crashed during a Police training mission	Ban Nong Kok
20-May-25	B737-400	ATB. Depressurisation en-route.	Le Rozier
21-May-25	B737-500	ATB. Crew report of navigation system failure.	Moscow
20-May-25	B737-800	Diverted from FL340 when cracks developed in a cockpit side window	NE of Sarajevo
19-May-25	B737-900	Burst tyre on take-off, continued to destination.	Chicago-O'Hare
21-May-25	B777-300	Collided with an airbridge puncturing the fuselage.	Brisbane
21-May-25	B787-9	High speed RTO due Nosewheel problem. Tyre deflated due braking.	Hyderabad-Rajiv
18-May-25	C550	Taxiway excursion	Gatlinburg–Pigeon
22-May-25	C550	Descent below glide, crashed on approach	Montgomery-Gibbs
20-May-25	DA42	Three DA42 training aircraft destroyed by fire. Suspected arson.	Montpellier
19-May-25	BK117	Forced landing. The tail rotor and tail gear box can be seen to have separated. Air ambulance.	Williams
18-May-25	PC12	Lateral RWEXC, veered off runway 17R and suffered a nose gear collapse	Henderson
23-May-25	R44	Crashed in a field.	Willis N Clark
24-May-25	S100	ATB due to a problem with the landing gear retraction	Salekhard

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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	17th	EASA	Ground Handling Implementation Webinar	Online	NEW
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	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	23rd	EASA	Ground Handling Implementation Webinar	Online	NEW
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	Bombardier	29th Bombardier Safety Standdown	Wichita, Kansas	
2025	Nov	19th	RIN	4th Annual UK PNT Leadership Seminar	London	
2025	Dec	2nd	UKFSC	473rd SIE	TBC	
2025	Dec	2nd	EASA	Ground Handling Implementation Webinar	Online	NEW