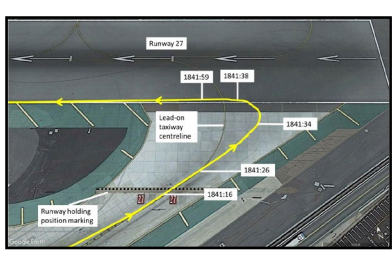




UK Flight Safety Committee

UKFSC News #31

03 July 2025



SKYBRARY

Misidentification of Centreline Lighting Leads to Runway Excursion



PANAMA AAC

Fokker 50 Runway Excursion



FSF

78th Annual International Aviation Safety Summit



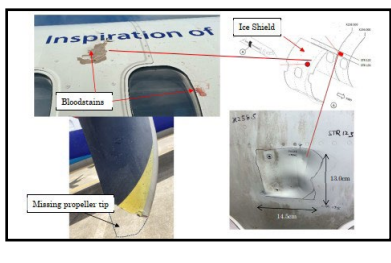
EASA WEBINAR

Summer Safety Finale - People Create Safety 14th July 2025



EASA

UPDATE 30/6/25: Conflict Zone Information Bulletins



JTSB

DHC 8 Bird Strike on Landing



PILOTS WHO ASK WHY

6 Techniques to Master Decision-Making When the Pressure's On



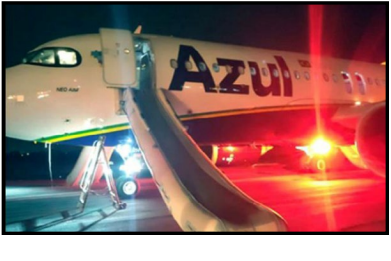
FAA SAIB

Helicopter Fuel Indicating Systems



CAA PUBLICATION

EASA Emergency Airworthiness Directive 2025-0136-E



CENIPA

A320 Uncommanded Evacuation



UKAB

Do You Plan for What-ifs?



NTSB

Lear Jet Fire & Loss of Control



CAA SKYWISE

Acceptance of ID for all Shared Services Centre Licensing Services



CAA SKYWISE

(A)Flying Display Director Training Courses 2025 - 2027



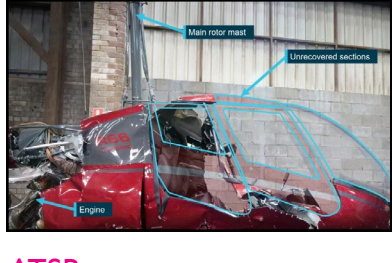
CAA SKYWISE

New Safety Sense Leaflet on Pilot Health and Performance



CENIPA

ATR 42 Electrical Failure & Gear Up Landing



ATSB

Robinson R66 Loss Of Control and In-Flight Break-Up



ICAO

ICAO Annex 6, Flight Data Analysis SARPS Changed



FSF

Recent Accidents from the Air Safety Network



UKFSC

Safety Conference Calendar

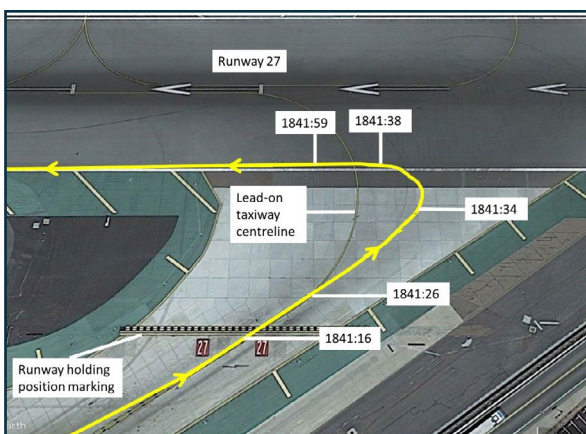
Contents

SKYBRARY

Misidentification of Centreline Lighting Leads to Runway Excursion

On 29 October 2021, an aircraft lined up and began a night takeoff at San Diego aligned with the left runway edge lights instead of the runway centreline damaging both edge lights and the aircraft wing and landing gear. The

Photo from the official report



pilots stated they had been unaware of their error until aircraft damage was found after landing despite returning to the runway after about a third of their takeoff roll. This apparent conflict between the crew statements and the evident aircraft realignment was not considered by the Investigation but subsequent minor modifications to related operator runway line-up procedure were noted.

[Learn More](#)

Related articles

[Runway Misalignment](#)

[Runway Excursion](#)

[Flight Crew Expectation Bias](#)



Images from the official report

PANAMA AAC

Fokker 50 Runway Excursion, 16th May 2025

The aircraft was scheduled to fly from Marcos A. Gelabert Airport (MPMG) to José Ezequiel Hall International Airport (MPBO) with 32 passengers and 3 crew, carrying fuel for 4 hours and an estimated flight time of 55 minutes. Departure was delayed by 3 hours due to adverse weather across the region. The First Officer was the pilot flying (PF), and the Captain was the pilot monitoring (PM).

The flight itself was uneventful until approach. At 4 nautical miles from the airport, the tower reported moderate rain, a wet runway, and electrical activity (CB) overhead. After touchdown on runway 27, the aircraft veered off to the right, entered a swamp, and came to a stop 720 meters from the runway threshold and 13 meters off the right edge. The flight crew initiated an evacuation following the excursion. The Report made six recommendations:

1. Reinforce flight crews' understanding of medication policies by distributing relevant guidance from the Operations Manual, Part A.
2. Integrate the Civil Aeronautical Authority's Medication Reference Guide into Human Factors in Aviation (CRM) training.
3. Improve cabin crew knowledge of emergency evacuations, including hazard lights and command distinctions like "evacuate" vs. "remain seated."
4. Allocate dedicated time before each flight for cabin crew to review emergency procedures, ideally with pilot participation.
5. Increase state funding to improve lighting and signage maintenance at José Ezequiel Hall Airport.
6. Add aiming point markings and install approach lights (PAPI or VASI) on runways 27 and 09 to support safer landings.

[Preliminary Report in Spanish](#)

FLIGHT SAFETY FOUNDATION

78th Annual International Aviation Safety Summit

Culture. Collaboration. Capability:
Building the Foundations for the Next
Generation of Aviation Safety

Tues, 4 Nov 25 - Thurs, 6 Nov 25

Early bird rates end 1st September.

[Registration Open](#)

EASA WEBINAR

Summer Safety Finale - People Create Safety 14th July 2025

For the finale of the Summer Safety series we will explore the crucial role of front line staff in delivering operational safety every day.

12.15 -13.15 CET 14/07/25

[Registration](#)

EASA

Conflict Zone Information Bulletins (CZIBs)

Airspace of the Middle East (Iran, Iraq, Israel, Jordan and Lebanon)

UPDATED 30/06/25

[CZIBS](#)



Contents

JAPAN TRANSPORT SAFETY BOARD

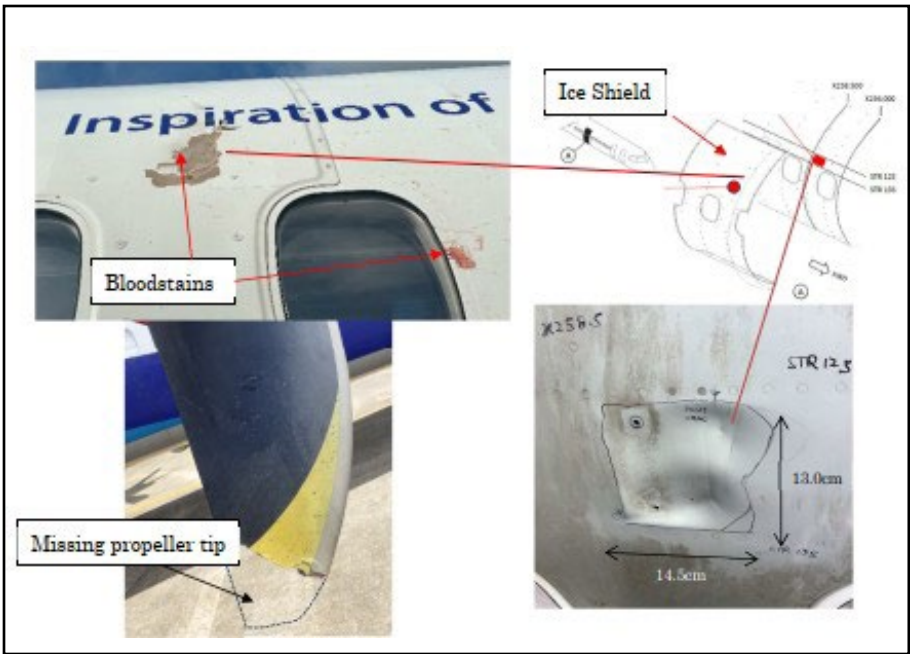
DHC 8 Bird Strike on Landing

On Saturday, July 20, 2024, the aircraft sustained damage due to bird strike while landing at Tsushima Airport on a scheduled Flight ORC79. There were 40 people on board, consisting of captain (PIC), three other crew members and 36 passengers. No one was injured.

The aircraft landed on Runway 32 of Tsushima Airport, during its landing roll, near Taxiway T-2, a bird at the right of the runway took off. The Captain and the FO noticed but before they could react, the bird struck the right propeller. The aircraft airspeed was about 75 kt.

Extent of Damage: Substantial (required major repair)

- A dent on the right fuselage 14.5cm wide, 13.0cm long and 0.5cm depth between stringers 12S and 13S.
- Damage including cracks on the ice shield which covers the dent described above.
- 8cm missing from the right propeller of Blade #2 tip.



There were bloodstains on the ice shield and right propeller #2 blade.

The bird was a black kite, about 40cm in length, weighing about 1kg. The JTSB concludes that it is certain that the bird struck the right propeller during the landing roll and the bird was accelerated by the propeller rotation into the fuselage.

[JTSB Report](#)



Image from Pilotswhoaskwhy.com

PILOTS WHO ASK WHY

6 Techniques to Master Decision-Making When the Pressure's On

There are countless moments in a pilot's career when the pressure's on, there's no checklist, and the pilot next to you doesn't have the answer.

It's on you. Time to decide.

Some of the HEMS captains I've flown with had been flying longer than I'd even been alive, and what blew me away was how they made decision-making under pressure look completely effortless.

Over the years, I've made it a mission to figure out how exactly, and I've boiled their approach down into six key techniques I now rely on every day in high pressure situations.

Making the right decision when the deck is stacked against you is easier said than done. And let's be honest: most pilot training (at least here in the UK) barely touches it.

[Read more.](#)

FAA SPECIAL AIRWORTHINESS INFORMATION BULLETIN

Helicopter Fuel Indicating Systems

The National Transportation Safety Board (NTSB) reviewed five accidents involving helicopters that were conducting sideward-pulling Class C RLC operations. The NTSB investigation determined that helicopters are particularly susceptible to unporting fuel tank pick-up ports when at high bank attitudes while dragging their loads. The NTSB investigation also determined that fuel unporting leading to fuel starvation and engine shutdown can occur at usable fuel quantity indications. The SAIB contains mitigation recommendations.

[SAIB 2025-05](#)

CAA PUBLICATION

EASA Emergency Airworthiness Directive 2025-0136-E

M&D Flugzeugbau JS-MD 3 RES powered sailplanes: Powerplant – Retractable Electric Propulsion System – Operation Prohibition / Sailplane Operation Restriction

Failures of the of the Retractable Electric System (RES) electrical propulsion system. If not corrected, could lead to failure of the RES during self-launch operation or sustained flight, including impossibility to retract the and stop windmilling, impacting sailplane gliding performance. [View EASA EAD 2025-0136-E](#)



Contents



Image from the official report

BRAZIL CENIPA

A320 Uncommanded Evacuation

During the takeoff roll, the pilots performed a low-energy rejected takeoff due to low-level indication in the yellow hydraulic system. Shortly after the rejected takeoff, a disturbance began on board, initiated by some passengers who believed there was fire outside the aircraft. The flight attendants reported that the pilots’ communication via PA instructing to “await instructions” was not understood. After the complete stop on the runway, the aircraft was evacuated without command from the pilots, and with the engines still running at idle. The PIC was unable to contact the flight attendants via interphone due to the disturbance in the passenger cabin.

Contributing Factors:

- Miscommunication between the cockpit and cabin crew—exacerbated by limited understanding among flight attendants and passengers.
- Failures and/or confusion in communication and non-compliance with operational procedures.
- Poor interaction and coordination among the flight

crew and cabin crew, including within the cabin team.

- The routine nature of operations may have dulled the crew’s situational awareness, limiting their ability to assess and respond to the unfolding scenario.
- The crew’s judgment was impaired by a misreading of the aircraft’s condition and the uncontrolled panic in the cabin, leading to poor decisions.

There were two recommendations: 1) Disseminate the lessons learned from this investigation to air transport companies, emphasizing the importance of cabin coordination and efficient, standardized communication between pilots and flight attendants, and, 2) Disseminate the lessons learned from this investigation to the Brazilian Commercial Aviation Safety Team (BCAST).

The operator included the scenario in their training programme, emphasising, evacuation based on evidence; situational awareness; the importance of communication between the pilot and passenger cabins; and the application of ‘command voices’. [CENIPA Report](#)



UK AIRPROX BOARD

Do You Plan For What-Ifs?

After highlighting in last month’s Insight considerations to reduce the likelihood of an Airprox in the circuit, I thought it would be useful to expand on that this month by looking at some of the situations the Airprox Board sees just outside — or sometimes inadvertently inside! — the circuit.

For example, at least three events that occurred either near to the ATZ boundary or, where there was no ATZ, within two miles of the aerodrome, were discussed at the Board’s recent May meeting.

[AIRPROX Insight May 2025](#)



Contents



By Yay Images Stock.Adobe.com

NTSB

Lear Jet Fire & Loss of Control

The accident airplane took off as the lead airplane in formation with a second Lear Jet airplane flying as wingman in a close formation position. The purpose of the flight was to participate in an exercise with the United States Navy in an over-water training area.

Shortly after entering the training area at 15,000 ft mean sea level (msl) the wingman positioned on the right side of the accident airplane, observed the flaps on the accident airplane were partially extended. They notified the pilot of the accident airplane who acknowledged the radio call. The wingman then observed the flaps retract and observed white or gray colored “smoke or gas” coming from the left aft side of the airplane. The pilot in the accident airplane then radioed that they detected an odor in the cabin. Seconds later, the wingman observed red fluid on the underside of the tail cone followed by flames coming from around the aft equipment bay (tail cone) access door. They informed the accident pilots that their airplane was on fire and the accident pilot declared an emergency along with their intentions to land at a nearby airfield on the island.

The wingman took over leading the formation and maneuvered in front of the accident airplane. The wingman last observed and heard radio transmissions from the accident airplane a short time later as they descended through about 7000 ft msl. The flight was above an overcast cloud layer that obstructed the view of the island at that time.

Recorded ADS-B data showed that the accident airplane subsequently made a series of descending turns before the data ended.

The National Transportation Safety Board determines the probable cause(s) of this accident to be:

The pilots’ loss of airplane control following a catastrophic fire that started on the left side of the aft equipment bay (tail cone). The fire likely initiated from a leak from the left fuel motive flow line due to a b-nut that loosened for reasons that could not be determined based on available evidence.

NTSB Report

CAA SKYWISE

Acceptance of ID for all Shared Services Centre Licensing Services

Where photographic ID is required for requests for examinations, the grant of medical certificates and licences, ratings and certificates for those involved in air traffic services, engineering and flight crew duties the CAA only accepts a 1) Valid passport, or 2) Valid UK photo driving licence.

Exam candidates are required to bring the same ID they registered with on the portal to the exam for verification.

If a candidate to change their ID, this must be done at least 7 days prior to the exam.

Requests to change ID outside this time frame may not be accepted and the candidate turned away on the exam day if their ID does not match the ID they registered with.

SW2025/I64

CAA SKYWISE

(A)Flying Display Director Training Courses 2025 - 2027

Places available on the forthcoming AFDD, FDD initial and FDD revalidation courses:

FDD revalidation course: 02 December 2025, 01 December 2026 and 30 Nov 2027

AFDD Course: 03 December 2025, 02 December 2026 and 01 December 2027

FDD initial courses: 03-04 December 2025, 02-03 December 2026 and 01-02 Dec 2027

Course venue: Defence Academy Shrivenham

Further details and registration are available at [UK Flying Display Director Accreditation Course | CAA/MAA Accreditation for Flying Display Directors](#)

SW2025/I55

CAA SKYWISE

New Safety Sense Leaflet on Pilot Health and Performance

The CAA has released a new Safety Sense Leaflet on [Pilot Health and Performance](#), including the considerations pilots must make before flight.

Including guidance on health risks associated with flying and how to stay healthy as a pilot.

SSL24 Pilot Health & Performance

SW2025/I65



Contents



Photos from the official accident report

CENIPA BRASIL

ATR 42 Electrical Failure & Gear Up Landing, 15th June 2019

On 23rd June CENIPA published the final report on this accident. Shortly after takeoff from SBEG, an electrical failure occurred, and the aircraft returned to the airport of departure, where it landed with the landing gear retracted. Emergency evacuation was carried out through the rear main door. The aircraft sustained substantial damage.

A failure in DC BUS 2 led to the loss of several flight instruments and systems, including the pitch trim control and autopilot, making manual flight difficult.

The hydraulic cross-feed valve (X FEED) was not activated, preventing normal landing gear extension.

The secondary landing gear indicator was also inoperative, so no alert was triggered for gear-up landing.

The crew made a rushed decision to return to the departure airport (SBEG) within 55 seconds of the failure, without fully diagnosing the issue or consulting the **Quick Reference Handbook (QRH).

Standard Operating Procedures (SOPs) requiring role reassignment during abnormal situations were not followed; the PIC remained as Pilot Flying throughout.

Communication between pilots was minimal and lacked depth, leading to low situational awareness and cognitive fixation on returning to base.

The Before-Landing Checklist was performed superficially, with automatic callouts suggesting the landing gear was down, despite no actual verification.

The PIC had a history of difficulty with manual flying and limited systems knowledge, and had only minimally passed emergency training.

These factors likely contributed to anxiety, poor judgment, and failure to follow procedures.

Maintenance was performed by a different company within

the same economic group, with unclear boundaries of responsibility and oversight.

The aircraft showed advanced corrosion, and a non-operational Starter-Generator may have caused the DC BUS 2 failure.

These issues suggest deficiencies in maintenance supervision and non-compliance with the airline’s Maintenance Program.

The airline was undergoing a management transition, leading to informal communication, uncertainty, and psychological stress among staff. This environment may have impaired operational performance and compromised safety.

Recommendations

ANAC should ensure the airline delivers a full CRM program to all flight crew, emphasising abnormal situations.

ANAC should conduct a follow-up inspection to verify the quality and completeness of CRM training.

Pilots should receive updated training on ATR-42 and ATR-72 electrical systems, focusing on understanding which equipment is affected by failures in each bus.

Ensure all maintenance services align with Operating Specifications, General Maintenance Manual, and approved Maintenance Program.

The Maintenance Program must meet manufacturer standards, especially regarding corrosion prevention.

Verify that all aircraft in the fleet meet airworthiness standards, particularly in light of corrosion issues identified in the accident aircraft.

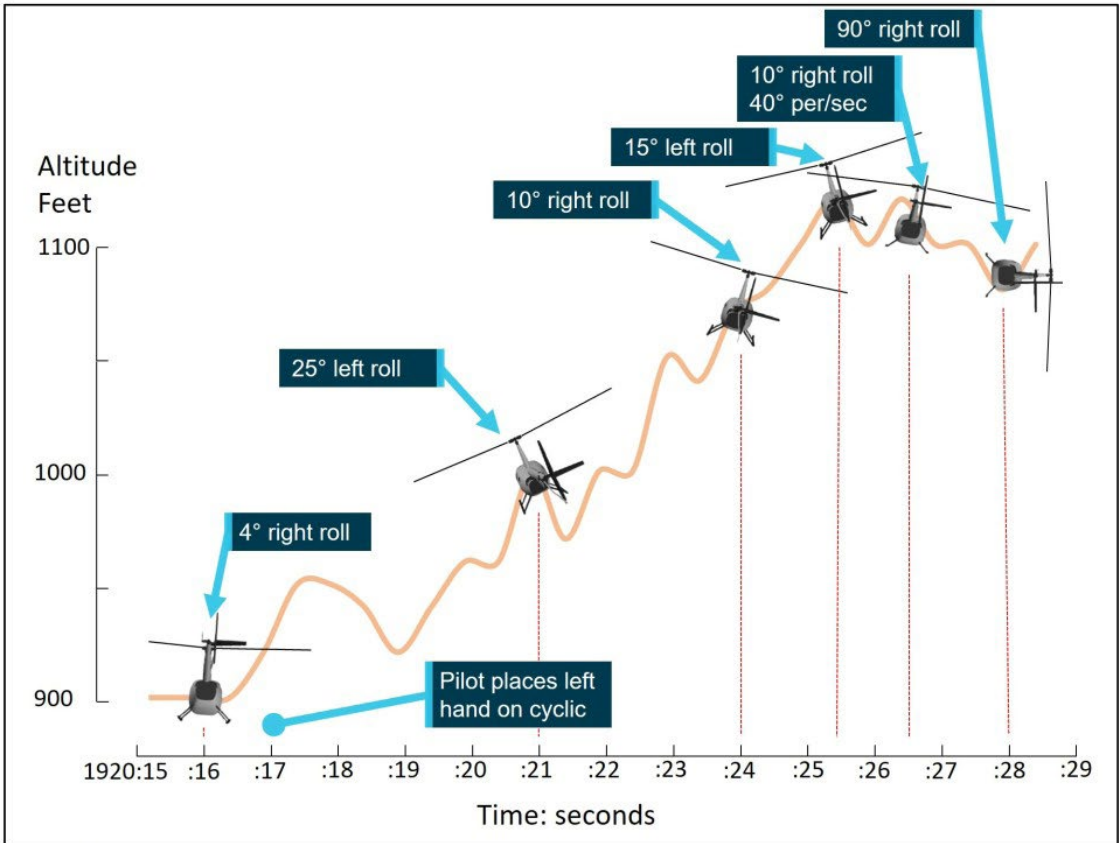
The airline should enhance internal communication to stabilize the organizational climate and keep employees informed about administrative and operational changes.

[CENIPA Report](#)



Contents

Figure 2: Aircraft attitude and altitude timeline



Source: ATSB

Image from the official report

AUSTRALIAN TRANSPORT SAFETY BUREAU

Robinson R66 Loss Of Control and In-Flight Break-Up

On 26 October 2023, a Robinson R66 helicopter (VH-KFT) departed Cessnock Airport, NSW, and flew north along the Williamtown coastal VFR route. At approximately 0920 local time, while crossing Yacaaba Headland at 900 ft and 115 kt, the helicopter experienced an in-flight break-up and crashed into Providence Bay, fatally injuring the pilot.

The ATSB investigation found that the helicopter entered a low-G condition due to turbulence and the pilot’s response, leading to an uncommanded right roll. The aircraft was flying above the manufacturer’s recommended turbulence airspeed, which increased the roll rate and reduced the pilot’s reaction time. The pilot was also flying with the left hand while the right was occupied, limiting effective control input.

Critically, aft cyclic was not applied to reload the main rotor, and progressively increasing left cyclic was also applied during the right roll, increasing the risk of an extreme teetering event. The helicopter’s asymmetric horizontal stabiliser design (common to R22, R44, and R66 models) significantly contributed to the severity of the roll in low-G conditions.

The pilot’s operating handbook lacked warnings about turbulence-induced low-G and did not provide guidance on appropriate control responses. The ATSB highlighted that the in-flight break-up occurred just 3.5 seconds after entering the low-G condition.

As a result, Robinson Helicopter Company has developed a symmetrical horizontal stabiliser, now standard on new helicopters and available as a retrofit. The company is also updating safety notices to better inform pilots about low-G risks and turbulence.

The ATSB urges pilots to avoid turbulence when possible, reduce airspeed in such conditions, and apply gentle aft cyclic immediately if low-G is encountered. The symmetrical stabiliser significantly improves recovery time and is strongly recommended for all Robinson helicopters. [ATSB Report](#)

ICAO

ICAO Annex 6 Part I Flight Data Analysis SARPS Changed

3.3.1 Recommendation.— The operator of an aeroplane of a certificated take-off mass in excess of ~~20 000~~ 15 000 kg should establish and maintain a flight data analysis programme as part of its safety management system.

- 3.3.2 All aeroplanes of a certificated take-off mass in excess of:
- a) 27 000 kg; or
 - b) 15 000 kg with a passenger seating capacity greater than 19, and with a certificate of airworthiness first issued on or after 1 January 2027 shall be equipped with a means to support a flight data analysis programme.

3.3.3 The operator of an aeroplane equipped as described in 3.3.2 shall establish and maintain a flight data analysis programme as part of its safety management system.



Contents

Recent Accidents & Incidents from the Air Safety Network Wikibase

Date	Type	Event	Location
26-Jun-25	A320	Diverted due to suspicious vibrations and a smell in the cabin	Ivanovo
29-Jun-25	A320	ATB, suspected engine surges	Zamboanga
27-Jun-25	A321	GCOL. While taxiing the right-hand wing of a B787 sliced through the rudder of a stationary A321.	Hanoi
27-Jun-25	A330-200	RTO, due to a bird strike during the take-off roll.	Karachi
28-Jun-25	AS350B	Crashed under unknown circumstances, rolled over and caught fire	Oberaletsch Glacier
25-Jun-25	AS350B	The helicopter was involved in a hard landing.	San Luis, AZ
30-Jun-25	B737-700	ATB due to a loss of pressurization.	South Atlantic
25-Jun-25	B737-700	On approach right hand passenger window abeam seat row 9 developed a crack. Bird strike reported.	Santa Cruz
27-Jun-25	B737-800	Diverted to Nanjing due to engine vibrations & burning smell.	Nanjing
27-Jun-25	B737-800	GCOL, the left-hand winglet of a B737-800 was severed after it sliced into the right-hand elevator of the Nordstar 737.	Adler/Sochi
28-Jun-25	B737-800	Diverted due engine problems while en-route	Bari
27-Jun-25	B737-800	GCOL, Right hand elevator struck by the left-hand winglet of a 737.	Adler/Sochi
30-Jun-25	B737-800	Diverted. Declared an emergency descended from 38650 feet to 10000 feet.	Kumamoto
27-Jun-25	B737-800	ATB, engine problems shortly after take-off, bird strike evidence found.	Dhaka
27-Jun-25	B787-9	GCOL. The right-hand wing of the B787 contacted and sliced through the rudder of an A321.	Hanoi
26-Jun-25	B787-9	Loss of cabin pressure while en-route over the Arabian Sea. Emergency descent to FL100. Continued to destination	Arabian Sea
25-Jun-25	C750	RWEXC, landed long and overran runway.	Dayton
26-Jun-25	DHC 8	ATB, a problem with one of the engines & smoke in the cabin after departure.	Bodø
29-Jun-25	ERJ170	GCOL, substantial damage when struck by a LSG Sky Chefs minivan while parked	Boston
27-Jun-25	Mi-8P	Bird strike (engine ingestion) and made an emergency landing in a field	Tver region
29-Jun-25	R44	The aircraft rolled over on landing.	Knik River
30-Jun-25	Yak-40	ATB due to a short-term increase in the temperature of the exhaust gases.	Vologda



Contents

Safety Conference Calendar

Year	Month	Day(s)	Org	Event	Location	Notes
2025	Jun	5 th – 6 th	FSF	Safety Forum 2025 - People at the Centre	Eurocontrol, BRU	
2025	Jun	10 th - 12 th	EASA	EASA-FAA International Aviation Safety Conference	Cologne	On site
2025	Jun	17 th	EASA	Ground Handling Implementation Webinar	Online	
2025	Jun	24 th	EURO-CONTROL	Understanding culture and conversation	Webinar 1430-1630 CET	
2025	Jun	25 th - 26 th	EASA	Part-IS Implementation Workshop	Cologne	Hybrid
2025	Jun	24 th	UKFSC	471 st SIE	Dublin	
2025	Jul	7 th - 9 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	
2025	Sep	15 th – 17 th	UKFSC	FSO Course	Gatwick	
2025	Sep	17 th - 18 th	Acron	Acron Aviation Customer Safety Seminar	MBW, Weybridge	
2025	Sep	23 rd	EASA	Ground Handling Implementation Webinar	Online	
2025	Sep	23 rd -24 th	EURO-CONTROL	Just Culture Conference	Ljubljana	
2025	Sep/Oct	29 th – 4 th	ISASI	ISASI 2025 - Soaring to New Heights: A World of Innovation	Denver, Colorado	
2025	Sep/Oct	30 th - 1 st	EASA	SAFE 360° Safety in Aviation Forum Europe	Cologne	
2025	Oct	6 th – 7 th	SAE	Defence Aviation Safety Conference	London	
2025	Oct	14 th	EURO-CONTROL	Advancing Safety Management through pro-active weak signal detection	Webinar 1400-1530 CET	
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	29 th Bombardier Safety Standdown	Wichita, Kansas	
2025	Nov	19 th	RIN	4th Annual UK PNT Leadership Seminar	London	
2025	Dec	2 nd	UKFSC	473 rd SIE	TBC	
2025	Dec	2 nd	EASA	Ground Handling Implementation Webinar	Online	