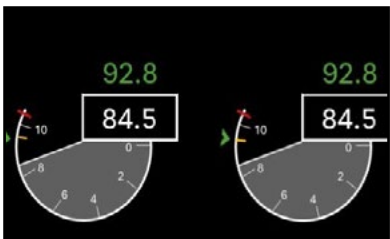




UK Flight Safety Committee

UKFSC News #27

03 June 2025



SKYBRARY

Check that Intended Thrust is Achieved



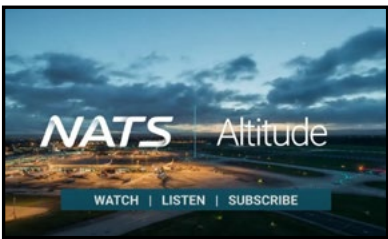
TAIC NZ

B777 Runway Excursion



EASA SIB

Risks of Lithium Batteries



NATS ALTITUDE 42

Heathrow, Drones and Digital Towers



CAA YOUTUBE VIDEO

Incorrect Altimeter Setting Risk



SWISS HELICOPTER ASSOC.

Mountain Flying Handbook



EASA SIB

RNP - VPT = Safer Circling



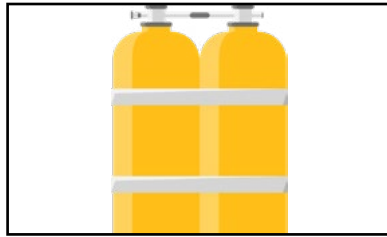
BEA

Dual Inputs on Conventional flight Controls



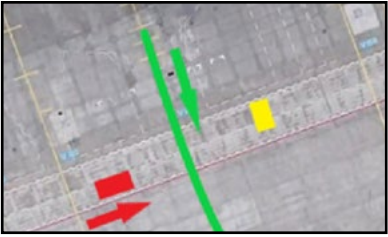
ATSB

B737 Turbulence & Cabin Crew Injury



EASA SIB

Use of PBE



BFU

B757 Hard Braking Cabin Crew Severely Injured



PILOTS WHO ASK WHY

AW139 Crew Complete Loss of Collective



NTSB

HA421 Runway Excursion



CHIRP

CHIRP GA FEEDBACK 104



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SKYBRARY

Check that Intended Thrust is Achieved

On 4 March 2024, an aircraft departing Bristol took longer than expected to become airborne and passed over the end of the runway at approximately 10 feet. It was then initially unable to climb at a speed much above V2 until it was recognised that the thrust set was significantly below that intended.

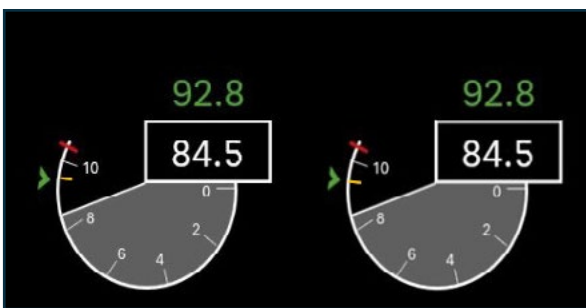


Photo by Jarod Barton: <https://www.pexels.com/>

TRANSPORT ACCIDENT INVESTIGATION COMMISSION NEW ZEALAND

B777 Runway Excursion

What Happened: As the aeroplane approached Auckland, heavy rain was encountered and the wind changed in direction and strength. Nearing the runway the aircraft began to drift right of the centreline, veering off the runway after touchdown, striking six runway edge lights before returning to the centreline. Five tyres were damaged and one of these had deflated.

Why it Happened: The heavy rain likely contributed to the decision to disengage the autopilot low. The late disengagement and the flying technique, resulted in insufficient time to correct the flightpath before landing. The PF was therefore unable to prevent the drift. The briefing did not meet the operator's guidelines.

What We Can Learn: Knowledge and understanding of operator and aircraft manuals and procedures complemented by recurrent training helps mitigate the risk of an adverse outcome. It is important that crews act in a cohesive manner and are as prepared as possible for any unforeseen eventualities.

Key lessons:

Being familiar with operator and aircraft manuals and procedures and adhering to these documents is essential for a safe operation.

A briefing is a core element of CRM and ensures a crew has a clear, unified understanding of what is intended for managing the risks and a safe outcome.

There were no recommendations because the operator instigated safety actions: including the event in evidence based training, adding lateral deviations to FOQA, allowing briefings flexibility to include threats, training for autopilot disengagement in crosswinds and an article in their safety publication reinforcing expectations for the prevention and recovery from an unstable approach or undesired aircraft state. Details in the [ATSB Report here](#).

The NI display as it would have looked for most of the takeoff without being noticed. [Reproduced from the Official Report]

Despite the flight being used for new Captain line training, a check at 80 knots that correct thrust was set did not occur and the fact that the autothrottle had not been successfully re-engaged after it dropped out when takeoff thrust was being set went unrecognised.

[Learn More](#)

Related articles

[Autothrottle/Autothrust](#)

[Use of Erroneous Parameters at Takeoff](#)

[Reduced Thrust Takeoff](#)

EASA SIB 2025-03

Passenger and Crew Awareness on the Risks of Lithium Batteries

For passenger aircraft operators, aerodrome operators and ground handling service providers on actions that should be taken to make passengers aware of the restrictions and conditions applicable to carriage.

[SIB 2025-03](#)

NATS ALTITUDE

NATS Altitude 42: Heathrow, Drones and Digital Towers

Bitesize Interviews at Airspace World. Discussing runway efficiency, drone integration, data integration and airport technology convergence.

[NATS Altitude 42](#)

CAA

The Risk Of Incorrect Altimeter Settings

A short video on how to look out for a wrong altimeter setting.

[CAA YouTube Video](#)



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Image By edb3_16 Stock.adobe.com



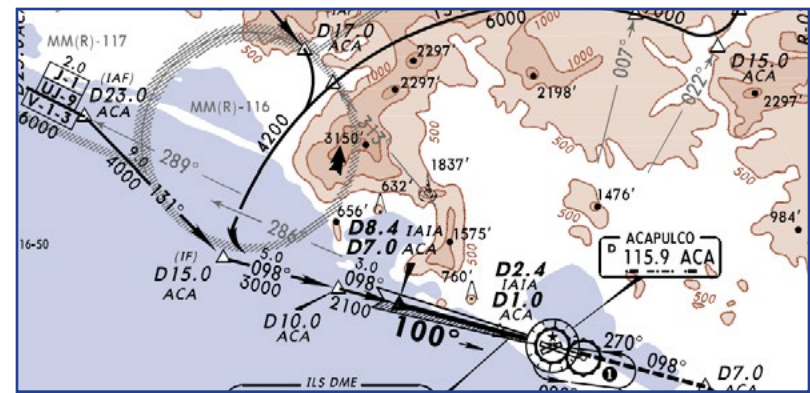
SWISS HELICOPTER ASSOCIATION (SHA)

The SHA’s Mountain Flying Handbook

The Swiss Helicopter Association’s Mountain Flying Handbook is game-changing resource that could significantly elevate the safety and training of mountain helicopter operations.

“Nowhere else demands as much of man and machine as the mountains. The interplay of technology and nature in almost perfect harmony makes the impossible possible.” - Simon Wittinger, SHA

SHA’s Mountain Flying Handbook.



EASA
Development and Usage of Procedures for Visual Manoeuvring with Prescribed Tracks Relying on Required Navigation Performance

Traditional visual manoeuvring procedures, particularly circling approaches, require pilots to rely heavily on visual cues. This can be challenging in adverse weather conditions, near complex terrain, or when the flight crew is not familiar with the aerodrome environment and noise-sensitive areas.

The visual segment of a Required Navigation Performance (RNP) Visual manoeuvre with Prescribed Track (VPT) is a visual procedure that allows for more structured and precise visual manoeuvring, whereby the Flight Management System provides horizontal and vertical guidance to be followed during the approach.

Thus, it reduces pilot workload and enhances safety and the predictability during visual manoeuvring – provided it is properly designed and coded in the aircraft navigation database, and crews are trained appropriately. However, risks are also existing and need to be properly assessed and effectively mitigated.

SIB 2025-05



BEA Photo by Terrence Bowen: <https://www.pexels.com>

Dual Inputs: An Underestimated Phenomenon on Aeroplanes with Conventional Flight Controls

Dual inputs, or simultaneous inputs, are when both pilots perform simultaneous, sometimes opposing, actions on the flight controls. For a long time, this phenomenon was considered to be specific to aeroplanes with side-sticks. On these aeroplanes, both the difficulty of visually perceiving the action of the other pilot and the absence of force feedback in the side-stick led to the provision of an aural and visual warning indicating dual inputs by both pilots. In a 2006 analysis, Airbus identified 3 types of dual inputs:

- “Spurious” actions, the consequences of which are generally marginal, of limited duration and amplitude.
- “Comfort” actions, consisting of brief interventions to modify the aeroplane’s flight path. These actions generally have a minor impact on flight safety, unless the PF, surprised by the aeroplane’s behaviour and unaware of the reason for it, tries to counter the PM’s actions.
- “Instinctive” actions in response to an unexpected event. Airbus observed that these actions were more significant in terms of deflection and duration.

A number of occurrences show that the phenomenon of dual inputs exists on aeroplanes with conventional flight controls, and the consequences can be significant.

BEA Report



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Image from the official report

ATSB

B737 Turbulence Event and Cabin Crew Injury

What Happened

In the latter stages of descent, after passing 11,400 ft the aircraft experienced unanticipated severe turbulence. Three cabin crew suffered injuries during the occurrence. Two minor injuries, including a facial injury and concussion, whilst the third was seriously injured with a fractured ankle.

What the ATSB Found

The ATSB found that the captain did not inform the cabin crew about the expected turbulence during descent, likely due to not being aware of its severity. This resulted in 3 unrestrained cabin crew.

Following the turbulence, the captain instructed all passengers and crew to return to their seats and fasten seatbelts. However, 2 cabin crew and 2 passengers remained unrestrained in the rear galley to assist the seriously injured crew member during landing. When the flight crew were informed of this, the captain repeated the instruction that everyone besides the injured crew member was to return to their seats for landing.

Assuming the cabin would be secured after the repeated instruction, the flight crew proceeded with the landing, unaware that 4 crew and passengers remained unrestrained. This could have hindered any post landing evacuation. Qantas 737 standard operating procedures relied on the customer service manager to inform the flight crew if the cabin crew had not secured the cabin for landing.

A crew member who had sustained a concussion returned to work without medical treatment. The ATSB found that the operator did not have a procedure to ensure that crew were assessed for fitness for duty after a significant injury.

What Has Been Done As A Result

Qantas has updated the integrated operation control procedures for requesting medical assistance for cases where any crew member or passenger is significantly injured.

Updated protocols now mandate that a doctor will immediately be required to assess the fitness of cabin crew members prior to commencing work-related duties.

Additionally, the operator will arrange immediate medical assessment following any turbulence classified as moderate or severe with injuries or unrestrained crew.

Safety message

Effective coordination and communication among all crew members is critical in managing turbulence and ensuring cabin safety. This coordination should extend beyond pre-flight briefings to include continuous communication in-flight.

Collaboration between the flight and cabin crew helps ensure the timely completion of service-related tasks while minimising the risk of injury during turbulence.

Flight crew rely on clear and timely communication from the cabin crew to maintain awareness of the condition in the cabin. When there is a different understanding of the state of the cabin, there is an increased risk.

Aircraft are more likely to experience the effects of weather and wake turbulence during the descent, approach, and landing. Crew communication will enhance cabin safety and minimise the risk of injury to passengers and crew.

In the report, the ‘Safety Analysis’, ‘Findings’ and ‘Safety issues and Actions’ sections of the report contain additional detailed safety learnings from this event. [ATSB Final Report](#)

EASA SIB

Use of Protective Breathing Equipment

This SIB is published to raise awareness that proper information shall be provided on how and when the PBE can be retrieved, unpacked, donned, activated and removed. It should include information on leaving the area exposed to open flame and sparks to safe location to remove the PBE as, for example, some residual oxygen may remain in the hair and clothes of the crew member which could pose a risk of injury to the cabin crew member concerned.

SIB 2025-04



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BFU Red: Luggage Car. Yellow: Follow-me Car. Green: Aircraft. Image from BFU report.

B757 Cabin Crew Severely Injured During Hard Braking

The taxi area road south of the parking position was blocked off by a Follow-me vehicle. The taxi clearance, from Frankfurt Ground was left turn, November eight, hold short November. Low Visibility Operations in force.

The CVR show that the flight crew checked the taxiway to the right and left before moving. Then the co-pilot can be heard repeatedly asking someone is coming, does he stop? Within 12s, the aircraft accelerated to 5 kt and was then brought to a stop within 2s.

During the braking, one flight attendant fell in the cabin. She had been busy with the seatbelt check as the aircraft suddenly braked hard. She had felt two braking actions. During the first, she had lost her balance and tried to support herself. The second braking action was even sharper and she fell against the back of the last row of seats in front of toilet four. She had come to rest on her left in the aircraft aisle, her head pointing towards the cockpit, completely immobile. She received first aid in the aircraft and was then transported to hospital by helicopter.

The driver of the vehicle, who had approached from the right, said to the BFU that he was collecting two luggage wagons.

He had noticed the cordoning-off Follow-me vehicle and then the taxiing aircraft and stopped immediately. Initially, the aircraft had continued to taxi but then stopped. He was abeam the luggage wagons. There was no definite stop position or stop line. He had stopped late, because he had been distracted by the search for the luggage wagons.

The driver of the Follow-me vehicle had positioned himself to the left of the taxi direction of the B757. He had the aircraft and the road in view. The luggage car approached from the west and stopped. As the airplane began to taxi, it began to move again. The B757 braked to a stop. The driver of the luggage car then backed off a bit. At no time had the luggage car been in front of the aircraft nose.

Due to the braking of the aircraft, the flight attendant suffered a complete fracture of the first lumbar vertebra during the fall against the back of the seat.

On 14 December 2011, a similar accident occurred at Berlin. A flight attendant suffered severe injuries after she fell due to sudden braking because a vehicle approached.

[BFU Report](#)

PILOTS WHO ASK WHY

How This AW139 Crew Dealt With Complete Loss of Collective Control



You're in the cruise, everything's stable. No warnings, no anomalies: just the hum of whatever normal sounds like. Then, out of nowhere, there's a burning smell, followed by a fire, smoke in the cockpit, and a collective that requires your full body weight to stay down, but the helicopter keeps climbing!

This wasn't a simulator drill. It was real, and none of this was triggered by pilot error...

In fact, it was pilot skill that got them out of it!

The crew didn't have a checklist for what they ended up dealing with, yet they managed to descend, land, and walk away

[Read More](#)



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Photo: Copyright North Bend Fire Department

NTSB

HA-420 Runway Excursion

On April 7, 2025, at 0606 Pacific daylight time, a Honda Aircraft Company HA-420, N826E, was substantially damaged when it was involved in an accident in North Bend, Oregon. The pilot and three passengers sustained minor injuries; one passenger sustained serious injuries.

On the day of the accident, the pilot reported a normal approach with a crosswind of nine knots and limited visibility due to early morning darkness. Although he didn’t observe standing water, he was aware of recent heavy rainfall. The airplane crossed the runway threshold around 117-118 knots, slightly above the VREF calculated speed of 113 knots, which he configured due to the crosswind. The airplane touched down on the runway surface at approximately 1,000 feet from the approach end near 113 knots, consistent with his typical procedures.

Initially, braking felt normal, and the pilot expected to exit at taxiway Bravo. However, midway down the runway, braking became ineffective without any cockpit warnings. Both the pilot and right-seat passenger applied maximum braking, but the aircraft failed to respond. As it neared the localizer antenna, the pilot veered right to avoid a collision. The aircraft exited the runway, traversed grass and mud, and descended a 15-foot embankment into shallow salt water. All occupants exited safely through the main door.

ADS-B data confirmed touchdown near the aiming point at 0606:14, with ground speed decreasing from 128 to 125 knots near taxiway Bravo. No skid marks or anti-skid activity were found on the runway. Light tire tracks were visible in the overrun area, with the left track 23 feet from the antenna structure. A visual examination of the runway surface revealed no evidence of skid marks or indications of the anti-skid braking system operating. Light tire tracks were observed on the overrun area and through the grass with no indication of braking.

The aircraft lacked thrust reversers or spoilers, though the speed brake was deployed. The airplane was not equipped with thrust reversers or spoilers. During landing, the speed brake was deployed; the emergency braking system was not used. The initial examination of the wheels and braking system revealed no evidence of failures, excessive wear, or malfunctions. The only notable difference from prior flights was a slightly higher touchdown speed.

NTSB Preliminary Report

CHIRP

CHIRP General Aviation FEEDBACK Edition 104

This May 2025 edition of [CHIRP General Aviation FEEDBACK](#) focuses on managing attention under pressure, emphasising both the benefits and risks of task fixation and distraction. Reports include accounts of a flap oversight during touch-and-go, near runway incursion and parachute malfunction, showcasing human factors like distraction, communication and decision-making. We have a thought-provoking “I learned about ...” tale of poltergeist instructors – do you know who’s actually flying your aircraft?! In order to bring you these key aviation safety insights we rely on your reports. Whatever the incident or experience, please share with CHIRP, in complete confidence, at [Report to CHIRP](#).

CHIRP General Aviation FEEDBACK

CAA SKYWISE

Jetstream 4100 – Suspension of TCAS II and Global GNS-XLS STCs

The UK CAA is issuing [UK.CN.00005](#) and [UK.CN.00006](#) Notification of STC suspension for the Jetstream 4100. This is as a result of the DOA(H) (Cranfield Aerospace Solutions Ltd) application to surrender STCs EASA.A.S.00186 EASA.A.S.01669.

The Effective Date of suspension is 29 May 2025.

SW2025/I21

CAA SKYWISE

Update of ANSP Compliance Matrices

The Compliance Matrices for UK Regulations (EU) 2017/373 and 376/2014 published on the CAA Website [ANSP Certification and designation page](#) have been reviewed. Some guidance notes have been updated and other minor changes made.

ANSPs should ensure that when maintaining their Compliance Matrices that the latest versions are used.

SW2025/I17

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Source: Photo Markus Mainka - stock.adobe.com

TRANSPORT SAFETY INVESTIGATION BUREAU OF SINGAPORE (TSIB)

Preliminary Investigation Findings Turbulence Incident Involving SQ321

The investigation team has compiled a chronology of events based on preliminary analysis of the data from FDR and CVR:

SQ321 departed London on 20 May 24 and the flight was normal prior to the turbulence event. At 07:49:21 hr (UTC) on 21 May 24, the aircraft was passing over the south of Myanmar at 37,000 ft and likely flying over an area of developing convective activity. The Gravitational force (G), recorded as vertical accelerations, fluctuated between positive (+ve) 0.44G and +ve 1.57G for a period of about 19 sec. (This would have caused the flight to begin to experience slight vibration).

Around the same time as the onset of the slight vibration, an uncommanded increase in aircraft altitude, reaching a peak of 37,362 ft, was recorded. In response to this uncommanded altitude increase, the autopilot pitched the aircraft downwards to descend back to the selected altitude of 37,000 ft. In addition, the pilots observed an uncommanded increase in airspeed which they arrested by extending the speed brakes. While managing the airspeed, at 07:49:32 hr, it was heard that a pilot called out that the fasten seat belt sign had been switched on.

This uncommanded increase in aircraft altitude and airspeed mentioned in (b) are most likely due to the aircraft being acted upon by an updraft (the upward movement of air). The autopilot was engaged during this period.

At 07:49:40 hr, the aircraft experienced a rapid change in G as recorded vertical acceleration decreased from +ve 1.35G to negative (-ve) 1.5G, within 0.6 sec. This likely resulted in the occupants who were not belted up to become airborne.

At 07:49:41 hr, the vertical acceleration changed from -ve 1.5G to +ve 1.5G within 4 sec. This likely resulted in the occupants who were airborne to fall back down.

The rapid changes in G over the 4.6 sec duration resulted in an altitude drop of 178 ft, from 37,362 ft to 37,184 ft. This sequence of events likely caused the injuries to the crew and passengers.

In the midst of the sequence of rapid changes in G, recorded data indicated that the pilots initiated control inputs to stabilise the aircraft, disengaging the autopilot in this process. The pilots manually controlled the aircraft for 21 sec and reengaged the autopilot at 07:50:05 hr.

The recorded vertical acceleration showed more gradual fluctuations over the next 24 sec, ranging from +ve 0.9G to +ve 1.1G, while the aircraft returned to 37,000 ft at 07:50:23 hr.

After the pilots were informed by the cabin crew that there were injured passengers in the cabin, the decision was made to divert to Suvarnabhumi Airport, Bangkok, Thailand. On the way to Bangkok, the pilots requested for medical services to meet the aircraft on arrival.

Approximately 17 minutes after the turbulence event, at 08:06:51 hr, the pilots initiated a normal, controlled descent from 37,000 ft and the aircraft reached 31,000 ft at 08:10:00 hr. The data showed that the aircraft did not encounter further severe turbulence during this diversion, and touched down in Suvarnabhumi Airport at 08:45:12 hr.

Investigations are ongoing.

[TSIB Preliminary Report](#)



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Photo by FAA from NTSB report

NTSB

Boeing 757-236 Failure To Extend Landing Gear Approaching Chattanooga Metropolitan

Shortly after take-off, the landing gear retracted normally. Within 22 seconds, hydraulic fluid quantity and pressure in the left system began to drop. The crew received a low hydraulic quantity warning and followed the Quick Reference Handbook (QRH) procedures.

Upon attempting to land, the gear failed to extend. The crew declared an emergency and tried the alternate gear extension system, which also failed.

The aircraft landed without extended gear, overran the runway, and struck localizer antennas. The left door jammed during evacuation, but the right door was forced open and the slide deployed. The doors jamming was attributed to non-compliance with an AD. All occupants evacuated safely and were uninjured.

A leak was found in the left landing gear door actuator hose. The hydraulic system was fully depleted shortly after take-off. After replacing the hose and refilling the system, the gear extended normally. The leak prevented sufficient pressure to unlock the gear doors, rendering both normal and alternate extension systems ineffective.

Crew Resource Management (CRM)

Hallmarks of good CRM include effective communication, strong leadership, assertiveness, adaptability to changing situations, open feedback loops, appropriate task allocation, situational awareness, stress management, and a culture of actively listening to all crew members’ opinions and concerns, allowing for diverse perspectives to be considered.

The crew demonstrated good CRM by remaining calm and professional throughout the accident sequence of events. They displayed effective workload management by distributing the tasks of handling the emergency amongst themselves to avoid overload and maintain optimal performance which, resulted in the captain flying and the FO working to resolve the issue with ATC.

The crew maintained clear and concise communication between all crew members to include a jump seat occupant, and with ATC, actively soliciting feedback and input, and cross-checking with one another to ensure everyone was working with the same mental model.

Once the crew realized the landing gear was inoperable, they methodically worked through the QRH, confirming each step out loud, and demonstrated flexibility by adjusting their plans and strategies based on changing circumstances.

The crew used all available resources and included some non-standard attempts at troubleshooting, such as pulling circuit breakers, while under the direction of FedEx maintenance staff. NTSB staff concedes there is some concern that troubleshooting attempts not previously established on any checklist could yield results that would be unknown to the flight crew, and those attempts should be limited as they can introduce additional risk to an already hazardous situation.

Probable Cause and Findings

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

The failure of the alternate gear extension system, which prevented the landing gear from being lowered. The cause of the system failure was a broken wire, due to tensile overload, between the alternate gear extend switch and the alternate extension power pack (AEPP), preventing the AEPP from energizing and supplying hydraulic fluid to the door lock release actuators for the nose landing gear and main landing gear. Contributing to the accident was the loss of the left hydraulic system due to a ruptured left main gear door actuator hose from fatigue, which prevented normal landing gear operation.

NTSB Report

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Recent Accidents & Incidents from the Air Safety Network Wikibase

Date	Type	Event	Location
31-May-25	A320	Descent to FL090 due to a pressurization issue. Squawked 7700.	Thailand
31-May-25	A320	Diverted after a power bank and a camera battery fire developed in an over-head luggage compartment.	Hangzhou
01-Jun-25	A320	Diverted due to an engine failure.	Talakan
26-May-25	A321	Diverted due to an engine failure.	Rotweil
26-May-25	AN24	On landing the nose landing gear collapsed, causing a runway excursion.	Kirensk
30-May-25	KING AIR	ATB & RWEXC. Tyre burst during take-off, during landing veered off runway.	Franca, SP
25-May-25	B737 MAX8	Lightning strike on approach at 11,000 feet. Subsequently ATC could not hear the aircraft, transmitted instructions blind, which the aircraft followed to landing.	Denver
27-May-25	B737-8	FL380 began to descend to FL100 most likely due to a depressurization. The aircraft briefly squawked 7700 then continued to destination.	Near Liepaja
28-May-25	B737-8	RWEXC briefly veered off the right of runway resulting in damaged tyres.	Da Nang
31-May-25	B737-8	Climbing through FL090 stopped the climb due to a likely loss of pressurization.	Dalry
27-May-25	B737-300	In descent struck by lightning damaging the left transponder and left spots of visible damage to the hull.	SE of Atlanta
28-May-25	B767-300	Landed on the wrong runway at Xian-Xianyang International Airport	Xian-Xianyang
26-May-25	B777-200	RTO. Engine failure during take-off multiple tires deflated.	Beijing
28-May-25	B787-9	Catering struck the rear fuselage of parked aircraft.	LHR
30-May-25	BD100	Diverted, climbing through FL380 when it declared an emergency and started a descent mostly likely due to a loss of pressurization.	Felt, OK
30-May-25	C525	Diverted, descent to FL100 due to a likely pressurization issue.	Orlando, FL
31-May-25	C550	Continued, ambulance flight descended to FL100 due to a likely pressurization issue.	Hesse
30-May-25	C560	ATB, engine fire climbing through 5,000 ft.	San Jose, CA
30-May-25	DA42	Crashed following an engine failure after take-off	Lesce-Bled
29-May-25	EMB505	RWEXC. The aircraft veered off runway 36 into the grass during landing.	Marshall
29-May-25	G650	Continued, cracked cockpit windshield en-route at FL350, descent to 9950 feet and declared an emergency.	Kagoshima
29-May-25	G-IV	Tyre burst while landing.	Roberts
31-May-25	KC130	Diverted, climbing through FL160 began descending to FL100 most likely due to a loss of pressurization.	Sabtang Island
27-May-25	PC12	Landed with the nose landing gear retracted	Lincoln



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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	10th - 12th	EASA	EASA-FAA International Aviation Safety Conference	Cologne	On site
2025	Jun	17th	EASA	Ground Handling Implementation Webinar	Online	
2025	Jun	24th	EURO-CONTROL	Understanding culture and conversation	Webinar 1430-1630 CET	NEW
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	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	17th - 18th	Acron	Acron Aviation Customer Safety Seminar	MBW, Weybridge	
2025	Sep	23rd	EASA	Ground Handling Implementation Webinar	Online	
2025	Sep/Oct	29 th – 4th	ISASI	ISASI 2025 - Soaring to New Heights: A World of Innovation	Denver, Colorado	
2025	Sep/Oct	30th - 1st	EASA	SAFE 360° Safety in Aviation Forum Europe	Cologne	
2025	Oct	6 th – 7 th	SAE	Defence Aviation Safety Conference	London	
2025	Oct	14th	EURO-CONTROL	Advancing Safety Management through pro-active weak signal detection	Webinar 1400-1530 CET	NEW
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	19th	RIN	4th Annual UK PNT Leadership Seminar	London	
2025	Dec	2 nd	UKFSC	473 rd SIE	TBC	
2025	Dec	2nd	EASA	Ground Handling Implementation Webinar	Online	