UK Flight Safety Committee

UKFSC News #32

15 July 2025

Tuesday 15 Jul, 2025

CONTENTS

Issue #32

SKYBRARY

Manual Pressurisation: Guidance for Flight Crews

AAIB INDIA

Air India B787 Crash after Take-off

EUROCONTROL

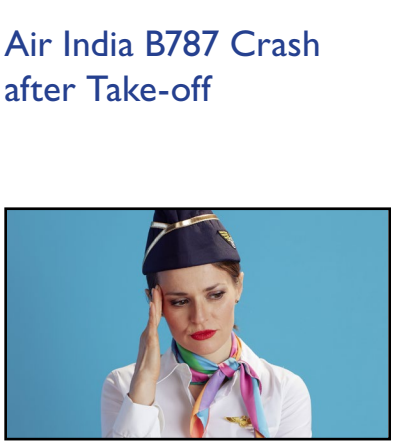
Human Factors Newsletter

CAA SAFETY FILES PODCAST

Lithium Batteries - Unpacking The Risks

CAA PUBLICATION

EASA EAD AS332 Emergency Sea Anchor Pin Inspection / Replacement



CHIRP

Cabin Crew Feedback 87, July 2025

AIRBUS SAFETY FIRST

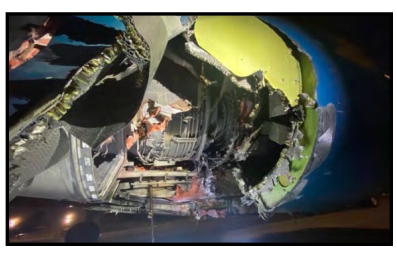
Lithium Battery Fire in the Cabin or in the Cockpit

EASA NPA

NPA 2025-01 Take-off Performance Parameters — Large Aeroplanes

AIRBUS

Statistical Analysis of Commercial Aviation Accidents 1958 - 2024



CAA VIETNAM

A321 Uncontained Engine Failure & RTO

NBAA

SMS for Small Operators: A Practical Guide

TONGA CAO

SAAB 340B Loss of Control During Taxi and Ground Collision

CAA SKYWISE

Dangerous Goods Occurrence Reporting System Launch

CAA SKYWISE

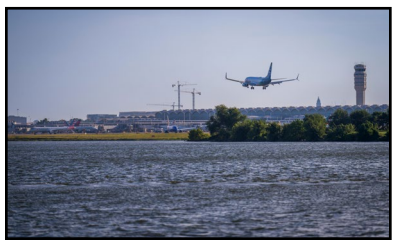
Revised CAA Standards Document 29 - HF Training

CAA SKYWISE

Operational Multi-Pilot Limitation Amendments

AAIB INDIA

Indigo ATR-72-600 Hard Bounced Landings



NTSB

Loss of Separation Incident, Washington DCA

CAA SKYWISE

Radio Operators Certificate of Competence (ROCC) Examiner Form

FSF

Recent Accidents from the Air Safety Network

UKFSC

Safety Conference Calendar

Tuesday 15 Jul, 2025

UKFSC NEWS

The latest news from the flight safety world

Issue #32

Contents

SKYBRARY

Manual Pressurisation: Guidance for Flight Crews

This article deals specifically with issues pertaining to manual control of an aircraft's pressurisation system, which is typically required by a non-normal checklist (NNC) for failure of the system's automatic control. For information on other types of

By Petr stock.adobe.com

pressurisation problems, such as rapid decompression, please see Pressurisation Problems: Guidance for Flight Crews.

Nothing herein supersedes aircraft-specific guidance in an aircraft flight manual (AFM).

Learn More

Startle Effect SkyClip

Short animation on Startle Effect

Image from the official report

AIRCRAFT ACCIDENT INVESTIGATION BUREAU INDIA

Air India B787 Crash after Take-off

As per the EAFR data, the aircraft crossed the take-off decision speed V1 and the Vr speed (155 kt) was achieved at 08:08:35 UTC. The aircraft air/ground sensors transitioned to air mode, consistent with liftoff at 08:08:39 UTC.

The aircraft achieved the maximum recorded airspeed of 180 Knots IAS at about 08:08:42 UTC and immediately thereafter, the Engine 1 and Engine 2 fuel cutoff switches transitioned from RUN to CUTOFF position one after another with a time gap of 01 sec. The Engine N1 and N2 began to decrease from their take-off values as the fuel supply to the engines was cut off.

In the cockpit voice recording, one of the pilots is heard asking the other why did he cutoff. The other pilot responded that he did not do so.

The CCTV footage obtained from the airport showed Ram Air Turbine (RAT) getting deployed during the initial climb immediately after lift-off (fig. 15). No significant bird activity is observed in the vicinity of the flight path. The aircraft started to lose altitude before crossing the airport perimeter wall.

As per the EAFR data both engines N2 values passed below minimum idle speed, and the RAT hydraulic pump began supplying hydraulic power.

As per the EAFR, the Engine 1 fuel cutoff switch transitioned from CUTOFF to RUN at about 08:08:52 UTC. The APU Inlet Door began opening at about 08:08:54 UTC, consistent with the APU Auto Start logic. Thereafter at 08:08:56 UTC the Engine 2 fuel cutoff switch also transitions from CUTOFF to RUN. The EGT was observed to be rising for both engines indicating relight. The EAFR recording stopped at 08:09:11 UTC.

The flaps were found set at 5 and the landing gear lever in the down position.

The report references FAA SAIB NM-18-33, 2018, regarding the potential disengagement of the fuel control switch locking on Boeing and MD aircraft.

Interim Report

EUROCONTROL

Human Factors Newsletter

The new EUROCONTROL Human Factors (HF) newsletter provides updates on EUROCONTROL's HF initiatives, details of recent conferences, upcoming events and training courses.

Read More

CAA SAFETY FILES PODCAST

Lithium Batteries - Unpacking The Risks

About the risks and safety guidance for staff at check-in, boarding gate, the ramp or in cargo. Staff at easyJet explain how they manage this risk across their network.

Listen here

CAA PUBLICATION

EASA EAD 2025-0146-E: Airbus Helicopters AS 332: Equipment / Furnishings – Emergency Sea Anchor Pin – Inspection / Replacement

EASA Emergency Airworthiness Directive.

View EASA EAD 2025-0146-E

Contents

CHIRP

Cabin Crew Feedback 87, July 2025

Fatigue – it's a shared responsibility for safer skies

Year on year since the COVID-19 pandemic, fatigue has consistently remained one of the top-3 key concerns reported to CHIRP by cabin crew which is why it's often discussed in these editorials.

Fatigue isn't about feeling tired; while tiredness is a normal response to a long shift, fatigue is a serious issue. ICAO defines fatigue as: 'A physiological state of reduced mental or physical performance capability resulting from sleep loss, extended wakefulness, circadian phase, and/or workload (mental / physical activity) that can impair a person's alertness and ability to perform safety-related operational duties.' Fatigue can impair alertness, decision-making, reaction times, and communication.

CCFB 87

Images By Alliance stock.adobe.com

Image from safetyfirst.airbus.com

AIRBUS SAFETY FIRST

Lithium Battery Fire in the Cabin or in the Cockpit

A lithium battery fire during flight is a significantly growing threat due to the increasing number of portable electronic devices carried by aircraft occupants. This new Safety First' article explains the specific firefighting steps to fight a lithium battery fire. It also recalls the various procedures that must be followed to deal with a fire in the cabin or in the cockpit.

"*Estimates suggest that each passenger onboard an aircraft now typically carries four to five Portable Electronic Devices (PEDs) when they take a flight. With five billion passengers expected to fly on aircraft in 2025, we are talking about a staggering 20 to 25 billion lithium batteries flying every year, representing a very widespread risk. Measures taken by the industry are a must to contain this risk, including making sure that crews are trained to timely and efficiently address lithium battery fires. However, containing this risk also relies on every single passenger being increasingly aware of their personal impact on aviation safety. We should consider doing more information sharing on this subject." Yannick Malinge, SVP - Head of Aviation Safety.*

Read more

EASA

NPA 2025-01 Take-off Performance Parameters and Position Errors — Large Aeroplanes

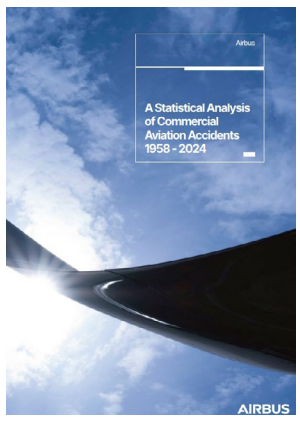
This NPA proposes to require some large aeroplanes to be equipped with a take-off performance monitoring system (TOPMS). The proposal addresses new designs, with an amendment of the Certification Specifications and AMC.

The objective is to mitigate, using an on-board alerting system, the risk of large aeroplane accidents or incidents caused by the use of erroneous take-off performance parameters and erroneous take-off positions. Such errors have the potential to result in runway excursions and aeroplane upsets, with subsequent loss of control and collision with terrain or obstacles.

NPA 2025-01

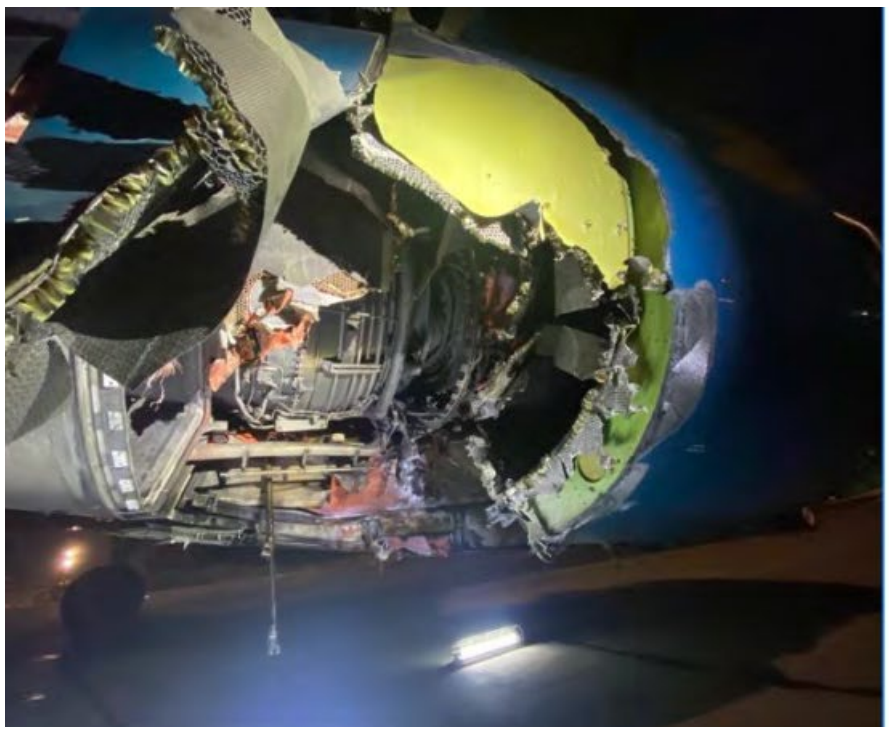
AIRBUS

Statistical Analysis of Commercial Aviation Accidents 1958 - 2024



Read Report

Contents



Images from the official report

CIVIL AVIATION AUTHORITY OF VIETNAM

Vietnam Airlines A321 Uncontained Engine Failure & Rejected Take-off

On departure from Tan Son Nhat International Airport (SGN), an A321 aircraft (VN-A392) lined up on runway 25L at 09:02:49 UTC. The crew received take-off clearance at 09:03:23, with the first officer flying and the captain monitoring. Engine parameters were normal as thrust levers advanced through IDLE, CLIMB, and FLEX/MCT settings.

At 09:04:07, while accelerating at 132 knots, the aircraft began drifting right and the crew heard a loud explosion from the right side. Engine #2 showed abnormal parameters. At 09:04:08, the crew initiated a rejected take-off (RTO) procedure. The aircraft came to a safe stop by 09:04:23. Engine #2 was shut down and fire extinguisher #1 was discharged.

Emergency services responded promptly. All passengers disembarked safely by 09:33 with no injuries reported.

Damage included:

- Major failure of Engine #2: HPT 1st disc rupture, torn thrust reverser, detached fan cowling.
- Damage to main wheels #2, #3, and #4.
- A hole on the right side of Engine #1.

There was a fire of grass on right side of runway 25L because of debris from engine.

Following the incident, the NTSB and Pratt & Whitney identified a manufacturing anomaly in the HPT 1st stage disc of the affected engine. On 21 March 2020, three days after the event, engine manufacturer IAE AG issued an immediate recall of all discs from the same heat lot installed on A321 aircraft.

In parallel, the FAA issued Emergency Airworthiness Directive 2020-07-51, mandating identification and removal of the affected discs.

Engine manufacturers P&W and NTSB have researched and improved the production process.

The report recommends: Continuing to monitor and verify the implementation of corrective actions already taken. Reviewing and improving production processes to prevent recurrence. Briefing flight crews on the incident details and investigation findings.

CAAV Report

NBAA

SMS for Small Operators: A Practical Guide

This guide is designed specifically for small operators who want to launch, implement and enhance their SMS. Whether you're just beginning your journey or looking to adapt an existing system, this guide will take you through the essentials of safety policy, safety risk management, safety assurance and safety promotion.

Explore interactive, scenario-based videos that bring the SMS elements to life, and help you confidently navigate your SMS implementation.

SMS Implementation Videos

Contents

Photo from the official report

TONGA CIVIL AVIATION OFFICE

SAAB 340B Loss of Control During Taxi and Ground Collision

On 8 December 2023, a Lulutai Airlines SAAB 340B aircraft (A3-PUA) was operating a scheduled passenger flight from Fua'amotu International Airport to Lupepau'u Airport, Vava'u. During descent into Vava'u, the flight crew noticed a loss of hydraulic pressure and no fluid indication in the main hydraulic system. Believing it to be a hydraulic leak, they elected to return to Fua'amotu, successfully deploying the landing gear using the auxiliary system.

After landing, the aircraft lost brake pressure while taxiing, veered off the taxiway, and collided with a disused refuelling bund, causing the right landing gear to collapse. All 38 occupants evacuated safely without injury.

The investigation revealed that a tripped circuit breaker had disabled key hydraulic indicators. This was not detected during initial troubleshooting, likely due to an expectancy error. The crew misdiagnosed the issue as a fluid leak and followed the hydraulic loss checklist, which included switching off the hydraulic pump—disabling automatic pressure supply. The checklist was only partially reviewed, and the crew's limited understanding of the hydraulic system led to an incomplete assessment of its limitations.

After landing, the captain noted residual brake pressure and, lacking a tug, chose to taxi to the terminal. However, hydraulic pressure depleted en route, resulting in loss of braking and directional control.

Further investigation found that the flight data recorder was not recording due to a fault in the acquisition unit, misdiagnosed as a radio issue and isolated with a locking collar eight days prior. Additionally, the cockpit voice recorder's underwater locator beacon had been removed months earlier. These defects were not logged or properly addressed.

Although the CEO was seated on the flight deck, there was no evidence of interference in crew decision-making.

Lulutai Airlines has since reviewed maintenance practices and integrated lessons learned into procedures. The incident underscores the importance of accurate system assessment, full checklist adherence, and robust defect reporting to ensure aircraft safety and airworthiness.

Final Report

CAA SKYWISE

Dangerous Goods Occurrence Reporting System Launch

The UK Civil Aviation Authority launched a new Dangerous Goods Occurrence Reporting system on 4 July 2025.

The updated system features a streamlined online form, simplified reporting guidance, and automatic email updates to reduce admin and improve user experience.

It replaces the existing submission process through SRG2808 and SRG2809 forms which have now been withdrawn.

Dangerous Goods Occurrences must be reported within 72 hours of them becoming known to the reporter.

Access to the new online form and more information is available on the CAA website:

Report a Dangerous Goods Occurrence

SW2025/178

CAA SKYWISE

Revised CAA Standards Document 29

Revision and update to the Guidance for the training and assessment of Human Factors for Flight Crew.

This version clarifies the differences between Part FCL and Part ORO requirements, and offers clear guidance on training design.

SW2025/177

CAA SKYWISE

Operational Multi-Pilot Limitation Amendments

The Civil Aviation Authority (CAA) is considering amendments to the implementing rules in Annex IV (Part-MED) of the Aircrew Regulation (UK Regulation (EU) No 1178/2011) which impose restrictions on the application and management of operational multi-pilot limitations (OML) on Class 1 medical certificates.

Stakeholders can give their views.

SW2025/172

Contents

Photos from the official accident report

AAIB INDIA

Indigo ATR-72-600 Hard Bounced Landings

The aircraft met stabilised approach criteria at 500 ft AAL but maintained a nose-down profile until 5 ft RA, where the crew initiated a delayed flare—well below the 20 ft recommended in the FCOM/FCTM. The aircraft touched down at a higher-than-target speed with a nose-down attitude, resulting in a hard landing and significant bounce. Due to delayed flare, higher IAS than targeted speed (+13 than Vapp)and pitch angle -0.3° aircraft touched down with a VRTG of +1.9 G. Due to nose down attitude of the aircraft, the touchdown was a three pointer i.e., all three gears compressed simultaneously.

Despite the bounce, the pilot flying (PF) did not initiate a go-around. After a second bounce, the pilot monitoring (PM) called for a go-around, but the PF did not act. The aircraft experienced four bounces in total, with the PF continuing to input nose-down commands. A go-around was finally initiated after the fourth bounce, during which dual inputs occurred in the same direction.

A landing gear unsafe indication appeared but went unnoticed. The aircraft entered a holding pattern and re-approached the same runway. This time, the crew noticed the gear warning and followed the QRH procedure.

On the second approach, the aircraft again landed with high vertical acceleration. After the first bounce, the PM called for a go-around, but the PF declined. The aircraft bounced four more times before coming to a stop.

The probable cause of this accident is attributed to inappropriate aircraft landing technique and not following the bounced landing recovery procedure i.e., delayed flare, high speed at touchdown and delay in initiating a "Go-Around". Contributory factors for this accident were lack of situational awareness and lack of commitment to initiate a "Go-Around" after experiencing a significant bounce.

The pilot flying (PF) delayed the go-around decision despite multiple bounces, contrary to the bounce recovery procedures outlined in the FCOM. Continued nose-down inputs indicated a lack of commitment to go around.

On the second approach, the PF again appeared determined to land regardless of conditions. Additionally, data showed the pilot-in-command had a history of high vertical acceleration landings on 19 occasions between March and June 2021.

Conclusion: The landing technique used did not comply with the operator's documented procedures (FCOM/ FCTM/FSM).

The crew of VT-IYX was fully aware of the prevailing weather and runway conditions, including visibility, wind, light rain, and a wet runway, as communicated by ATC Hubli. Despite receiving updated METARs and pilot reports of turbulent, gusty conditions, the crew chose to continue both approaches to runway 26 without reporting any adverse weather concerns or intent to divert.

Conclusion: Weather was not a contributing factor to the accident.

On the first approach, the aircraft bounced multiple times after an initial touchdown with 1.9G, causing significant damage to the nose landing gear (NLG) and forward fuselage. On the second approach, it bounced four more times before stopping 1,300m from the runway threshold. The NLG tyre burst and wheel was severely damaged.

Recommendations:

DGCA should implement post-flight medical/BA tests for serious incidents.

Involved crew should receive corrective training focused on go-arounds and bounced landing recovery.

IndiGo should brief all pilots on bounced landing procedures.

Final Report

Contents

Photo by Mark Stebnicki: https://www.pexels.com

NATIONAL TRANSPORTATION SAFETY BOARD

Loss of Separation Incident, Washington National Airport (DCA), 28 March 2025

On 28 March 2025, a near mid-air collision occurred between Delta Air Lines Flight 2983 (DAL2983), an Airbus A319 departing Ronald Reagan Washington National Airport (DCA), and DRAGO61, a formation of four US Air Force Northrop T-38s conducting a ceremonial flyover at Arlington National Cemetery. The incident took place approximately 0.6 nautical miles south of DCA at 15:16 EDT. No injuries or aircraft damage were reported.

The event unfolded during moderate traffic and complexity under visual meteorological conditions. DRAGO61 was under Potomac Consolidated TRACON (PCT) control, while DAL2983 was managed by DCA Tower. A miscommunication occurred regarding the "hard stop" time for departures to accommodate the flyover. Although the PCT Operations Supervisor (OS) communicated a stop time of 15:17, DCA Tower continued to clear departures, including DAL2983 at 15:15.

As DAL2983 departed, DRAGO61 was issued traffic advisories and instructed to maintain visual separation. The aircraft came within 0.64 nautical miles and 100 feet vertically of each other. DRAGO61 reported visual contact and adjusted course accordingly.

Post-incident, the FAA, NTSB, NATCA, and USAF formed an investigative group. Initial findings highlight procedural confusion and breakdowns in coordination between TRACON and Tower controllers. Audio recordings, ADS-B data, and interviews are under review.

Weather was not a factor, with clear visibility and light winds. Both aircraft were operating under appropriate flight plans—IFR for DAL2983 and VFR for DRAGO61.

The investigation is ongoing, with emphasis on air traffic control communication protocols, coordination procedures, and supervisory oversight during special operations. No mechanical issues or pilot errors were identified at this stage.

NTSB Preliminary Report

CAA SKYKWISE

Radio Operators Certificate of Competence (ROCC) Examiner Application Form Published

An Application for Authorisation as a Radio Operators Certificate of Competence Examiner form SRG1413E published.

Use Application for Authorisation as a Radio Operator's Certificate of Competence Examiner (SRG1413E) form for initial application and renewal of ROCC Examiner authorisation privileges. Details on initial issue and renewal requirements can be found on the Authorised Examiners for Radio Operators Certificate of Competence page on the CAA website.

The ROCC Examiner authorisation is valid for 3 years (date shown on the issued certificate), unless revoked by the CAA or cancelled at holder's request. It is the holder's responsibility to renew the ROCC Examiner authorisation prior to expiry.
SW2025/170

Contents

Recent Accidents & Incidents from the Air Safety Network Wikibase

Date	Type	Event	Location
07-Jul-25	A220	Diverted smoke in the cabin while en-route	Friedrichshafen
08-Jul-25	A319	A male pursued by police airside, dashed beneath the fuselage to the left engine, which was still running, and jumped headfirst into it.	Bergamo
12-Jul-25	A320	Diverted, an engine fire (indication) while en-route	Turin
03-Jul-25	A320	GCOL, struck by a ground vehicle	Santa Maria-Vila
06-Jul-25	A320	ATB, a bird strike to the no.2 engine on departure	Lahore
11-Jul-25	A320	ATB, a bird strike on departure	Palermo
04-Jul-25	A320	TXWYEXC veered off taxiway E at Orlando	Orlando
09-Jul-25	A320	ATB, a bird strike after take-off	Patna Jay Prakash
07-Jul-25	A321	Diverted, encountered thunderstorm with hail after take-off	Rzeszów
01-Jul-25	A321	A tail strike during a landing and go-around	Dublin
08-Jul-25	A330-300	ATB, a bird strike (a flock of pigeons) on departure from Dublin Airport (DUB), causing engine vibrations in engine no.2.	Dublin
06-Jul-25	A330-300	Diverted, engine issues while en-route over the North Atlantic	North Atlantic
05-Jul-25	A340-600	GCOL, Hit by a ground vehicle while parked at the gate at BOS	Boston-Logan
12-Jul-25	A380	GCOL, Hit by the airbridge at gate 9 of Sydney	Sydney
06-Jul-25	H130	Ditched in the sea	Baltic sea
02-Jul-25	AN24	Sustained hail damage after flying near a thunderstorm.	Severo-Yeniseysk
10-Jul-25	B300 KA	ATB, a temporary patch detached from one of the wings during take-off	St Simons Island
03-Jul-25	B200 KA	ATB, lost an engine cowling on departure	Malta
13-Jul-25	B200 KA	Crashed immediately after take-off	London Southend
01-Jul-25	Bell 206	Crashed under unknown circumstances.	Ridgley
06-Jul-25	Bell 206	Crashed while landing	Hespero/Safron
06-Jul-25	Bell 407	Touched a street light pole and made a hard landing	Uchebnoye Lesnichestvo
13-Jul-25	B737-500	RWEXC overran runway 03 upon landing at Port Harcourt	Port Harcourt
05-Jul-25	B737-800	Evacuated on the apron at Palma de Mallorca Airport (PMI) after reports of an engine fire indication in the cockpit after pushback.	Palma de Mallorca
04-Jul-25	B737-800	ATB, a no.2 engine failure while climbing through about 22,000 feet	Buenos Aires
02-Jul-25	B737-900	A tail strike during landing	Las Vegas

Contents

Recent Accidents & Incidents from the Air Safety Network Wikibase

Date	Type	Event	Location
02-Jul-25	B737-900	On approach to KRDU when a wing flap departed the airplane	Raleigh-Durham
07-Jul-25	B757-200	Diverted, lithium battery of a passenger's power bank caught fire.	Fort Myers, FL
10-Jul-25	B787-9	Diverted due to a mechanical issue.	Xining Caojiapu
08-Jul-25	KC-46A	Lost its refuelling boom while refuelling F-22 aircraft	Atlantic Ocean
09-Jul-25	CRJ-900	Blew a tire on take-off	Northwest Florida
13-Jul-25	C208B	Landing accident, damage with all four propeller blades bent and damage to nose landing gear	Balimo
02-Jul-25	C208B	RWEXC overshot the runway	Cross Keys
08-Jul-25	C525A	RWEXC The aircraft rolled off the end of runway due to hy-droplaning.	Wheeling Ohio
08-Jul-25	Eclipse 500	RWEXC rolled off the end of the runway into the grass	John C Tune
06-Jul-25	EMB505	RWEXC overran the end of runway 26 on landing	Ludington-Mason
02-Jul-25	ERJ195	RTO due mechanical failure	Hohhot Baita
11-Jul-25	AS350B	Crashed into a small reservoir, transporting materials with its cargo hook.	Bettaforca
10-Jul-25	AS355N	Crashed into the water during a flypast	Sungai Pulai
05-Jul-25	MD82	Blown tire during landing	Brazzaville-Maya
06-Jul-25	R22	Crashed into trees during a training flight and rolled over.	Vetriolo
01-Jul-25	R22	The tail rotor struck a tree	Anthony Lagoon, NT
09-Jul-25	R44	Came down in the water, reported loss of power	Inlet, NY
06-Jul-25	R44	Crashed under unknown circumstances	Heber, UT
06-Jul-25	R44	Crashed into trees while attempting to land	Lone Butte
04-Jul-25	R44	Crashed landed under unknown circumstances during take-off.	Pecos, TX
30-Jun-25	R66	Hard landing	Boeing Field
03-Jul-25	R690B	The aircraft landed gear up.	Ladd Army Airfield

Contents

Safety Conference Calendar

Year	Month	Day(s)	Org	Event	Location	Notes
2025	Jun	5th – 6th	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	EUROCONTROL	Understanding culture and conversation	Webinar 1430-1630 CET	
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	17th - 18th	Acron	Acron Aviation Customer Safety Seminar	MBW, Weybridge	
2025	Sep	23rd	EASA	Ground Handling Implementation Webinar	Online	
2025	Sep	23rd-24th	EUROCONTROL	Just Culture Conference	Ljubljana	
2025	Sep/Oct	29th – 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	6th – 7th	SAE	Defence Aviation Safety Conference	London	
2025	Oct	14th	EUROCONTROL	Advancing Safety Management through pro-active weak signal detection	Webinar 1400-1530 CET	
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	