



UK Flight Safety Committee

UKFSC News #33

23 July 2025



SKYBRARY

Beware of Loose Objects
On The Flight Deck



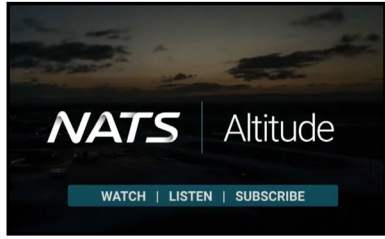
AAIC NEPAL

CRJ Stalled & Crashed
After Take-off



EASA SIB

Potential Risk Engine
Load Reduction Device
Activation



NATS

NATS Altitude 43:
Engineering the Future of
Flight



CAA CONSULTATION

Electronic Conspicuity
(EC) Consultation



NASA CALLBACK

Caution Hazardous Ramp
Operations



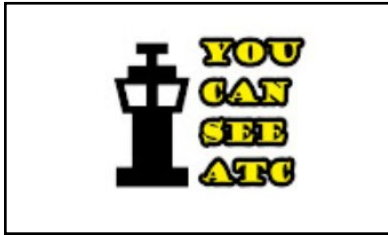
TSB CANADA

Runway Incursion -
Aircraft Take-off Over
Vehicles



FAA SAIB

High Pressure Turbines



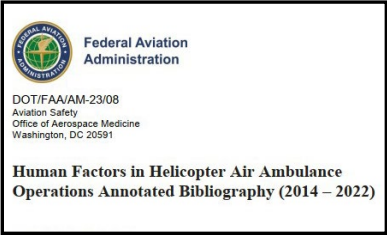
REAL ATC

Right Engine Stall. JetBlue
Airbus A321 Returns To
JFK With Engine Issue



BEA FRANCE

A380 Damage To
Leading Edge Slat During
Approach



FAA

Human Factors
in Helicopter Air
Ambulance Operations



NTSB

Cessna 680 Landing with
Gear Retracted



CAA SKYWISE

Fuel Tank Special
Conditions to Protect
Cabin Evacuations



CAA SKYWISE

UK PPL(BA) and UK
CPL(B) Licences No
Longer Being Issued



CAA SKYWISE

New Combined Licence
Document For Flight
Crew Licence Holders



ATSB

Control issues & Ditching
Involving 500 RPA Swarm



UAE GCAA

B787-9 Communication
Failure



CAA PUBLICATION

CAA Decision to
Adopt Certification
Specifications CS-29
Large Rotorcraft



FSF

Recent Accidents from
the Air Safety Network



UKFSC

Safety Conference
Calendar - **8 NEW**

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SKYBRARY

Beware Loose Objects On The Flight Deck

On 12 May 2022, an aircraft about to become airborne at Chongqing veered off the side of the runway at high speed following an inadvertent, unintended and inappropriate rudder input by the non-flying pilot when distracted by unexpected movement of a poorly-



Image from Skybrary

positioned loose object. Continuation over rough ground across an open ditch resulted in detachment of both engines and both main landing gear assemblies and a consequential fire which impeded the subsequent emergency evacuation. The severe fire and impact damage to the aircraft rendered it a hull loss but the evacuation was completed with only a few minor injuries.

[Learn More](#)

Related Articles

[Standard Operating Procedures \(SOPs\)](#)

[Runway Excursion](#)

[Post-Crash Fires](#)



Image from the official report

AIRCRAFT ACCIDENT INVESTIGATION COMMISSION NEPAL

CRJ Stalled & Crashed After Take-off

On July 24, 2024, the Saurya Airlines CRJ 200LR was scheduled for a ferry flight from Tribhuvan (VNKT), to Pokhara (VNPR). It crashed after take-off.

The probable cause of the accident was a deep stall on take-off due to an abnormally rapid pitch rate commanded at a lower than optimal rotation speed.

The report determined the contributory factors to the accident as:

1. Incorrect speeds calculated based on erroneous speed card. The interpolated speed card of the operator for 18,500 kg TOW mentions incorrect V-speeds for take-off. This error in the speed card went unnoticed since its development. There was no acceptance/approval of the speed card booklet.
2. Failure to identify and address multiple previous events of high pitch rate during take-off by the operator.
3. The operator showed gross negligence in complying with the prevailing practices of ferry flight planning, preparation and execution. There is a lack of consistent definition of ferry flights.
4. Gross negligence and non-compliances by the operator during the entire process of cargo and baggage handling (weighing, loading, distribution and latching), while violating the provisions of operational manual and ground handling manual. The load was not adequately secured with straps, tie-downs, or nets, while the flight preparation was rushed.

41 safety recommendations are made including 12 for all operators relating to FDM, SOPs, rotation rate training, digitisation of speed cards and RTOW charts, cockpit authority and pilot monitoring assertiveness, ramp handling and loading training, ramp supervision and accountability, pre-flight V speed validation and cross checking and SOPs for ferry and non-revenue flights.

[Final Report](#)

EASA SAFETY INFORMATION BULLETIN

Potential Risk Management Issue after Engine Load Reduction Device Activation

Leap 1A & 1B powered B737 Max and some A320 Neos LRD activation causes air conditioning smoke in the cabin and cockpit.

[SIB 2025-06](#)

NATS

NATS Altitude 43: Engineering the Future of Flight

Discussing surveillance systems, the uncrewed aerial vehicle, the Ultra and aircraft design.

[NATS YouTube Video.](#)

[Watch here](#)

CAA CONSULTATION

Initial Technical Concept of Operations (ConOps) for Electronic Conspicuity (EC) Consultation

For GA, UAS, ANSPs, Aerodromes and equipment manufacturers.

[Read the ConOps](#) and [respond to the consultation here.](#)



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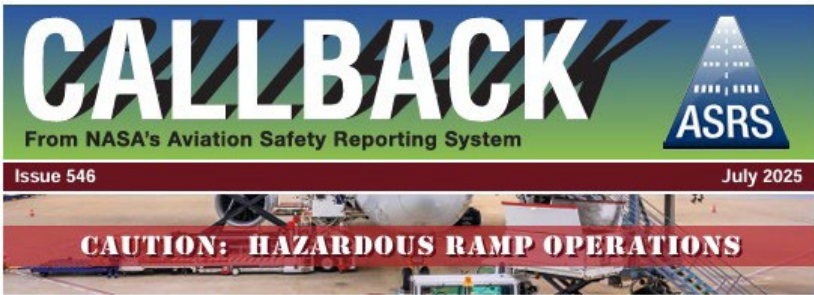
NASA CALLBACK 546

Caution Hazardous Ramp Operations

Ramp Operations (Ops) comprises a complex network of activity and includes most services that aircraft receive in between flights and overnight. Those services are many and varied. Fueling, loading, unloading, and moving aircraft are but a few, but every service presents specific and peculiar hazards for Ramp Agents and flight crews to navigate. The airport ramp is frequently viewed as a precarious work area with many hazards. Several factors are at play.

Diligence, strict adherence to procedures, situational awareness, and personal and professional discipline are fundamental in mitigating ramp hazards and ensuring ramp safety. This month, CALLBACK shares incident reports that reveal the multitude, magnitude, and range of Ramp Ops hazards and their inherent danger. Challenge yourself in determining how you might have recognized and mitigated these threats.

CALLBACK 546



Ramp Operations (Ops) comprises a complex network of activity and includes most services that aircraft receive in between flights and overnight. Those services are many and varied. Fueling, loading, unloading, and moving aircraft are but a few, but every service presents specific and peculiar hazards for Ramp Agents and flight crews to navigate.

The airport ramp is frequently viewed as a precarious work area with many hazards. Several factors are at play. Ramps can be crowded with aircraft and other large vehicles. Often, hazardous substances and servicing products are present. Diverse aircraft servicing requirements demand that workers with local goals and interests operate simultaneously and efficiently. Time is almost always compressed, and hazards can be overt or subdued and easily missed. Diligence, strict adherence to procedures, situational awareness, and personal and professional discipline are fundamental in mitigating ramp hazards and ensuring ramp safety.

This month, CALLBACK shares incident reports that reveal the multitude, magnitude, and range of Ramp Ops hazards and their inherent danger. Challenge yourself in determining how you might have recognized and mitigated these threats.

Part 121 – The Pit and the Pendulum

This Ramp Agent encountered an unusual, unanticipated, and frightening hazard while performing customary ramp duties. Fortunately, the incident concluded well.

I was in the forward pit looking for a couple of bags... I knew [Maintenance was] done with the pressurization test because... Operations said they had run the test and... needed 30 additional minutes to figure out [the] problem. There

really starting to hurt worse. I could hear someone trying to open the cargo door, but it wouldn't open. I knew there was a way to open the door from the inside, so I tried and I couldn't open it. I was really upset and panicking at this point. I wasn't sure if I was going to be ok because the plane was still pressurizing. There was a lot of chatter on [the] radio. I do remember the Operations Agent telling the Ramp Agent that Maintenance was going to depressurize the plane and not to open the door till they gave the word because it could be dangerous. Once... Maintenance told... Operations that it was clear, the Ramp Agent opened the door. It was so scary. I have never been that scared in my life. It was the unknown of what was happening or could happen.

Part 121 – A Real Twilight Zone

This Ramp Agent discovered a Fueler approaching imminent danger and unaware of the serious threat. Action was taken that may have saved this Fueler's life.

The airstart process had just finished, and the GPU and airstart hoses were being disconnected. [The] Fueler then began to walk underneath the aircraft and walk about 6-7 feet in front of the running #2 Engine. I noticed he was walking towards the plane and underneath, and I tried screaming and waving at him. Luckily, he saw me and ran towards me to avoid being ingested into the engine. I pulled him aside and had a stern talk [with him] about what just happened. He stated that he saw the airstart operator walk towards the aircraft and assumed the plane was off. He did not know about the airstart and that the engines were running. [The] Fueler was coming from [another] gate... and crossed through where the engine was running.



By IanDewarPhotography

TSB CANADA

Runway Incursion - Aircraft Take-off Over Vehicles

On 6 October 2023, two aircraft tow vehicles operated by Airport Terminal Services (ATS) entered Runway 17R at Calgary International Airport without clearance, while a Jazz Aviation DHC-8-402 aircraft was beginning its take-off roll. The aircraft passed overhead the tugs at 350 feet AGL. The incursion occurred during a planned outage of the airport's surface surveillance system (A-SMGCS).

Findings

The lead tug driver stopped too close to the runway holding position due to procedural drift and lack of recurrent training, leaving insufficient space to turn around. Misaligned mental models between the tug driver and ground controller led to misinterpretation of instructions. A steep authority gradient discouraged the tug driver from seeking clarification. The controller's abort instruction was not heard by the flight crew, due to non-standard phraseology and high cockpit workload. The absence of A-SMGCS and reliance on increased spacing increased the risk of late detection of incursions.

NAV CANADA updated its Tower Knowledge Verification to include emergency abort take-off phraseology, reinforcing correct communication in critical situations.

Final Report

FAA SAFETY AIRWORTHINESS INFORMATION BULLETIN

High Pressure Turbines

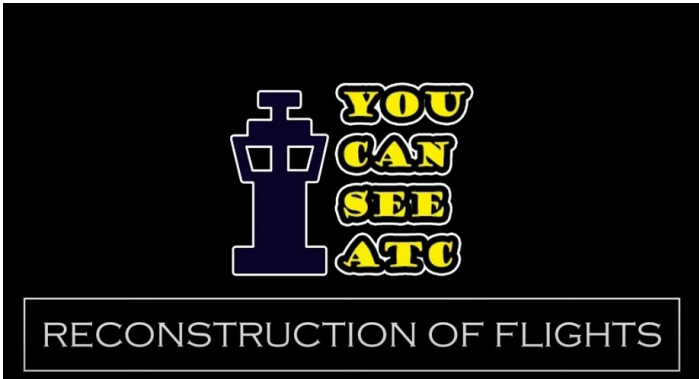
This SAIB relates to airplanes with Pratt & Whitney Division (P&W) Model PW4050, PW4052, PW4056, PW4060, PW4060A, PW4060C, PW4062, PW4062A, PW4152, PW4156, PW4156A, PW4158, PW4160, PW4460, PW4462, and PW4650 engines about a concern related to a failure mode in the high pressure turbine (HPT).

Following an uncontained engine failure the SAIB recommends implementing safety bulletins that play an important role in the durability of the HPT Stage 2 BOAS and reduces the failures of the outer transition duct.

SAIB 2025-06

REAL ATC

Right Engine Stall. JetBlue Airbus A321 Returns To JFK With Engine Issue



Watch Video



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By Lukas Wunderlich

BEA FRANCE

A380 Damage To Leading Edge Slat During Approach

On 18 August 2023, Emirates flight EK77, an Airbus A380-800 (registration A6-EOM), experienced an incident during approach to Nice–Côte d’Azur Airport. While descending at approximately 3,500 ft and 212 kt, the crew selected configuration 1. They heard a muffled noise and felt slight vibrations but continued the approach and landed without any warnings. Post-flight inspection revealed significant damage to the trailing edge of leading edge slat No. 2 on the right-hand wing.

The damage was initially suspected to be from a mid-air collision (e.g. with a drone), but investigations ruled this out. Examinations revealed pre-existing bonding defects between the slat’s honeycomb core and its skin, which likely weakened the structure. The damage did not affect the aircraft’s flight performance or safety margins, and no loss of lift was detected. Consequently, the event was reclassified from an “accident” to an “incident”.

Measures Taken

Airbus identified three similar incidents on other A380s within seven months, all involving damage to slat trailing edges.

Detailed inspections of the affected slats revealed bonding failures, though no production deviations were found.

Airbus, under EASA oversight, is continuing investigations to determine the root cause of the bonding defects.

As a precaution, Airbus plans to issue two service bulletins in January 2026 mandating repetitive inspections during A and C checks to detect cracks or delamination in slat trailing edges.

BEA Report



Federal Aviation
Administration

DOT/FAA/AM-23/08
Aviation Safety
Office of Aerospace Medicine
Washington, DC 20591

Human Factors in Helicopter Air Ambulance
Operations Annotated Bibliography (2014 – 2022)

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February 2023

FAA

Human Factors in Helicopter Air Ambulance Operations

Helicopter air ambulance (HAA) operations involve particularly challenging conditions, including landing at unfamiliar, remote, or unimproved sites with terrain and obstacle hazards, and involve urgent or time-sensitive situations. Associated human factors (HF) issues including fatigue, stress, human error, and perceived pressure to fly compound the challenging nature of HAA operations. This report aims to inform the current understanding of HF risks and considerations within HAA operations spanning 2014 – 2022 through a focused review of flight crew fatigue considerations, environmental conditions, areas for increased training opportunities, and other operational risk factors.

[Read More](#)



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Photo NTSB

NTSB

Cessna 680 Gear Up Landing

On 18 August 2024, a Cessna 680 business jet (registration N680SA) operated under Part 91 for positioning purposes, landed gear-up at Washington-Warren Airport (OCW), North Carolina. The aircraft slid along the runway and caught fire after coming to a stop. Both pilots escaped uninjured, but one ground personnel sustained minor injuries. The aircraft sustained substantial damage.

Scenario and Findings

The flight was conducted under visual meteorological conditions. During the visual approach, the landing gear was not extended.

The captain removed his headset due to a persistent 500Hz squeal, which was actually the gear warning horn. As a result, he missed the repeated “too low, gear” aural warnings.

The first officer did not hear the gear warning in her headset or overhead speaker and noted prior issues with the aircraft’s communication panel.

The cockpit voice recorder (CVR) revealed that checklist procedures were inconsistently followed, and crew coordination was poor.

The crew was aware of the communication system’s limitations but failed to effectively mitigate them.

Probable Cause

The National Transportation Safety Board (NTSB) determined the probable cause to be:

- The crew’s failure to configure the aircraft properly for landing.
- The captain’s failure to recognise the landing gear warning.

Contributing factors included inadequate checklist use, poor crew resource management (CRM), and known deficiencies in the aircraft’s communication system.

Final Report

CAA SKYWISE

Publication of Special Conditions UK.SC.C.0001 & UK.SC.E.0001

The CAA consulted in December 2024 on the Special Condition - Cabin Evacuation - Protection from Fuel Tank Explosion due to External Fuel Fed Ground Fire & Installation of Conformal Rear Centre Tank - Crashworthiness Conditions.

Special Condition UK.SC.C.001 Rear centre fuel tank crashworthiness to prevent leaks.

Special Condition UK.SC.E.0001 Centre fuel tank thermal protection to prevent auto-ignition and fuel tank explosion, due to external fuel fed ground fire.

The CAA has now published these Special Conditions within the [Aviation Regulatory Library](#).

SW2025/I94 & SW2025/I95

CAA SKYWISE

UK PPL(BA) and UK CPL(B) Licences No Longer Being Issued After 1st October 2025

As part of the Licensing and Training Simplification Project, UK CAA will no longer be issuing UK PPL(BA) or UK CPL(B) after 1st October 2025.

Applications received after 16th September will not be guaranteed to have a UK PPL(BA) or UK CPL(B) issued.

SW2025/203

CAA SKYWISE

Revised: New Combined Licence Document For Flight Crew Licence Holders

Following the completion of Phase 2 of the Licensing and Training Simplification project, the UK CAA will be offering a new combined licence from 1st October 2025.

The new combined licence allows both Part-21 and Non Part-21 aircraft ratings to be endorsed onto a single licence document.

More information can be found on the [CAA dedicated webpage](#).

SW2025/206



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Photos from the official accident report

AUSTRALIAN TRANSPORT SAFETY BUREAU

Control issues & Ditching Involving RPA Swarm of 500, Victoria Harbour, on 14 July 2023

On the evening of 14 July 2023, a planned aerial light show over Victoria Harbour, involving 500 remotely piloted aircraft (RPA) encountered a major failure:

Almost immediately after launching the drone swarm, the RPIC noticed multiple drones were out of position, visually and via errors on the Ground Control Station (GCS). Despite the issues, the drones began transitioning toward the show area, during which errors escalated. Drones began colliding mid-air, and many breached the geofence. The RPIC issued a loiter command and attempted to recover the most affected drones individually. However, the GCS lost connection to nearly 400 drones, most of which descended into the harbour. In total, 427 out of 500 drones were lost, with 236 later recovered by divers.

Cause of Incident: The drone swarm encountered wind conditions exceeding the aircrafts’ published limits shortly after launch. The Remote Pilot in Command (RPIC) did not recognise this because, although wind speed was displayed on the Ground Control Station (GCS), there was no alert system to flag exceedances.

Operational Oversight: The RPIC allowed the flight to continue into an area with wind speeds more than double the aircrafts’ limit, leading to loss of control, collisions, and geofence breaches. The RPIC did not utilise all available processes to assess wind conditions before launch. The RPIC was under high workload and pressure to conduct the show, which impaired decision-making.

Organisational Gaps: The operator had no procedure to ensure pilots were familiar with all GCS software functions.

Although not directly contributing to the incident, the flight crew failed to comply with regulatory and internal operational limitations.

The operator conducted a comprehensive review and implemented several procedural improvements:

Crew Requirements: Now mandates two Civil Aviation Safety Authority-approved pilots for every show.

Wind Testing: Introduced pre-show wind speed test flights using individual drones to assess real-time conditions.

Go/No-Go Points: Established multiple decision points during the launch sequence to allow stop/go decisions.

Sterile Cockpit Rule: Enforced sterile cockpit procedures to minimise distractions during critical pre-launch phases.

Additionally, the ATSB recommended the operator develop a process to ensure all pilots are informed of software changes before operations begin.

The manufacturer confirmed that adding a wind speed exceedance alert to the ground control station software, as recommended by the ATSB is technically feasible and is being considered for future updates.

Safety Message

Ground Control Station (GCS) Dependence: Flight crews rely heavily on GCS software for safe RPAS swarm operations. It’s essential they understand all functionalities and the data presented.

Alerting Features: Active alerts for exceedances in flight-critical parameters (e.g. wind speed) can significantly improve crew awareness and response.

Pilot Familiarity: Operators must ensure pilots are trained and familiar with new GCS functionalities before deployment.

Operational Documentation: Checklists and other materials should include prompts to help crews gather necessary information for sound decision-making.

Human Factors: Workload and operational pressure can affect RPAS operations just as they do in crewed aviation. These factors should be actively managed.

Regulatory Compliance: Adhering to operational guidelines and limitations set by regulators is vital—especially in high-risk environments like public displays in urban areas.

ATSB Report



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Photo By Travers Stock.adobe.com

UAE GCAA

B787-9 Communication Failure

On 10 March 2023, a Gulf Air Boeing 787-9 aircraft, was scheduled to operate from Bahrain International Airport to Dubai. The Commander was PF. The Copilot was PM>

At FL250 the crew initiated descent. At that point, they experienced a critical failure involving all three tuning control panels (TCPs)—right, left, and centre. This was followed by the loss of several key systems, including the transponder, weather radar, and the traffic collision avoidance system (TCAS). The crew also lost the ability to change radio frequencies.

The crew referred to the Quick Reference Handbook (QRH) and managed to establish communication with Dubai Approach using the standby radio on frequency 119.3. They received clearance to descend to 13,000 feet and proceed to VUTEB, where they entered a holding pattern at 18:03:57.

Due to the inoperative transponder, Dubai Approach could not track the aircraft. The PM attempted to find TCP reset procedures using the Flight Crew Operations Manual (FCOM) on the company iPad in the electronic flight bag (EFB), but was unsuccessful. The PF noted that while holding over VUTEB, they continued troubleshooting in hopes of resolving the issue before receiving landing clearance.

The crew did not discuss the relevant Flight Crew Operations Bulletin regarding TCP inoperative procedures. Eventually, Dubai Approach instructed the crew to declare a

radio communication failure emergency to facilitate landing clearance and emergency service readiness. At 18:22:15, the crew declared the emergency and began their approach to Dubai. The aircraft landed safely on runway 12L at 18:35:3

The crew was unable to restore the tuning control panels (TCPs) because the Copilot, acting as the pilot monitoring, could not locate the relevant reset procedures in the electronic flight crew operations bulletin stored in the electronic flight bag. This difficulty was compounded by the crew’s failure to follow the standard take-off briefing procedure, which includes checking current bulletins and NOTAM supplements. Their unfamiliarity with how to access the necessary flight crew operations bulletins ultimately hindered their ability to resolve the issue.

Safety Actions

The FCOM bulletin is now included as a green flag item during the type rating course. A Flight Crew Operations Notice has been distributed to all pilots, informing them of the new or revised bulletin. The bulletin review is now part of the system knowledge validation during the LPC and OPC. It is recommended that Gulf Air take measures for improving the pilots’ flight crew operations bulletins and NOTAM supplement check and adherence during the take-off briefing and utilizing the right procedures during the flight.

Incident Report

CAA PUBLICATION

ORS9 CAA Decision No.50: CAA Decision to Adopt Certification Specifications for UK Reg (EU) No. 748/2012 Pursuant to Article 76(3) UK Reg (EU) No. 2018/1139

The CAA has decided that EASA Certification Specifications, CS-29 Large Rotorcraft, CS-ACNS Airborne Communications, Navigation and Surveillance, and CS-E Engines are non-binding technical standards that may be used to meet the requirements of UK Reg (EU) No 748/2012. Adoption of up-to-date versions of these internationally harmonised Certification Specifications will enable British businesses to design Products, Parts and Appliances to the latest standards.

[View ORS9 CAA Decision No.50](#)



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Recent Accidents & Incidents from the Air Safety Network Wikibase

Date	Type	Event	Location
18-Jul-25	A220	GCOL, taxiing B787 wing tip struck the vertical stabilizer and rudder of the A220.	Charleston
17-Jul-25	A320	The aircraft sustained damage to the nose from hail on approach.	Chongqing
21-Jul-25	A320	RWEXC, temporary runway veer off during landing in heavy rain. The engine air intake lip and several tyres were damaged.	Mumbai
16-Jul-25	A320	Diverted, due to an engine failure while en route at FL340.	Mumbai
20-Jul-25	A321	Diverted, due smoke in the cockpit while en-route over Germany.	Hannover
15-Jul-25	ATR72	The cabin would not pressurize, continued to destination.	Antananarivo
13-Jul-25	B C90 KA	ATB, struck by a vulture during take-off.	Uberlândia
19-Jul-25	B737 MAX8	Bird strike on landing, one engine damaged.	Faisalabad
14-Jul-25	B737 MAX8	GCOL, A parked Akasa Air Boeing 737 was hit by a cargo truck at Mumbai Airport. Winglet damage.	Mumbai
16-Jul-25	B737-700	ATB, crew reported a low-pressure warning in engine number two.	Chicago
13-Jul-25	B737-800	ATB, no.2 engine surges on departure.	Los Angeles
17-Jul-25	B737-800	Diverted after a ruptured main gear tyre.	Rhodes
14-Jul-25	B737-800	ARC, a right main landing gear collapse accident during landing.	Kunming
19-Jul-25	B747-400	Engine failure on approach.	Netherlands
20-Jul-25	B767-200	ATB, a failure of the generator of engine No. 2.	Moscow
18-Jul-25	B767-400	ATB, flames were briefly observed from the no.1 engine.	Los Angeles
18-Jul-25	B787-10	GCOL, the taxiing B787 wing tip struck the vertical stabilizer and rudder of the A220.	Charleston
18-Jul-25	Bell 206	Struck power lines while doing aerial applications and crashed in a corn field.	Bloomington
14-Jul-25	Bell 206	During cruise, the helicopter struck a bird which crashed through the windscreen causing fatal injuries to the passenger. The pilot was able to conduct a forced landing.	Lake Evella
16-Jul-25	DHC8	RWEXC, runway excursion during the third attempt to land in heavy rain.	Mekele
14-Jul-25	DHC8	RWEXC, runway excursion after landing, 1300 m long asphalt runway.	Mohéli-Bandar
19-Jul-25	ERJ175	On approach, conducted an “aggressive manoeuvre” to the left to avoid a mid-air collision with a military Boeing B-52 Stratofortress.	Minot
14-Jul-25	Mil Mi-8T	The preliminary cause of the forced landing is a drop in engine speed.	Lensk
14-Jul-25	Mil Mi-8T	CFIT, impacted the slope of one of the mountains.	Kheijanskaya
20-Jul-25	R44	A hard landing in a Lake.	Lake Teletskoye
15-Jul-25	SI00	Diverted, due a failure of the cooling of the forward avionics compartment.	Uralsk
16-Jul-25	SAAB 340	Diverted due engine shutdown.	Budapest
15-Jul-25	SINO SJ30	RWEXC, veered off the right side of runway 13R during a take-off.	San Antonio



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Safety Conference Calendar

Year	Month	Day(s)	Org	Event	Location	Notes
2025	Jul/Aug	30th - 1st	NTSB	Investigative Hearing Washington DC Mid Air	Online	NEW
2025	Aug	27 th – 28 th	EASA	Artificial Intelligence in Aviation	Cologne	Hybrid
2025	Sep	10 th	UKFSC	472 nd SIE	Online	
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	23rd-24th	EURO-CONTROL	Just Culture Conference	Ljubljana	
2025	Sep	25th	CAA	Ground Handling Regulation Workshops	London	NEW
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	8th	RAeS	RAeS Mental Health in Aerospace Awareness Event	RAeS HQ, London	NEW
2025	Oct	14th	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	Oct	23rd	CAA	Ground Handling Regulation Workshops	Edinburgh	NEW
2025	Oct	28th	EASA	Ramp (SAFA/SACA) Inspection Forum 2025	Brussels	NEW
2025	Nov	4 th – 6 th	FSF	78th International Aviation Safety Summit	Lisbon, Portugal	
2025	Nov	6th	BHA	BHA Annual Safety Day info@britishhelicopteras-sociation.org	Cranfield University	NEW
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	12th - 13th	EASA	EASA Annual Safety Conference 2025	Copenhagen	NEW
2025	Nov	19th	RIN	4th Annual UK PNT Leadership Seminar	London	
2025	Nov	27th	CAA	Ground Handling Regulation Workshops	Manchester	NEW
2025	Dec	2nd	UKFSC	473rd SIE	Online	
2025	Dec	2nd	EASA	Ground Handling Implementation Webinar	Online	