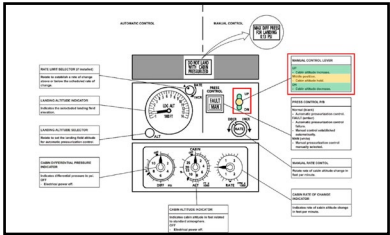




UK Flight Safety Committee

UKFSC News #30

27 June 2025



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Do Your Crews Know How To Manually Control Cabin Pressure?



AAIB
ATR 42-500 Engine Failure In Cruise



SKYBRARY
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SKYBRARY

Do Your Crews Know How To Manually Control Cabin Pressure?

On 20 February 2023, a crew only realised the landing altitude for their destination, Port Moresby, had not been set late in the descent. With insufficient time to eliminate the cabin pressure differential automatically, an



Image By Jason Wells Stock.adobe.com

AAIB

ATR 42-500 Engine Failure & Fire, NE of Aberdeen

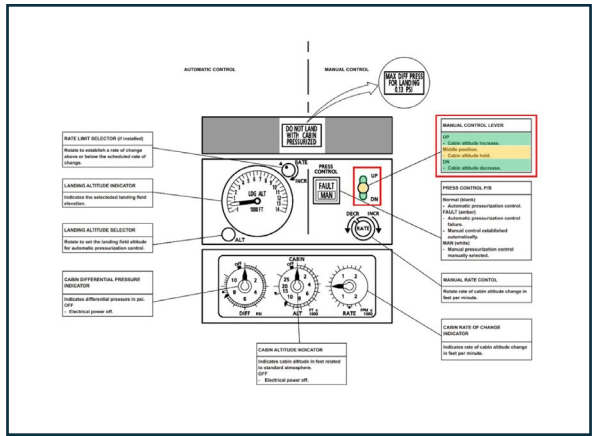
Whilst in the cruise, the aircraft suffered a contained failure of the No 1 engine and a subsequent fire. The flight crew correctly followed the checklist procedures to shut down the engine, and the fire was extinguished. This was due to significant degradation of its No 6 main bearing which resulted in the rotating high-pressure turbine being no longer correctly located. This allowed the rotating parts to contact adjacent parts causing significant damage to the turbine stages. There was an under-cowling fire which was due to leaking fuel igniting on hot engine parts. It was detected and extinguished by the crew using onboard systems; both fire bottles were discharged.

The fuel leak was from the connection between the HMU and the fuel return line which had become loose. Either the connection had not been tightened correctly when it was installed or that it had become loose due to the forces of the engine failure ‘whipping’ the fuel return line. Maintenance records, interviews with the maintenance staff and indicator markings appeared to confirm that it had been tightened correctly,.

Due to the fuel system design, specifically that of the motive flow valve, fuel continued to leak from the loosened fuel return line after the crew, as part of the Engine fire or Severe Mechanical Damage checklist, operated the fire handle to shut down the engine. It continued to leak until the crew selected the No 1 engine electrical fuel pump off as part of the Single Engine Operation checklist, as it was this selection to off that fully closed the motive flow valve. The fuel leak would have recommenced if the crew had needed to cross feed fuel to maintain the lateral balance of the aircraft as this process requires the electrical fuel pump to be selected on.

The aircraft met certification requirements in place at the time of certification, and there have been no other similar events in the history of the aircraft. The aircraft manufacturer has commenced a safety review to identify any possible safety actions which would further reduce the likelihood of leakage from the fuel return line. This review will be completed by the end of 2025.

AAIB Report



attempt to use the abnormal manual control procedure was made. When it became clear that this had not worked, a go-around was initiated but when the cabin pressure differential then rose rapidly to 6 psi, multiple passenger ear/nose/throat injuries resulted, some serious. Another abnormal procedure was then actioned and this fortuitously resolved the situation and the aircraft was able to land.

Learn More

Related articles

Aircraft Pressurisation Systems

Cabin Altitude

Abnormal and Emergency Operations

SKYBRARY

Safety Forum 2025 Videos and Presentations

The 12th Safety Forum was held June 5–6, 2025 at EUROCONTROL headquarters in Brussels. Organised by Flight Safety Foundation with EUROCONTROL and the European Regions Airline Association.

Forum Videos & Presentations

EASA

Conversation Aviation I-2025 - Summer Safety



Conversation Aviation

EASA

Conflict Zone Information Bulletins (CZIBs)

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

UPDATED

CZIBS



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Image from: <https://www.linkedin.com/in/expertaero-expertise-a%C3%A9ronautique-094ba215b/>

EASA CONSULTATION

Single Thrust Lever for Two Engines

A new concept of thrust control is proposed on a CS-25 aeroplane. Instead of one thrust lever per engine as known from traditional designs, there is a single thrust lever controlling the thrust delivered by two engines and a backup control means is used in case of engine failures requiring different thrust setting between both engines.

In normal operating conditions, the single thrust lever controls both engines thrust at the same time. The pilot inputs, when moving the lever, are acquired, processed and consolidated by the flight control system. A consolidated independent thrust order is then transmitted to each engine.

A backup system is introduced allowing separated thrust management for failure handling. This control knob allows to isolate the command of the faulty engine in order to set the appropriate thrust command on it.

EASA Consultation



Image from [Pilotswhoaskwhy.com](https://www.pilotswhoaskwhy.com)

PILOTS WHO ASK WHY

Understanding Rotor Downwash: The Ultimate Pilot Guide

Rotor Downwash: The topic that is either actively avoided by pilots, or assumed to be some dark magic that no puny mortal could possibly understand.

Unfortunately it's not a topic that gets a lot of attention from sources that make it really easy to understand properly.

Well, that's what we're going to fix today. We're going to keep things as simple as possible, while making sure we cover the most important items.

The goal here is to understand what exactly is going on with rotor downwash, without needing a fluid dynamics PhD! We'll also cover the biggest threats of rotor downwash, and how to manage them!

[Read more.](#)

AIR MEDICAL JOURNAL

Human Factors in Helicopter Air Ambulance Accidents, Incidents, and Safety Reports

Helicopter air ambulance (HAA) operations are subject to unique risks due to their time-sensitive and safety critical nature.

The Civil Aerospace Medical Institute completed analyses of the National Transportation Safety Board's (NTSB) Case Analysis and Reporting Online aviation accident and serious incident database and the National Aeronautics and Space Administration's Aviation Safety Reporting System data in a 10-year span. In total, 102 Aviation Safety Reporting System reports, 53 final NTSB accident reports, and 3 final NTSB incident reports involving HAA from 2013 to 2023 that occurred within the United States were coded for human factors and organizational risk factors.

The analyses identified several human factor risks affecting HAA pilots related to situation awareness, judgment and decision making, adherence to procedures, and experience and training. Furthermore, organizational issues influencing HAA operations, such as communication, safety culture, and those involving operator policy and procedure, were identified. These human factors and organizational safety findings suggest potential areas for safety interventions or mitigations in HAA operations.

[Read More](#)

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Image By Ahmed Stock.adobe.com

EASA & IATA

EASA and IATA Publish Comprehensive Plan To Mitigate GNSS Interference Risks

I. Enhanced Reporting and Monitoring

- Agree on standard radio calls for reporting GNSS interference and standardized notice to airmen (NOTAM) coding, i.e. Q codes.
- Define and implement monitoring and warning procedures, including real-time airspace monitoring.
- Ensure dissemination of information without delays to relevant parties for formal reporting.

2. Prevention and Mitigation

- Tighten controls (including export and licensing restrictions) on jamming devices.
- Support the development of technical solutions to:
 - reduce false terrain warnings;
 - improve situational interference with portable spoofing detectors; and
 - ensure rapid and reliable GPS equipment recovery.

3. Infrastructure and Airspace Management

- Maintain a backup for GNSS with a minimum operational network of traditional navigation aids.
- Better utilize military air traffic management (ATM) capabilities, including tactical air navigation networks and real-time airspace GNSS incident monitoring.
- Enhance procedures for airspace contingency and reversion planning so aircraft can navigate safely even if interference occurs.

4. Coordination and Preparedness

- Improve civil-military coordination, including the sharing of GNSS radio frequency interference (RFI) event data.
- Prepare for evolving-threat capabilities, also for drones.

[EASA Press Release](#)

EUROCONTROL

ACUTE Project – Facts And Findings On UAS Traffic in European Cities



The increasing use of Unmanned Aircraft System (UAS) is posing challenges to aviation authorities, especially in their integration with manned aviation. Through the ACUTE (Affordable Cooperative UAS Traffic Detection) project, an initiative of EUROCONTROL, UAS detection antennas are deployed in European cities to collect actual data on current UAS flights. This paper presents statistical analysis on detected UAS traffic and its proximity to manned aviation, as well as analysis using machine learning algorithms to detect patterns in UAS operations. The findings highlight a significant number of UAS users in various environments, as well as traffic fairly close to manned aviation. All these results will help Member States to refine airspace management and improve the safety of UAS operations.

[ACUTE Project Paper](#)



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Photo by Kevin Yang: <https://www.pexels.com>

NTSB

A350 Turbulence Encounter Causes Serious Injuries

Two passengers and two flight attendants received serious injuries aboard Delta Air Lines flight 175 when it encountered turbulence during descent into Hartsfield-Jackson Atlanta International Airport (ATL), Atlanta, Georgia. The flight was an international scheduled passenger flight operated as a Title 14 Code of Federal Regulation Part 121 from Milan Malpensa Airport (MXP), Ferno, Italy to ATL.

The flight crew’s performance leading up to the turbulence encounter was consistent with standard practices. The investigation evaluated the potential for crew awareness of the rapidly building cell where the flight encountered severe turbulence. The flight crew was aware and monitoring the general convective weather in the area and showed intention to deviate around other potential convective cells. However, the rapid development of cloud buildup that caused this turbulence event and the lack of precipitation associated with it, meant that the risk of turbulence was not apparent on aircraft weather radar nor on air traffic control scopes.

In anticipation of another convective cell a few minutes further down their route, the crew took steps to advise the flight attendants to secure the cabin early and the seat belt sign was illuminated. Unfortunately, the timing of the unexpected turbulence meant that cabin crew were not seated during the event, resulting in multiple injuries.

The investigation evaluated whether existing technology would have been sufficient to give the crew advance warning of the rapidly building cell. The Graphic Turbulence Guidance Nowcast (GTGN) or “Turbulence Nowcast” provides a computer-generated four-dimensional forecast related to the expected intensity of atmospheric turbulence in convection provided in eddy dissipation rate (EDR) as based on estimated vertical wind velocity or aircraft vertical acceleration to provide aircraft specific turbulence intensity values. While the accident aircraft did not have this capability, a Southwest Airlines flight immediately behind the accident flight on the route had in-situ capability and reported severe turbulence in the location where the turbulence event occurred. The GTGN can provide nowcasts corresponding to observed severity in near real time and could have alerted the flight crew earlier to secure the cabin.

Probable Cause: The flight crew’s unintentional encounter with rapidly developing cumulus clouds which resulted in an encounter with severe convectively induced turbulence.

NTSB Report

CAA SKYWISE

Department for Transport targeted stakeholder consultation: Views on the Civil Aviation Safety Regulatory Framework

The Department for Transport is launching a consultation to gather views from stakeholders on the aviation safety regulatory framework and potential options for reform. A wide range of stakeholders will be interested in the important issues presented in this document and the related consultation. Responses are welcome from all stakeholders who are regulated under aviation safety legislation. This consultation will close on 25 July.

They are inviting stakeholders to provide responses to the questions set out, share their views on potential future approaches to aviation safety regulation, and/or to provide views on any issue relevant to the effective operation of the UK’s framework for aviation safety regulation.

[Access the consultation here.](#)

SW2025/I51

CAA SKYWISE

Consultation for Special Condition - Installation of Mini-suite Seating

The UK CAA is consulting on a Special Condition that is applicable to CS-25 Large Aeroplanes.

This Special Condition is to address the design change that introduces mini-suite type seating with moveable walls, for twin-aisle Large Aeroplanes.

[They invite stake holders to give their views.](#)

SW2025/I50

CAA SKYWISE

DAA Policy Concept Consultation Response Published

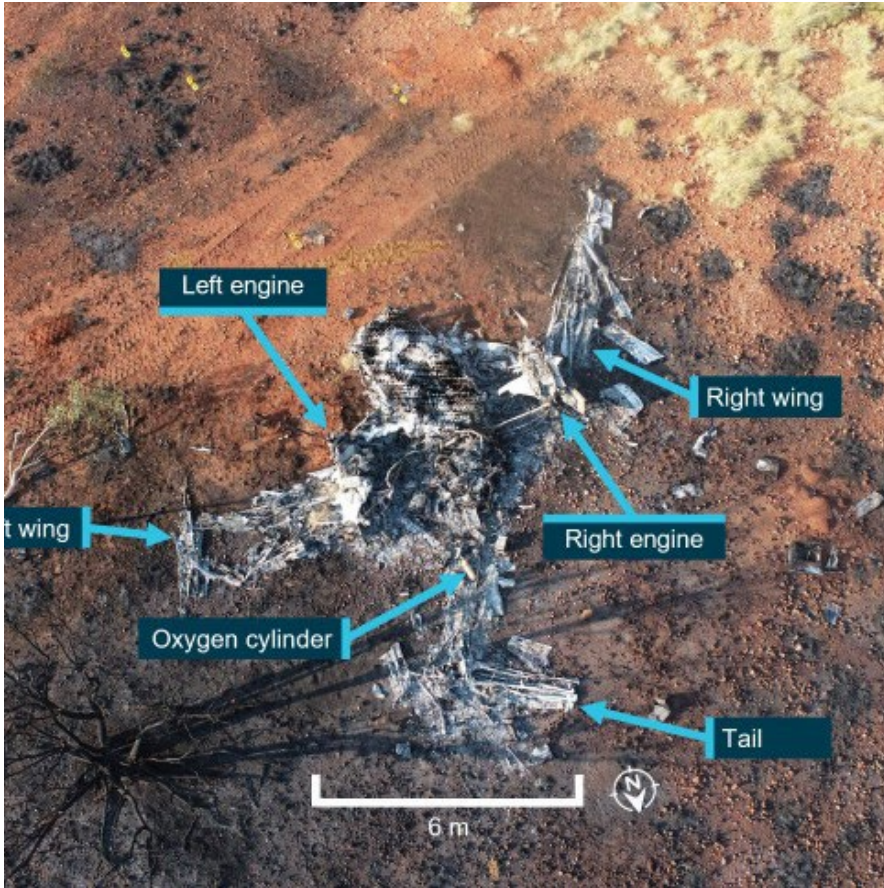
The CAA has published its response to the 2024 consultation on Detect and Avoid (DAA), a key enabler for safe, scalable BVLOS drone operations in UK airspace.

The summary outlines key themes, stakeholder feedback, and next steps as we move into a test phase.

[For more information see www.caa.co.uk/CAP3127](http://www.caa.co.uk/CAP3127)

SW2025/I46

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AUSTRALIAN TRANSPORT SAFETY BUREAU

Photos from the official accident report

Gulfstream 695A Pilot Incapacitation, Loss Of Control And Collision With Terrain

About 1 hour and 50 minutes into cruise at FL280, ATC lost radio contact with VH-HPY. Multiple attempts to re-establish contact failed. After 30 minutes, ATC reached the pilot via mobile phone. The pilot’s speech was slow and flat, prompting ATC to initiate hypoxia emergency procedures.

A nearby aircraft briefly re-established contact. The pilot’s speech continued to deteriorate—slow, quiet, repetitive, and confused. The pilot’s last radio call was the slowest and most impaired. No further responses were received after that.

The aircraft entered a descending anticlockwise turn, likely transitioned into a spin at 10,500 ft, and impacted terrain at high speed. Crash Site: 55 km southeast of Cloncurry. A post-impact fire occurred.

The aircraft had a long-standing, intermittent pressurisation defect that limited cabin pressure. AGAIR senior management was aware of the issue but:

- Did not formally record it.
- Did not notify the safety manager.
- Did not conduct a formal risk assessment.
- Did not provide pilots with procedures to manage it.

AGAIR management encouraged continued operations at altitudes requiring oxygen, despite the aircraft lacking a suitable oxygen supply. The accident pilot had a history of operating the aircraft with the defect, using emergency oxygen and brief descents to manage hypoxia symptoms—an unsafe workaround.

During the accident flight, the pressurisation system likely failed to maintain safe cabin altitude. The pilot probably relied on the emergency oxygen system, which was not designed for sustained use. ATC recordings showed the

pilot’s speech deteriorated significantly—consistent with hypoxia—impairing safe operation.

The pilot likely reduced power without initiating descent, causing airspeed to drop. The aircraft entered a descending turn, then likely transitioned into an aerodynamic spin at 10,500 ft. A recovery attempt was made but failed, leading to terrain impact.

The AGAIR Head of Flying Operations failed to disclose the known pressurisation defect when contacted by ATC during the emergency. This omission prevented ATC from instructing a descent, which might have saved the flight. ATC downgraded the emergency response based on the pilot’s misleading assurance that operations were normal. The ATC hypoxia checklist lacked guidance on when to cease emergency response, increasing the risk of premature downgrade.

AGAIR routinely operated Gulfstream 690/695 aircraft with known defects unrecorded on maintenance releases.

This accident highlights the dangers of operational practices that intentionally circumvent critical safety defences. The acceptance of these actions at an individual and organisational level normalises that behaviour and exposes the operation to an unnecessarily increased level of risk.

This accident also underscores the insidious and deadly potential of altitude hypoxia, and pilots need to be alert to this significant hazard when operating at high altitude. Life support and emergency alerting systems are often the final line of defence against hypoxic incapacitation, and they should only be used in accordance with the manufacturer’s procedures.

[ATSB Report](#) [ATSB Video](#)

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Photo by Jeffry S.S.: <https://www.pexels.com>

NATIONAL TRANSPORTATION SAFETY BOARD

B737-9 In-Flight Separation of Left Mid Exit Door Plug

On January 5, 2024, a Boeing 737-9 airplane operated by Alaska Airlines as flight 1282 experienced an in-flight separation of the left mid exit door (MED) plug and rapid depressurisation when climbing through about 14,830 ft after take-off from Portland International Airport (PDX), Portland, Oregon. One flight attendant and 7 passengers received minor injuries; the captain, the first officer, 3 flight attendants, and 164 passengers were uninjured; and the airplane sustained substantial damage. The flight and cabin crews executed the emergency procedures in response to the rapid depressurisation, and the flight returned to PDX for a safe landing.

The NTSB found that the four bolts that secured the left MED plug to prevent it from moving upward vertically were missing before the newly manufactured airplane was delivered to Alaska Airlines. As a result, the left MED plug was able to become displaced gradually upward (by fractions of an inch) during previous flights until, during the accident flight, it displaced upward enough to disengage from its stop fittings and separate in flight.

The probable cause of this accident was the in-flight separation of the left MED plug due to Boeing’s failure to provide adequate training, guidance, and oversight necessary to ensure that manufacturing personnel could consistently and correctly comply with its parts removal process, which was intended to document and ensure that 3 the securing bolts and hardware that were removed to facilitate rework during the manufacturing process were properly reinstalled. Contributing to the accident was the FAA’s ineffective compliance enforcement surveillance and audit planning activities, which failed to adequately identify and ensure that Boeing addressed the repetitive and systemic non-conformance issues associated with its parts removal process.

The NTSB made 19 recommendations in addition to those issued in the preliminary report.

Synopsis from the NTSB’s report

IATA

New IATA Aviation Security Position Papers



- Airspace Risk Assessment Management Checklist (2025)
- Aviation Security Trust Framework Whitepaper (2025)
- AVSEC Panel 36 Information Paper: Aviation Security Trust Framework (2025)
- Full Supporting Guidance for AOSP / SSPs (2025)
- Hold Baggage Reconciliation (2025)
- Operational Risk Management in Aviation Security (2025)
- Professionalization of Airport Security Screening Checkpoint Operations (2025)
- Reporting of Aviation Security Occurrences and Incidents (2025)
- The Threat of Improvised Incendiary Devices to Aviation (2025)

IATA Position Papers



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Photo by Jeffry S.S.: <https://www.pexels.com>

NATIONAL TRANSPORTATION SAFETY BOARD

NTSB Recommends Modifications to LEAP-IB Engines (NTSB Press Release)

WASHINGTON (June 18, 2025) — The National Transportation Safety Board issued an urgent safety recommendation Wednesday to address the possibility of smoke entering the cockpit or cabin of airplanes equipped with CFM International LEAP-IB engines and issued additional recommendations to evaluate the potential for the same issue with LEAP-IA and -IC engines.

CFM LEAP engines are used on variants of Airbus A320neo and Boeing 737 Max narrow-body passenger jets.

The NTSB found that the engine load reduction device, or LRD, a safety feature designed to reduce the severity of vibrations transmitted from a damaged engine to the airframe, can result in damage to the engine oil system. Such a condition can allow smoke from hot oil to enter the ventilation system and ultimately the cockpit or passenger cabin.

The recommendations stem from the NTSB’s investigation into a December 2023 incident in which smoke entered the airplane after a bird was ingested into the left engine of a Southwest Airlines Boeing 737-8 shortly after departing New Orleans, Louisiana. The flight deck filled with what the crew described as “acrid white smoke” so thick that the captain had difficulty seeing the instrument panel. The crew donned masks, were able to clear the smoke, and landed the airplane back in New Orleans. None of the crew or passengers were injured.

A similar engine damage event occurred in March 2023 on another Southwest flight when vapour fog filled the passenger cabin after birds were ingested into the right engine shortly after departing Havana, Cuba. The flight crew declared an emergency and returned to the departure airport without further incident.

Concerned that flight crews operating these airplanes may not be fully aware of the potential hazard of an LRD smoke-related event along with the appropriate mitigation actions, the NTSB issued an urgent safety recommendation to the Federal Aviation Administration asking the agency to ensure that operators inform flight crews of airplanes equipped with the affected engines. Boeing has revised flight manuals for pilots detailing the steps to take to prevent smoke from entering the cockpit or cabin following an LRD activation.

In safety recommendations issued to the FAA, the European Union Aviation Safety Agency (EASA) and the Civil Aviation Administration of China, the NTSB asked the aviation regulators to determine if other variants of the CFM LEAP engine are also susceptible to smoke in the cabin or cockpit when an LRD activates.

The NTSB also asked the FAA and EASA to require all operators of the affected engines to incorporate software modifications developed by CFM and Boeing.

The 11-page aviation investigation report is available online.

To report an incident/accident or if you are a public safety agency, please call 1-844-373-9922 or 202-314-6290 to speak to a Watch Officer at the NTSB Response Operations Center (ROC) in Washington, DC (24/7).

Mitigations Concerning Load Reduction Device Activation in CFM International LEAP-IB Engines

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Recent Accidents & Incidents from the Air Safety Network Wikibase

Date	Type	Event	Location
19-Jun-25	A319	ATB, after smoke was reported immediately after takeoff	Athens
17-Jun-25	A320	Diverted due to a smell of smoke	Munich
23-Jun-25	A320	GCOL, struck by a stair vehicle	Aden
20-Jun-25	A320	Bird Strike.	Pune
15-Jun-25	A320	ATB, pressurisation issue.	Tucson
25-Jun-25	A321	ATB, No.1 engine issue.	Smolensk
16-Jun-25	A321	Bird strike on approach	Dallas
19-Jun-25	A321	Declared a low fuel emergency during a diversion to BLR	BLR
25-Jun-25	A321	ATB due engine surge shortly after take off.	Las Vegas, NV
25-Jun-25	A321	ATB, problem with engine no.1	Smolensk
23-Jun-25	A330-200	ATB, due to an odour in the cockpit	Tokyo
21-Jun-25	A330-300	ATB, No.1 engine issue, flames and smoke.	Seoul
20-Jun-25	A330KC2	Vandalised by the direct action protest group “Palestine Action”	BZZ
20-Jun-25	A330 KC2	Vandalised by the direct action protest group “Palestine Action”	BZZ
18-Jun-25	B200	Forced landing, substantial damage.	Mbire
19-Jun-25	B737 MAX8	Contact with a fence while taxiing	KLX
18-Jun-25	B737-800	Collided with the passenger bridge while taxiing	BNE
18-Jun-25	B737-800	Turbulence. One cabin crew sustained serious injuries, and two cabin crew and four passengers received minor injuries.	Florida
17-Jun-25	B737-800	GCOL, A bus hit the wing	FRA
15-Jun-25	B737-900	Turbulence. One cabin crew member sustained serious injuries. One cabin crew member had minor injuries.	Fort Lauderdale
24-Jun-25	B767-300	RTO, due to technical issues. As a result, three tires went flat.	Zurich
18-Jun-25	GLOBAL	ATB, smoke in the cockpit after departure	Austin, TX
19-Jun-25	C525B	Suffered a baggage fire at BUR. The fire was extinguished.	Hollywood
17-Jun-25	FALCON	ATB, struck a bird on departure	Louisville
23-Jun-25	DHC6	ATB, suffered a massive tail strike on takeoff due to incorrectly restrained cargo shifting upon rotation.	Mt. Hagen
22-Jun-25	EI95	One of the wheels sink into the tarmac while being towed.	FEN
18-Jun-25	EI45	Diverted as one of the pilots fell ill.	Manchester
18-Jun-25	EI75	Emergency declared on final approach. Stopped on runway, slides deployed and all passages evacuated.	Charleston
22-Jun-25	ECI30	Suffered a dynamic rollover while attempting to land	Pearl Beach
25-Jun-25	MD500	Crashed in mountainous terrain.	Meeker, CO
22-Jun-25	R44	The helicopter impacted trees and crashed into a dam during an early morning frost/moisture control flight.	Nylstroom
25-Jun-25	R44	Spraying crops, struck powerlines	Hancock County
15-Jun-25	SI00	ATB, lost the cowlings of the right engine during takeoff.	Moscow



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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	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	NEW
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	