UK Flight Safety Committee

UKFSC News #34

29 July 2025

Tuesday 29 Jul, 2025

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Issue #34

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UKFSC NEWS

The latest news from the flight safety world

Issue #34

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On 4 December 2023, a Boeing 737-8200 (EI-HET) operated by Ryanair on a scheduled international passenger flight from Klagenfurt, Austria, to London Stansted with the captain as pilot flying (PF) commenced a go-around at destination. The go-around

Photo by Mehdi S on unsplash.com

began from significantly above decision altitude in day instrument weather conditions (IMC) after a mismanaged and unstable ILS approach. The go-around continued significantly above the missed approach stop altitude until Air Traffic Control (ATC) alerted the crew. But the recovery then involved a second level bust at a high rate of descent with an Enhanced Ground Proximity Warning System (EGPWS) Mode 1 warning occurring as recovery climb was initiated. Once finally level at 3,000 feet, the arrival was completed without further event.

Learn More

Related Articles

Energy Management During Approach

Missed Approach

Level Bust

By Markus Mainka

NORWEGIAN SAFETY INVESTIGATION AUTHORITY

S92A Spurious Fire Warning

On Tuesday October 20, 2020, Sikorsky S-92A LN-OMI, operated by Bristow Norway AS, was en route from Stavanger Airport Sola (ENZV) to the Ekofisk Kilo (ENXK) oil and gas platform. Just under an hour into the flight, a fire warning for engine 1 was triggered. The crew decided to stop the engine and used the two fire extinguishers that were available. The fire alarm continued, but since they did not register any other indications of fire, they concluded that the alarm was false. They therefore restarted the engine and continued towards Ekofisk oil and gas field where they landed at Ekofisk Lima.

After landing, the engine and engine compartment were inspected, and it was ascertained that there had been no fire. The crew that was involved in this incident had not been trained specifically to handle false warnings. They did have a checklist they could use, but a situation with a continuous false warning was not mentioned. Consequently, the crew had to make several decisions based on their best judgement.

There have been a number of false engine fire warnings on S-92 helicopters. However, the warnings have normally only lasted a short time. The NSIA believes that false warnings poses a serious problem, particularly because false warnings reduce confidence in the fire warning system. The incident touches on several issues concerning false fire warnings and how they are dealt with.

About half of Bristow Norway's helicopters are currently equipped with tail-mounted cameras, which also is a requirement according to Document 066 from Offshore Norge. This can help the crews determine whether there is a real fire. In the opinion of the NSIA, consideration must be given to having a uniformly equipped helicopter fleet.

The report makes no recommendations.

NSIA Report

SPIRENT WEBINAR

GNSS Resilience in Action: Testing, Simulation & CRPA Innovation

International experts explore how CRPA technology is evolving to meet today's toughest challenges in GNSS resilience.

Watch the free webinar on demand.

TSB CANADA

PT6B-37A Engines PY Lines And Fuel Control Unit (FCU) Contamination

Civil Aviation Safety Alert (CASA) is to provide awareness of reported contamination of the Py lines and FCU on P&WC PT6B-37A engines. CASA-2025-07

EUROCONTROL WEBINAR

Dr Kevin Fong- Aviation, Space and Extreme Environment Medicine

Fri 26th of Sept 14:00-15:30 CET. This webinar series explores the careers of people who have made a significant difference to safety-critical industries. Register

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CHIRP

Air Transport Feedback

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- Flight Crew Refuelling Operations
- Sickness Mobbing
- Cleared To Flight Level Below Transition Level
- Taxi Provision
- Ground Duties In Own Time

ATFB 155 July 2025


AVIATION FEEDBACK

CHIRP An independent and confidential reporting system for the Aviation industry

AIR TRANSPORT Edition ATFB 155 July 2025

SUBMIT A REPORT

CHIRP always protects the identity of our reporters. All personal details are deleted from our system once a report is completed.

ONLINE

Reports can be submitted easily through our encrypted online form www.chirp.co.uk/aviation/submit-a-report

Safety Culture

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William Dean
Air Transport Programme Manager

CHIRP reporting themes

My first six months as Air Transport (AT) and Advanced Air Mobility (AAM) programme manager in CHIRP's aviation team has been both enlightening and professionally rewarding. Having previously been a member of the Air Transport Advisory Board (ATAB) I was very familiar with how CHIRP's advisory boards dealt with the human factors based reports presented to them for discussion, but now that I've taken on the newly created AT/AAM PM role, I have more insight into the reports as they arrive into CHIRP, and importantly, I'm able to have direct contact with the individuals who report in to us with their concerns. Reporters' motivations for submitting confidential reports to CHIRP vary

Photo from the official report

IRAN CIVIL AVIATION ORGANISATION

Lightning Strike & Loss Of Cabin Pressurisation Control

On 24 May 2024, Iran Air flight IRA445, a Fokker 100 departed from Mehrabad to Tabriz. At FL300, the aircraft experienced a loss of the AC Essential Bus (ESS AC BUS), likely triggered by a lightning strike. This led to the failure of weather radar, ATC transponder, TCAS, captain's Primary Flight Display (PFD), Navigation Display (ND), and Multi-Function Display Units and the automatic cabin pressurisation system.

The crew attempted manual cabin pressure control but failed. As cabin altitude rose uncontrollably, they declared a MAYDAY and diverted to Ardabil.

The cause was tripping of the ESS AC BUS circuit breaker (CB). Contributory factors were high crew workload following the ESS AC BUS failure hindered effective manual control of cabin pressure. The Cabin Air Pressure Selector showed minor deviations from specifications that contributed to control difficulties. The recorders were powered by the ESS AC BUS, no data or voice was captured, complicating post-incident analysis.

The operator issued an Operational Technical Inspection Requirement (OTIR) for inspections of the ESS AC BUS CB for signs of overheating, degradation, or damage with corrective actions if any anomalies are found. CAO Report

CAA SAFETY NOTICE

Pitot Blockage Events

The UK CAA have been advised of recent events occurring at London Heathrow Airport, whereby aircraft have been the subject of pitot blockages that resulted in airspeed discrepancies, high-speed rejected take-off and associated crew actions. Subsequent inspections of the pitot probes on these aircraft have confirmed the return of risk associated with Solitary Bee activity previously experienced in 2021/22 (post pandemic).

Crews should be made aware of this potential issue, reminded of the importance of the speed checks during the take-off roll and the actions to be taken in the case of a discrepancy, as well as the appropriate unreliable speed indications for their aircraft type should they discover the issue once airborne.

SN-2025-010

CAA PUBLICATION

FOCA AD HB-2025-002: Pilatus Aircraft PC-21: Crew Escape and Safety – Ejection Seats - Barostatic Time Release Unit Attachment Hardware – Inspection

FOCA Airworthiness Directive - Although FOCA have not designated this an Emergency AD, the CAA are sending out this notification because of the short compliance period.

View FOCA AD HB-2025-002

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Photo: Panama City Airport ARFF

NTSB

Falcon 10 Runway Excursion

Upon arriving at the destination airport, the business jet touched down about 2,500 ft beyond the threshold of the 10,000-ft-long runway. The pilot extended the airplane's flight spoilers and attempted to activate the thrust reversers, but the airplane did not decelerate as expected and a warning horn sounded. The pilots then attempted to apply normal followed by emergency braking, both of which were ineffective in slowing the airplane. The airplane subsequently overran the runway and struck several approach lighting stanchions, coming to rest after the landing gear collapsed. The airplane's occupants were uninjured, but the airplane was substantially damaged during the accident sequence.

Following the accident, the captain noticed he had forgotten to move the thrust reverser emergency stow switches to their normal operating position after completing a preflight check. The warning horn heard during the landing was an indication of the stowed thrust reverser switches. The ineffective braking likely occurred because of the engines' increased thrust output due to the attempted application of the thrust reversers with the switches in the stowed position.

A post accident examination of the wreckage confirmed that there was no evidence of any preimpact mechanical malfunctions or failures that would have precluded normal operation of the airplane. The airplane checklist found in the cockpit was marked "For Training Purposes Only" and for an airplane that was not equipped with thrust reversers.

Probable Cause and Findings

The flight crew's failure to appropriately configure the airplane for landing, which resulted in a failed attempt to utilize the thrust reversers during landing and the inability to stop the airplane using its brakes due to increased forward thrust. Contributing to the accident was the flight crew's failure to utilize the appropriate checklist for the thrust reverser equipped airplane.

NTSB Report

FAA SAFO

Risks Associated with Visual Approaches

Following several high visibility events this SAFO applies to all air carrier operations.

The primary purpose of the Air Traffic Control (ATC) system is to prevent aircraft collisions. Effective communication between pilots and air traffic controllers is essential to achieving this safety goal. ATC supports the pilot-in-command's (PIC) authority to declare "unable" when a clearance reduces the safety margin. This includes, but is not limited to, vectors, speeds, or altitudes that increase pilot workload. Examples include unexpected vectors inside normal descent profiles, airspeed restrictions, and requests to: Use a runway as a taxiway; Use a shorter runway than expected; Conduct land-and-hold-short operations; Perform circling maneuvers associated with an instrument approach; Maneuver at low altitudes on a visual approach; Land with tailwinds or crosswinds that may increase risk to an unacceptable level; Execute Line Up and Wait clearances; Perform intersection takeoffs; Follow runway exit instructions onto intersecting runways during the landing roll; and Make changes to departure, arrival, approach, runway assignments, or requesting operators execute a visual approach. Read More

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Photo by Robert

NTSB

BD100 Challenger Inflight Upset Cabin Crew Injured

An aircraft on a positioning flight with two pilots and one cabin attendant from the flight data recorder (FDR) indicated that the autopilot was engaged after takeoff as the airplane climbed through about 4,200 ft pressure altitude. About five seconds later, an AP STAB TRIM FAIL message appeared on the crew alerting system (CAS). The message was acknowledged by the flight crew 5 seconds later, as indicated by the deactivation of the master caution recorded in the FDR. Fourteen seconds after the appearance of the AP STAB TRIM FAIL message, an AP HOLDING NOSE DOWN message posted on the CAS, which the crew acknowledged about 6 seconds later.

According to the flight crew, the pilot-in-command (PIC) began to review the checklist in the quick reference handbook (QRH) and assumed control of the airplane from the second-in-command (SIC) after a positive exchange of controls. Both pilots reported that the autopilot disconnected shortly after they exchanged control, and the airplane immediately pitched up. The SIC reported that, after "several hard oscillations," the PIC was able to recover the airplane into straight and level flight. The cabin attendant sustained serious injuries during the in-flight upset. The PIC reported that he did not feel comfortable reengaging the autopilot and continued to manually fly the airplane.

The airplane was above 10,000 ft, the altitude at which company procedures permitted cabin attendants to remove their seat belts and move about the cabin. The cockpit voice recorder was overwritten, so it's unclear whether the crew followed the checklist procedures, which advised securing seat belts and holding flight controls firmly. The cabin attendant was not instructed to remain seated, despite the checklist warning of abrupt control changes.

Post-accident testing found no mechanical faults with the autopilot. It's likely the disconnect was due to inadvertent pilot input, though the exact cause remains undetermined. The manufacturer noted that such failures could occur if the autopilot is engaged in an out-of-trim condition, but whether this applied here couldn't be confirmed.

Probable cause: An in-flight upset resulting in serious injury to the cabin attendant following an autopilot disconnect for reasons that could not be determined. NTSB Report

CAA SKYWISE

UK CAA Publishes Aeroplane CO2 Database

New aeroplane types and aeroplanes in-production after 2027 are required to comply with the CO2 emissions Standard prescribed in Volume III of ICAO Annex 16. The Standard obliges CAA to publish the CO2 emissions values for any aeroplane for which they are approved. CAA has recently approved its first CO2 metric values. Details can be found at UK CAA Aeroplane Carbon Dioxide emissions database. The database will be updated as and when new approvals are granted.

SW2025/210

CAA SKYWISE

Consultation on Amendments to CAP 168

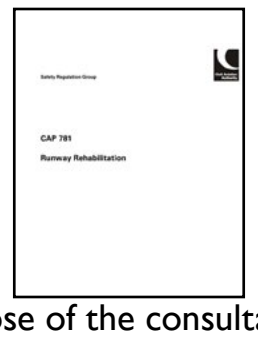
This consultation's purpose is to introduce the new format CAP168 and its amendments prior to publication. The amendments have previously been subject to two previous consultations.

The CAA invite stakeholders to give their views, the closing date is 15 July 2025.

SW2025/226

CAA SKYWISE

Aerodromes Consultation on the Update of CAP781 Runway Rehabilitation and Maintenance



The purpose of the consultation is to gain feedback from industry and the wider public on the proposed amendments to CAP781 as a result to the CAAs periodic review and update of the guidance material.

The CAA invite stakeholders to give their views, the closing date is 18 August 2025.

SW2025/227

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Photo By Markus Mainka

BUREAU D'ENQUETES ET D'ANALYSES

ATR 72 Take-off With Incorrect Centre of Gravity

On 21 September 2024, an ATR72-212A aircraft operated by Chalair Aviation took off from Caen-Carpiquet Airport for a commercial passenger flight to Kerry, Ireland. During takeoff, the captain experienced unusually heavy control input resulting in a trim setting of 2.2 UP compared to the take-off trim setting of 1.2 UP. This discrepancy was due to an incorrect centre of gravity (CG) caused by a data entry error in the Dry Operating Index (DOI), entered into the Departure Control System iPort software.

The agent was informed of the DOI verbally and the error originated when they mistakenly entered "15.5" instead of "-15.5" for the DOI. This led to a miscalculated Centre of Gravity resulting in most passengers seated forward. The cabin crew member who carried out the count found the passenger distribution unusual, given the small number of passengers on board. They were mainly seated in the middle and front sections. She pointed this out to the cabin manager. She told him that this distribution had been validated by the pilots. The pilots were not informed.

After take-off, the captain contacted the RDOS (Designated Ground Operations Manager), who coordinated with ATC (Air Traffic Control) to instruct the crew to move six passengers rearward during approach. The aircraft landed safely without further incident.

Lessons Learned

Human error in data entry: A simple data entry error in the DOI field had a significant impact on aircraft balance.

Lack of robust training: Operations agents had inconsistent and insufficient training on the DCS iPort system.

Software vulnerability: The system allowed manual overwriting of critical pre-filled data without safeguards.

Communication gaps: Cabin crew noticed unusual passenger distribution but did not escalate it to the captain, assuming it had been validated.

Actions Taken

By Chalair Aviation:

Suspended use of DCS iPort (Departure Control System iPort) at Caen station for weight and balance calculations.

Centralised responsibility for weight and balance estimates to the CCO (Operations Control Centre).

Restricted DOI (Dry Operating Index) modifications to authorised personnel only.

Issued internal guidance emphasising the importance of complete and accurate data entry 1.

By Caen Airport:

Planned a structured training programme for operations staff on DCS iPort, including skill verification.

Initiated a review of staff fatigue cycles to optimise shift rotations and reduce error likelihood.

Safety Recommendations

Implement software safeguards to prevent unauthorised or incorrect modification of critical flight parameters like DOI.

Standardise and verify training for all operations agents, especially on low-frequency routes.

Establish clear protocols for cabin crew to report anomalies in passenger distribution directly to the flight deck.

Monitor and manage staff fatigue proactively, especially during early shifts or extended duty cycles.

BEA Report

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Photo from the interim report

INTERSTATE AVIATION COMMITTEE MAK

S100 Loss of Control

The final report was recently published by th Interstate Aviation Committee (MAK). The preliminary report was included in Newsletter 12 on 28th January. On 12 July 2024, a RRJ-95LR-100 aircraft crashed near Apraxsino, Moscow region, during a ferry flight from Lukhoviy to Moscow following scheduled maintenance.

The aircraft's automatic protection system for overspeed and high AoA was triggered based on faulty data from incorrectly installed AoA sensors.

The crew's decision-making process during the incident as detailed in the report reveals a complex interplay of procedural adherence, situational misinterpretation, and psychological stress. Upon encountering abnormal flight behaviour, the captain initiated actions based on the QRH procedure for "Unreliable Airspeed Indication." This included: Setting the thrust levers to the CLIMB position. Pulling the control column fully aft to stabilise the aircraft in level flight. Using the QRH's PITCH/AoA/THRUST table to guide control inputs. The crew interpreted the situation as a failure in airspeed indication (ADS), not as an angle of attack (AoA) error. This led them to increase engine thrust up to take-off power, which caused the aircraft to exceed VMO (maximum operating speed), triggering overspeed warnings and automatic spoiler deployment

The captain likely perceived the "NAV ADS DISAGREE" message as valid and attempted to follow QRH procedures. However, the absence of guidance for intermittent or disappearing CAS messages, and the lack of QRH instructions for AoA sensor failure, left the crew without a clear path forward.

In the final moments, throttle movements (CLIMB - IDLE - TOGA - IDLE) suggest the captain was attempting to probe the aircraft's response, possibly in a last effort to regain control under extreme psychological pressure

The accident was primarily caused by the incorrect installation of AoA sensors due to procedural lapses and inadequate documentation. Contributing factors included, crew reliance on faulty data, despite following SOPs, the crew could not stabilise the aircraft due to misleading instrument readings. Lack of specific QRH procedures to cover the simultaneous activation of overspeed and AoA protections. Failure to establish contact with ATC due to incorrect radio settings. Training did not prepare the crew for this specific failure scenario.

Following the accident an Information Letter was issued to operators stressing proper AoA sensor replacement. A Bulletin SB-RRJ-34-0675 was published for non-removable installation of AoA sensor covers and the Flight Operations Manual was updated with new procedures for AoA limitation functions. Several recommendatons were made reinforcing these actions.

Final Report in Russian

EASA COMMUNITY NETWORK

Three Key Messages for Passengers

From Sven - Safewings Cabin Manager:

1. **"Charge Smart, Stay Safe"** - Care of Lithium battery powered devices.
2. **"Put Yourself in Flight Mode"** - A calm cooperative mindset to prevent disruptive behaviour.
3. **"Leave Bags Behind"** - In an evacuation leave everything and just go!

Read More

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Recent Accidents & Incidents from the Air Safety Network Wikibase

Date	Type	Event	Location
24-Jul-25	A319	Diverted passenger's mobile charger caught fire.	Soeng Sang
25-Jul-25	A320	Diverted no. 2 engine fail	Buffalo, NY
27-Jul-25	A330	Diverted electrical failure mid-flight to two of its four generators.	Scotland
24-Jul-25	AN24	Crashed in a forest	Tynda Airport
22-Jul-25	ATR72	Engine failure while on approach	Kithira
23-Jul-25	B200 KA	GCOL, taxiing for departure and struck a runway light damaging the right prop and nose gear door.	Nome Airport
23-Jul-25	BELL 206	Clipped power lines and crashed	Thibodaux, LA
26-Jul-25	B737 MAX8	GCOL, hit by the aerobridge	Brisbane
26-Jul-25	B737 MAX8	RTO, the left main gear collapsed and a small fire broke out. All 176 passengers and 6 crew members evacuated safely.	Denver
24-Jul-25	B737 MAX8	Hit two or three deer during landing	Kodiak
25-Jul-25	B737-700	Climbing through 14,000 ft when the flight crew conducted a descent to avoid a Hawker Hunter Mk.58 (N335AX).	Santa Clarita
27-Jul-25	B737-800	GCOL, being towed to the maintenance hangar at Melbourne Airport when it became disconnected from the tug vehicle, causing the tug to impact the side of the aircraft.	Melbourne
21-Jul-25	B737-800	RWINC, DL590, a Boeing 737-800 lined up on runway 05R 500 m before the threshold and held, AM1631, an ERJ-190 overflew the Delta B737 and touched down on runway 05R. DL590 had already commenced the take-off roll and 60 knots. The aircraft aborted the take-off.	Mexico City
25-Jul-25	B737-800	ATB, to check the pressurization systems.	Chulym
21-Jul-25	B737-800	A lithium battery in passenger's bag inside an overhead compartment experienced a thermal runaway.	NNE of Hobart
21-Jul-25	ERJ-175LR	Encountered turbulence.	Jacksonville, FL
21-Jul-25	ERJ-190LR	RWINC, DL590, a Boeing 737-800 lined up on runway 05R 500 m before the threshold and held, AM1631, an ERJ-190 overflew the Delta B737 and touched down on runway 05R. DL590 had already commenced the take-off roll and 60 knots. The aircraft aborted the take-off.	Mexico City
22-Jul-25	MD-11F	Blown tyre on landing.	Miami
21-Jul-25	R66	Experienced engine issues and crashed in a field.	Oelwein, IA
22-Jul-25	S64	A firefighting helicopter crashed into the sea off Elefsina.	Elefsina

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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	
2025	Aug	27th – 28th	EASA	Artificial Intelligence in Aviation	Cologne	Hybrid
2025	Sep	10th	UKFSC	472nd SIE	Online	
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	EURO-CONTROL	Just Culture Conference	Ljubljana	
2025	Sep	25th	CAA	Ground Handling Regulation Workshops	London	
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	8th	RAeS	RAeS Mental Health in Aerospace Awareness Event	RAeS HQ, London	
2025	Oct	14th	EURO-CONTROL	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	Oct	22nd	Met Off	2025 Met Office Aviation User Forum	Met Office, Exeter	**NEW**
2025	Oct	23rd	CAA	Ground Handling Regulation Workshops	Edinburgh	
2025	Oct	28th	EASA	Ramp (SAFA/SACA) Inspection Forum 2025	Brussels	
2025	Nov	4th – 6th	FSF	78th International Aviation Safety Summit	Lisbon, Portugal	
2025	Nov	6th	BHA	BHA Annual Safety Day info@britishhelicopteras-sociation.org	Cranfield University	
2025	Nov	10th – 12th	UKFSC	FSO Course	Gatwick	
2025	Nov	11th – 13th	Bombar-dier	29th Bombardier Safety Standdown	Wichita, Kansas	
2025	Nov	12th - 13th	EASA	EASA Annual Safety Conference 2025	Copenhagen	
2025	Nov	17th -20th	EASA	Rotorcraft Symposium and European Rotors 2025	Cologne	**NEW**
2025	Nov	19th	RIN	4th Annual UK PNT Leadership Seminar	London	
2025	Nov	27th	CAA	Ground Handling Regulation Workshops	Manchester	
2025	Dec	2nd	UKFSC	473rd SIE	Online	
2025	Dec	2nd	EASA	Ground Handling Implementation Webinar	Online	