

4 February 2015  
Reference: F0002203

Dear XXXX

I am writing in respect of your recent request of 14 January 2015 for the release of information held by the Civil Aviation Authority (CAA).

Your original request:

*For the calendar years 2013 and 2014, can you please supply?*

*Details of all onboard safety incidents occurring on flights in airspace over the United Kingdom. These should include any incidents occurring during take-off or landing.*

*Details of the relevant flight / airport in each case (flight departure point/destination)*

*Details of the action taken in each case. Eg, was a diversion necessitated?*

*Details of any recorded injuries to passengers/crew.*

*This request was modified with your consent on the 22 January 2015 to cover:*

- *UK airspace*
- *Commercial Air Transport only*
- *High risk graded events as well as those categorised by the Air Accidents Investigation Branch (AAIB) as an accident or serious incident.*

Our response:

Having considered your modified request in line with the provisions of the Freedom of Information Act 2000 (FOIA), we are able to provide the information below.

Incident reports are provided to the CAA under the terms of the Mandatory Occurrence Reporting (MOR) scheme, as described under Article 226 of the Air Navigation Order 2009 (ANO). Each incident report is reviewed and, where appropriate, further investigation is carried out and action taken.

We have carried out a search of the UK CAA MOR database to provide an excel summary of high risk events (as classified by the CAA in accordance with internal policies) including Accidents and Serious Incidents (classified separately by the Air Accident Investigation Branch and reported to the CAA) for any commercially operated aircraft regardless of nationality or aircraft type whilst in UK Airspace for the full calendar years 2013 and 2014.

**Civil Aviation Authority**

Aviation House Gatwick Airport South Gatwick RH6 0YR [www.caa.co.uk](http://www.caa.co.uk)

Telephone 01293 768512 [foi.requests@caa.co.uk](mailto:foi.requests@caa.co.uk)

We have not included identifying information in these summary reports as this information is exempt from disclosure under Section 44(1)(a) of the FOIA.

Section 44(1)(a) of the FOIA provides that information is exempt information if its disclosure is prohibited by, or under, any enactment. Under Section 23 of the Civil Aviation Act 1982, information which relates to a particular person (which includes a company or organisation) and has been supplied to the CAA pursuant to an Air Navigation Order is prohibited from disclosure (a copy of this exemption can be found enclosed).

Accordingly, we have not been able to supply the aircraft flight details or details of route information as this would be subject to the above legislation.

For more information about the Mandatory Occurrence Reporting scheme, please refer to CAP382 which can be found at: [www.caa.co.uk/cap382](http://www.caa.co.uk/cap382)

If you are not satisfied with how we have dealt with your request in the first instance you should approach the CAA in writing at:-

Caroline Chalk  
Head of External Information Services  
Civil Aviation Authority  
Aviation House  
Gatwick Airport South  
Gatwick  
RH6 0YR

[caroline.chalk@caa.co.uk](mailto:caroline.chalk@caa.co.uk)

The CAA has a formal internal review process for dealing with appeals or complaints in connection with Freedom of Information requests. The key steps in this process are set in the attachment.

Should you remain dissatisfied with the outcome you have a right under Section 50 of the FOIA to appeal against the decision by contacting the Information Commissioner at:-

Information Commissioner's Office  
FOI/EIR Complaints Resolution  
Wycliffe House  
Water Lane  
Wilmslow  
SK9 5AF  
[www.ico.gov.uk/complaints.aspx](http://www.ico.gov.uk/complaints.aspx)

If you wish to request further information from the CAA, please use the form on the CAA website at <http://www.caa.co.uk/application.aspx?catid=286&pagetype=65&appid=24>.

Yours sincerely

A handwritten signature in black ink, appearing to read 'W. Pounder', with a horizontal line underneath.

William Pounder  
Information Rights Officer

**CAA INTERNAL REVIEW & COMPLAINTS PROCEDURE**

- The original case to which the appeal or complaint relates is identified and the case file is made available;
- The appeal or complaint is allocated to an Appeal Manager, the appeal is acknowledged and the details of the Appeal Manager are provided to the applicant;
- The Appeal Manager reviews the case to understand the nature of the appeal or complaint, reviews the actions and decisions taken in connection with the original case and takes account of any new information that may have been received. This will typically require contact with those persons involved in the original case and consultation with the CAA Legal Department;
- The Appeal Manager concludes the review and, after consultation with those involved with the case, and with the CAA Legal Department, agrees on the course of action to be taken;
- The Appeal Manager prepares the necessary response and collates any information to be provided to the applicant;
- The response and any necessary information is sent to the applicant, together with information about further rights of appeal to the Information Commissioners Office, including full contact details.

**Freedom of Information Act: Section 44**

(1) Information is exempt information if its disclosure (otherwise than under this Act) by the public authority holding it-

- (a) is prohibited by or under any enactment,
- (b) is incompatible with any Community obligation, or
- (c) would constitute or be punishable as a contempt of court.

(2) The duty to confirm or deny does not arise if the confirmation or denial that would have to be given to comply with section 1(1)(a) would (apart from this Act) fall within any of paragraphs (a) to (c) of subsection (1).

File number	UTC date	Operation type	Occurrence class	Location of occ	Phase of Flight	Injury level	Headline	Narrative text
201301477	13/02/2013	Passenger	Incident	EGNX (EMA): NOTTINGHAM EAST MIDLANDS	Take-off run		Tailstrike on departure. A/c returned.	<p>First Officer on conversion training from another a/c type. Initially normal rotation rate that 'sped up' to 10deg. Cabin staff confirm unfamiliar noise on rotation and ATC CCTV confirm tail strike. Decision made to return for overweight landing. Inspection of tail strike indicator found 3mm depression. A/c returned to service following tail strike and overweight landing checks. □</p> <p>CAA Closure: A full investigation was completed by the operator. This was a nominal cross-wind take-off (10kts) by an experienced pilot undergoing line training on to a new type. Initially the rotation rate was normal but appeared to speed up through 10deg pitch up. The Captain and Safety Pilot reported feeling a 'light bump' during rotation. The cabin crew at the rear of the a/c reported hearing a loud bang during take-off. A decision was taken to return for an uneventful overweight landing. ATC confirmed the tail strike on final approach after reviewing a recording of the take-off. After landing a tail skid (and overweight landing) inspection confirmed the tail skid shoe was still within limits and the a/c was released to service. At rotation the F/O</p>
201305141	09/05/2013	Passenger	Incident	EGCC (MAN): Manchester/Intl	Normal descent		MAYDAY declared and emergency descent carried out due to rapid depressurisation.	<p>During normal descent from FL360 to cleared level of FL310, the 'RH bleed trip off' light illuminated. QRH was called for but before it could be actioned, the 'LH bleed trip off' also illuminated. Cabin rate of climb was significant and pressurisation was confirmed as uncontrollable, the cabin altitude warning horn sounded. MAYDAY declared and an emergency descent was initiated. QRH drills were performed during the descent and the aircraft was levelled at 8000ft. ATC stated that the pilot was wearing an oxygen mask. All passengers and crew were safe and well throughout and the aircraft landed successfully. □</p> <p>CAA Closure: Dual bleed trip attributed to three component failures, on the right hand side a pre-cooler control valve failed at 45deg closed. On the left hand side a cracked pre-cooler operating at lower than normal efficiency and a out of calibration 390deg pre-cooler control valve sensor sending a spurious sense to shut the otherwise normally functioning left hand PCCV thus reducing cold airflow. Currently operator carries out Single Pack Confidence Checks post heavy maintenance. Operator now intends to also carry out Single Pack Confidence Checks out at SC7 where appropriate. Pre-coolers currently soft lifed at 4C (due 2017 on this aircraft). AMP to be adjusted to replace pre-coolers at every 2C. Currently the pre-cooler control valves are set at the aforementioned 4C interval. AMP to be adjusted to replace both pre-cooler control valves and pre-cooler control valve sensors at 2C.</p>
201305898	24/05/2013	Passenger	Accident	EGLL (LHR): London/Heathrow	Initial climb	None	UK Reportable Accident: On departure, engine cowlings fell onto runway. One engine shut down and a/c returned. Passengers evacuated via emergency slides. 80 POB, no injuries. A/c damage to be advised. AAIB Field investigation.	<p>Initial AAIB investigations (Special Bulletin S3/2013) found that the fan cowl doors from both engines detached as the a/c departed the runway during take-off. This punctured a fuel pipe on the RH engine and damaged the airframe and some systems. The crew elected to return and on the approach to land an external fire developed on the RH engine. The LH engine continued to perform normally throughout the flight. The RH engine was shut down and the a/c landed safely and was brought to a stop on the runway. The emergency services quickly attended and extinguished the fire in the RH engine and the passengers and crew evacuated the a/c via the escape slides without injury.</p>

201307142	18/06/2013	Passenger	Incident	EGLL (LHR): London/Heathrow	Approach - holding		PAN declared due to flight crew incapacitation.	Captain suddenly became unwell and lost consciousness during a brief hold. Commuting cabin crew member occupying third seat on flight deck undertook pilot incapacitation drill while first officer summoned senior cabin crew to flight deck. Unconscious crew member secured away from controls, PAN declared. Manual full flap landing made with expeditious taxi to stand for medical assistance.
201307346	22/06/2013	Passenger	Incident	EGLC (LCY): London city	Initial climb		UK AIRPROX 2013/052 - RJ100 and a Bell 206, 1.5nm W London City.	The AIRPROX occurred when the Thames Radar controller, believing that London City had no more movements, cleared the Bell 206 to leave the zone to the North from the Isle of Dogs, crossing the climb-out for R/W27 at London City and routeing the Bell 206 into conflict with the departing RJ100. □ CAA Closure: As a result of this AIRPROX various measures at unit level have been taken to prevent recurrence. This AIRPROX has been subject to a separate review by the United Kingdom AIRPROX Board (UKAB). AIRPROX Board (UKAB) information indicates that this AIRPROX was due to the Thames controller allowing the Bell 206 to fly into conflict with the RJ100.
201308793	18/07/2013	Passenger	Incident	EGMC (SEN): Southend	Normal descent		UK AIRPROX 2013/082 - A319 in receipt of a Deconfliction Service and a paramotor at 2000ft, 7nm South Southwest of Southend in Class G airspace.	CAA Closure: □ AIRPROX Board (UKAB) information indicates that this AIRPROX was due to, effectively a non-sighting by the A319 pilot. This AIRPROX has been subject to a separate review by the United Kingdom AIRPROX Board (UKAB).
201308829	19/07/2013	Passenger	Serious incident	East Fields Farm, Lanark	Landing	Minor	Serious Incident: Unexpected descent. Balloon struck two fences before coming to rest. Eleven POB, minor injuries sustained. AAIB AARF investigation.	CAA Closure: The pilot was unable to arrest an unexpected descent as the balloon was in the final stages of its approach to landing. The basket struck two fences, causing some damage to its frame, before coming to rest in the chosen landing field. AAIB Bulletin 10/2013, Ref: EW/G2013/07/18.
201309051	22/07/2013	Passenger	Incident	IDESI	Normal descent		When passing IDESI at FL160, Falcon 900 in descent to LAPRA to FL120, encountered severe wake turbulence from preceding A320 11nm ahead. 60deg bank reported. Traffic info given.	

201309605	02/08/2013	Passenger	Incident	EGNM (LBA): LEEDS BRADFORD	Initial climb		Aircraft suffered multiple electrical system failures after take-off and returned safely to departure airport. AAIB Field investigation.	CAA Closure: <input type="checkbox"/> The aircraft suffered an electrical failure after departure, which led to the loss of the commander's primary flight instruments, navigation equipment and other electrical services. There was also a smell of electrical burning in the passenger cabin, so an immediate return to the airport was carried out. The loss of power was caused by a fatigue failure of the terminal lug on the end of the No 1 generator phase 'A' ground cable. An inspection revealed a number of other lugs which had cracked in the same location, two of which were close to failing in the same manner. The lugs had probably cracked as a result of a combination of engine vibration, a rough surface finish and bending of the lug during installation. AAIB Bulletin 08/2014, Ref: EW/C2013/08/01.
201310418	17/08/2013	Passenger	Serious incident	EGNT (NCL): Newcastle	Missed approach or	None	Serious Incident: Missed approach mishandled which led to a slat and flap overspeed. Diversion initiated and MAYDAY subsequently declared due to low fuel status. AAIB Field investigation.	CAA Closure: <input type="checkbox"/> During an ILS approach, ATC instructed the crew to conduct a go-around. This manoeuvre was mishandled and it led to a slat and flap overspeed with an associated caution message. The Quick Reference Handbook (QRH) actions in response to this message were not followed correctly. Consequently the crew assumed that they would have to make a flapless landing and they decided to divert to an airport with a longer runway. They realised they would have to use some of the final reserve fuel but, when a low fuel caution light came on, the appropriate QRH checklist was not actioned. The crew continued to try to resolve the flap problem and, despite straying from the QRH instructions, they did ultimately regain normal flap control. When the aircraft arrived on stand at the diversion location, the total fuel was 700 kg below the final reserve figure and there was an imbalance of 500 kg between the tanks. This serious incident had its origin in an incorrectly executed G/A from well above decision altitude. The approach briefing had not mentioned the techniques that might be employed in such a circumstance. Initially the autothrottle disconnect switch was operated rather than the G/A switch and the thrust levers were advanced manually. In order to climb, the autopilot was disconnected but the flight director remained in approach mode and did not provide the pilots with appropriate guidance. SOPs were not adhered to and consequently the pilots' situational awareness became degraded and their workload was increased. As a result there was a slat/flap overspeed which necessitated the use of the QRH to address a non-normal situation. The pilots became stressed and task-saturated and were unable to follow the checklists correctly in order to regain full use of the slats and flaps and then land at their destination. When a decision was made to divert, it was accepted that the fuel in tanks would drop below the final reserve level before landing. However, fuel caution messages were overlooked because a low fuel state was seen as an integral part of the solution to the earlier difficulties. The low and imbalanced fuel state which developed could have had serious implications in the event of a further G/A. The outcome could have been improved by greater adherence to SOPs along with better monitoring and workload management skills. One tool that was overlooked and which could have helped with decision making in these unfamiliar circumstances was the mnemonic TDODAR. AAIB Bulletin 10/2014, Ref: EW/G2013/08/19.

201311880	16/09/2013	Off-shore	Incident	EGPM (SCS): Scatsta	Normal descent		UK AIRPROX 2013/134 - S92 in receipt of a Procedural Service and an EC135, 8nm Northeast of Scatsta in Class G airspace. Traffic info given. ATC informed.	CAA Closure: The controller passed appropriate traffic info to the S92 on a Procedural Service and also to the EC135 on a Basic Service. The two aircraft were operating in a Class G environment and were ultimately responsible for their own collision avoidance. The controller was not required to provide any Deconfliction minima between the two aircraft. The S92 pilot sighted the EC135 and took avoiding action. □ This AIRPROX has been subject to a separate review by the United Kingdom AIRPROX Board (UKAB). AIRPROX Board (UKAB) information indicates that this AIRPROX was due to a late sighting by the S92 pilot and a non-sighting by the EC135 pilot.
201313149	14/10/2013	Passenger	Serious incident	Over London	Cruise	None	Serious Incident: In-flight entertainment system (IFE) caught fire in the cabin. 292 POB, no injuries. AAIB AARF investigation.	CAA Closure: □ The aircraft was about 2 hours from its destination, when the flight crew and some members of the cabin crew smelt an "acrid, electrical burning smell". Flames and smoke were then reported to be emanating from an item of In-Flight Entertainment (IFE) equipment located in the Galley 4 area. The cabin crew tackled the fire with BCF extinguishers but had difficulty due to continual re-ignition of the fire. It was subsequently considered that the unit had not been electrically isolated during the event and the operator has accordingly made several internal safety recommendations regarding both cabin and flight crew procedures and training. The VMOD unit was sent to its manufacturer for investigation but, at the time of preparation of this account, their report has not been received. However it was noted that the unit is certified to self-extinguish when electrically isolated. An internal investigation by the operator concluded that it was likely the VMOD had remained powered during the incident and this was the reason it continued to re-ignite. One of the cabin crew described how he believed he had isolated the IFE, but his description of events suggested that he had only actioned the 'seat/pc electrics isolation' part of the 'Safety Equipment and Procedures Manual' and that this had been done from memory. AAIB Bulletin 04/2014, Ref: EW/G2013/10/07.

201313655	23/10/2013	Passenger	Serious incident	UMBEL	Cruise	None	<p>Serious Incident: PAN declared and aircraft diverted due to multiple system failures. 24 POB, no injuries. AAIB AARF investigation.</p>	<p>CAA Closure: □</p> <p>Whilst enroute, the crew experienced a number of cautions and warnings on the Central warning Panel (CWP). The number of these increased, and cabin and cockpit lights also started to fail. The aircraft diverted, where an uneventful landing was made. It is suspected that there had been a failure of the right starter/generator or its Generator Control Unit (GCU) and that a further latent failure of a contactor had prevented automatic connection of the right DC bus to the left DC bus. The services normally powered by the right DC bus would now be powered by the main aircraft battery, which would progressively discharge. At the time of preparation of this Bulletin, the manufacturer was continuing with their examination of the components and any significant findings will be reported in a later bulletin. AAIB Bulletin 06/2014, Ref: EW/G2013/10/13. □</p> <p>Supplementary 13/11/14: □</p> <p>A report has subsequently been received from the manufacturer containing the following findings from their examination of the components: □</p> <ol style="list-style-type: none"> <li>1) The brushes and collector of the DC generator were found severely worn and damaged □</li> <li>2) No fault found with the Generator Line Contactor (GLC) K2 □</li> <li>3) No fault found with DC GCU □</li> </ol> <p>The AAIB report also contained the conclusion that loss of contact between the brushes and armature: □</p> <p>'...while backed up by the battery allowed the condition to be undetected by normal generator power quality protection circuits. In the absence of detection, the GCU and EPCU do not reconfigure the system as would be the case for a power quality failure. This failure mode is detectable by the pilot through observation of zero generator output current on the electrical load meter page. Additionally, abnormal positive discharge current from [the] battery when the generator is believed to be on-line is an indication of impending ... battery depletion.... resumption of DC power to the Right DC buses could be accomplished through...turning off the DC Generator switch to the faulty side which will enable cross tying of the opposite side to supply the load as well as charging the battery.' □</p> <p>The aircraft manufacturer advises that they propose to amend the Aircraft Flight</p>
201314026	31/10/2013	Passenger	Incident	EGKK (LGW): London/Gatwick	Cruise		<p>Whilst in the cruise both engine fuel filter bypass warning lights came on. Aircraft diverted. AAIB Field investigation.</p>	<p>CAA Closure: □</p> <p>The aircraft diverted after both FUEL FLTR BYPASS warning lights illuminated during the cruise, indicating that the fuel filters were obstructed. The aircraft landed without further incident. The investigation concluded that the obstruction was probably caused by ice forming on the fuel filters due to insufficient anti-icing additive being added to the fuel during the previous refuelling. AAIB Bulletin 04/2014, Ref: EW/C2013/10/03.</p>

201314387	08/11/2013	Passenger	Incident	EGLC (LCY): London city	Normal descent		UK AIRPROX 2013/174 - RJ100 and an FK50 at 2000ft, 4nm East of London City Airport in Class D airspace. STCA activated. Traffic info and avoiding action given.	Investigations revealed that an AIRPROX occurred in the London City CTR, Class D, when the London City Director instructed the FK50 to conduct an orbit in order to achieve the required separation on final approach. The southerly wind caused a degree of northerly drift as the FK50 completed the orbit, bringing the FK50 into conflict with the RJ100. In attempting to resolve the situation the controller instructed the RJ100 to descend to 1000ft, below the minimum altitude to be allocated in accordance with the SMAC and in contradiction with the warning published on the ILS(5.5°GP)/DME/NDB(L) RWY 09 chart for London City, coming into close proximity with Canary Wharf. As a result of the incident it has been recommended that TRUCE or other recurrent training includes opportunities for Thames controllers to practise the handling of unusual situations when options are limited. A safety notice was issued detailing the event and providing advice on avoiding action in situations where aircraft are operating close to the minimum safe altitude. The unit also briefed all Thames controllers on the incident and the implications of the avoiding action used. It was also noted during the course of the investigation that the Shard is not indicated on the instrument approach charts for London City - action has been taken to ensure the charts are updated at the earliest opportunity. □
201314453	10/11/2013	Passenger	Incident	EGGP (LPL): Liverpool	Initial climb		UK AIRPROX 2013/157 - EC135 and a PA31, 7nm NW of Liverpool Airport in Class D airspace. Traffic info not given to the EC135.	<p>This AIRPROX has been subject to a separate review by the United Kingdom AIRPROX Board (UKAB). AIRPROX Board (UKAB) information indicates that in the absence of any traffic info, the PA31 pilot flew into conflict with the EC135. Contributory Factors: 1. The Liverpool Tower Controller did not perceive that the PA31 would depart towards the EC135. 2. The EC135 TCAS provided no warnings. □</p> <p>CAA Closure: □</p> <p>In the absence of traffic info being provided to either aircraft the PA31 and the EC35 flew into conflict with each other approximately 7nm NW of Liverpool Airport. Neither aircraft saw each other until the AIRPROX and the distance between the two aircraft was estimated by both pilots to be approximately 100ft. The Tower controller did not pass traffic info to the PA31 due to their belief that the PA31's routeing would ensure that it remained well to the West of the EC135 and the Radar controller did not pass traffic info to the EC135 due to workload, partially caused by the issuance of a routeing to a VFR aircraft to a point that is not a notified VRP. Liverpool ATC produced an ATC Standards Bulletin which reminds controllers of their responsibilities for passing traffic info, gives guidance on coordination of traffic operating in or near VFR exit lanes and also reminds controllers to use notified VRPs as routeings for VFR aircraft. As an indirect part of this investigation the CAA noted that the Liverpool MATS Part 2 instructs controller 'Unless otherwise coordinated VFR inbound aircraft will be routing to and have a clearance limit as follows: • Inbound for Runway 27 - Western edge of Helsby or the Jaguar Factory • Inbound for Runway 09 - The Cheshire Oaks Outlet Village (Jnc 10, M53) or Garston Docks' Only one of these points (Helsby) is marked on the Topographical Air Chart of the United Kingdom 1:250000 and none of the points are notified VRPs. It is difficult to see how non-locally based pilots would easily locate the points that are used as standard clearance limits inbound. It is therefore recommended by the CAA that Liverpool review the published VFR inbound clearance limits to assess their continued suitability for positioning of VFR inbound aircraft for their subsequent integration into the aerodrome circuit.</p>

201314886	19/11/2013	Cargo	Incident	Overhead EGGW (LTN): London/Luton	Cruise	None	Left engine suffered a major mechanical failure. Aircraft diverted and an emergency landing completed. Two POB, no injuries. AAIB AARF investigation.	CAA Closure: <input type="checkbox"/> During cruise at FL80, the left engine suffered a mechanical failure. The crew shut down the engine and feathered the propeller but were unable to maintain altitude. An emergency landing was completed without further incident. Inspection found the No.2 cylinder assembly of the left engine had detached from the crankcase due to an internal failure. At the time of writing a detailed examination of the engine had not taken place, so it is not possible to draw any firm conclusions as to the cause of the failure. AAIB Bulletin 06/2014, Ref: EW/G2013/11/04.
201314981	19/11/2013	Cargo	Serious incident	EGPH (EDI): Edinburgh	Standing	None	Serious Incident: Freight ULD loaded in reverse order. Three POB, no injuries reported. Subject to AAIB AARF investigation.	CAA Closure: <input type="checkbox"/> The aircraft was loaded with the unit load devices (ULD) in the reverse order to that intended. This resulted in the aircraft CG being forward of the flight envelope limits. The crew encountered handling issues during takeoff but the aircraft landed safely at the destination. AAIB Bulletin 04/2014, Ref: EW/G2013/11/09.
201315729	03/12/2013	Passenger	Accident	EGLL (LHR): London/Heathrow	Level off-touchdown	None	UK Reportable Accident: Tail strike on landing. 64 POB, no injuries. Damage to rear fuselage skin. AAIB AARF investigation.	CAA Closure: <input type="checkbox"/> During the landing, on a line training flight in benign weather, the tail of the aircraft struck the runway surface, causing airframe damage. The commander reported that the aircraft was on a stable approach, with full flap. The co-pilot smoothly commenced the flare at the correct height; however, at about 10 ft radio altitude he made an additional nose-up sidestick input. This resulted in an unusually high pitch attitude and, as the airspeed washed off, the aircraft started to sink. The co-pilot countered with an additional nose-up input as the main landing gear touched down. The ground spoilers automatically deployed and the pitch attitude continued to rise to a maximum of 12.3°, causing the tail to strike the runway. As the ground spoilers deployed the commander attempted to counter the increasing pitch with a large forward sidestick input. However, he did not press the 'take over' button and the flight control software summed the inputs of the two sidesticks. As the co-pilot reduced his sidestick pitch input, the aircraft pitched down to 0° in three seconds. AAIB Bulletin 08/2014, Ref: EW/G2013/12/01.
201315846	06/12/2013	Passenger	Incident	EGPM (SCS): Scatsta	Final approach		Stick shaker and LH wing drop on approach.	Turning onto localiser with approach armed and LOC captured, autopilot engaged and clean configuration. Stick shaker activated briefly and simultaneously LH wing dropped by approx 30-40deg. Wings levelled and stall recovery initiated, with maximum power applied and climb commenced. During climb out, left wing dropped again and aircraft difficult to control. When aircraft stabilised autopilot re-engaged. At the time flight crew unsure of the exact cause of the problem, initially suspected frozen controls as the aircraft had transited some precipitation on the approach. PAN declared and aircraft diverted but destination airport was closed at the time due to weather conditions (snow). After the event both flight crew suggested that despite not seeing any ice, the aircraft had either accumulated clear ice on the wing or partial freezing of the control surfaces.
201315939	10/12/2013	Passenger	Serious incident	EGSS (STN): London/Stansted	Final approach	None	Serious Incident: Very low approach to landing. Aircraft struck ILS antenna and localiser array. Five POB, no injuries. Substantial damage to aircraft and mast. Subject to AAIB Field investigation.	

201316420	18/12/2013	Passenger	Incident	EGGD (BRS): Bristol/Lulsgate	Landing roll - on runway	Runway side excursion after landing.	Go-around actioned from 1000ft on approach due to cross winds out of limitations. On second approach cross wind still out of limits at times, but last three wind checks within limits and approach stable by 500ft. Continued landing applying rudder to reduce drift during flare landing slightly to the left of centreline. Aircraft appeared to weather cock. Late application of reverse thrust but aircraft continuing to drift further to the left. At approx 100kts aircraft continued deviating and the LH main wheels left the runway approx 1.5m onto the grassed area for 70m. At some time during the excursion, throttle levers were advanced inadvertently too far forward in order to cancel excursion. Not far enough for take-off but far enough to generate a take-off config warning. <input type="checkbox"/> CAA Closure: <input type="checkbox"/> Investigations concluded various factors contributing to the event. Human factors, training simulation in poor weather and operational procedures. The organisation is to introduce further simulated training in poor weather and review recovery techniques for divergence from the centreline. The flight operations department will review the transition of first officer crosswind limits of 20kts to Captains crosswind limits of 38kts.	
201400364	12/01/2014	Passenger	Serious incident	EGJA (ACI): Alderney, Channel Is.	Landing roll - on runway	None	Serious Incident: During a landing in heavy rain and with a strong crosswind the aircraft was blown from the runway surface onto the grass edge of the runway, damaging three runway lights. Six POB, no injuries. AAIB AARF investigation.	CAA Closure: <input type="checkbox"/> During a landing in heavy rain and with a strong crosswind the aircraft was blown from the asphalt runway surface onto the grass edge of the runway, damaging three runway lights. The aircraft was undamaged. The aircraft encountered heavy rain shortly before touchdown and a strong crosswind gust shortly after touchdown. The strong gust and loss of the main landing gear grip in standing water caused the aircraft to veer to the right, off the asphalt surface and onto the grass area to the side of the runway. AAIB Bulletin 05/2014, Ref: EW/G2013/10/23.
201401434	07/02/2014	Passenger	Accident	En route	Cruise	Serious	UK Reportable Accident: Severe clear air turbulence encounter. 75 POB, one cabin crew member seriously injured and one passenger minor injuries. AAIB AARF investigation.	CAA Closure: <input type="checkbox"/> The aircraft experienced a sudden onset of severe turbulence when in cruise flight, in VMC, at FL220. A cabin crew member was seriously injured. One passenger suffered a minor injury. AAIB Bulletin 09/2014, Ref: EW/G2014/02/01.
201402694	06/03/2014	Passenger	Accident	EGPK (PIK): GLASGOW PRESTWICK	Level off-touchdown	None	UK Reportable Accident: RH wing struck ground on landing. Six POB, no injuries. AAIB Field investigation.	CAA Closure: <input type="checkbox"/> The right wing touched the runway while landing at night in a crosswind. The technique employed during the landing was different from that recommended in training material published by the manufacturer. Furthermore, the information in the training material about crosswind landings, and data on reduced wingtip clearance with increasing pitch attitude, had not been incorporated into the Airplane Flight Manual (AFM) or the Flight Crew Operating Manual (FCOM). The pilot flying (PF) was looking through a Head-Up Display (HUD) and his view of the runway may have been impeded because the symbols on the HUD screen were set too bright. While the investigation was underway, another operator's aircraft struck a wingtip during a night-time, crosswind landing. The landing technique employed on the other incident shared certain similarities with this incident. Following these two accidents several safety actions were taken, including amendment of the FCOM to include the Manufacturer's recommended technique when landing with a crosswind. AAIB Bulletin 10/2014, Ref: EW/C2014/03/01.

201403597	27/03/2014	Passenger	Incident	EGLC (LCY): London city	Maintaining position	Minor	Engine fire as aircraft was lined up on runway. Slide evacuation carried out. 78 POB, three suffered minor injuries during evacuation.	CAA Closure: AAIB downgrade to 'Non-Reportable' from AARF investigation. No further investigation to be progressed by the AAIB.
201405175	29/04/2014	Cargo	Accident	EGNX (EMA): NOTTINGHAM EAST MIDLANDS	Landing roll - on run	None	UK Reportable Accident: LH undercarriage collapsed after landing. Runway blocked. Two POB, no injuries. Aircraft damage to be confirmed. Subject to AAIB Field investigation.	
201407661	01/06/2014	Passenger	Incident	Great Malvern	Normal descent		UK AIRPROX 2014/076 - LET 410 and a Nimbus glider in the vicinity of Great Malvern in Class G airspace.	The AIRPROX occurred when the LET 410 and glider came into close proximity whilst operating in Class G airspace where pilots are ultimately responsible for traffic avoidance. The LET 410 was in receipt of a Procedural Service without the aid of surveillance equipment and the controller was not aware of the glider's position or intention and was unable to pass any specific traffic info to the LET 410 pilot. The ATIS has been broadcasting a general warning of Intense Gliding Activity. <input type="checkbox"/> CAA Closure: <input type="checkbox"/> The LET 410 pilot took avoiding action as a result of this incident. No further CAA action. <input type="checkbox"/> This AIRPROX has been subject to a separate review by the United Kingdom AIRPROX Board (UKAB). AIRPROX Board (UKAB) information indicates that this AIRPROX was due to a late sighting by the LET 410 pilot.
201409903	22/07/2014	Passenger	Incident	EGLL (LHR): London/Heathrow	Final approach		UK AIRPROX 2014/117 - A320 on final approach to R/W09L and a radio controlled helicopter, in Class A airspace.	CAA Closure: <input type="checkbox"/> Whilst on final approach to R/W09L, the A320 reported that a small black object was observed to the left of the a/c which passed over the wing by 20 feet and appeared to be a small radio controlled helicopter. Following a/c were informed by Heathrow ATC however no further sightings were reported. The Aerodrome Authority and the Police were informed at the time. A Police unit sent out to investigate did not find anything. This AIRPROX will be subject to a separate review by the United Kingdom AIRPROX Board (UKAB).
201410331	29/07/2014	Passenger	Accident	EGSS (STN): London/Stansted	Landing	None	UK Reportable Accident: Bounced landing and tail strike. Damage to underside of rear fuselage. 177 POB, no injuries. AAIB AARF investigation.	CAA Closure: <input type="checkbox"/> After a stable instrument approach, the engines remained at approach power during the landing flare and the aircraft bounced. The thrust levers were then moved to idle, the speed brakes deployed automatically and during the subsequent heavy landing, the tail of the aircraft scraped along the runway. The visible damage consisted of a large scrape along the skin of the tail section of the aircraft; numerous stringers and frames beneath the surface were also damaged, requiring a substantial repair before the aircraft was returned to service. The commander considered that the aircraft bounced because the first touchdown occurred with higher than idle thrust. When the thrust lever was selected to idle during the bounce, the speedbrakes deployed automatically; this caused a loss of lift, the nose of the aircraft to pitch up, and the subsequent tailstrike on touchdown. AAIB Bulletin 12/2014, Ref: EW/G2014/07/31.

201410409	31/07/2014	Passenger	Incident	EGSS (STN): London/Stansted	Climb into traffic pattern		MAYDAY declared due to engine failure after take-off. Second aircraft broken off approach to allow emergency aircraft priority landing.	<p>I was the AIR controller. The aircraft was cleared for take off and appeared to depart normally. When I instructed the aircraft to transfer to 118.825 I was told to standby. The Captain then declared a MAYDAY reporting an engine failure after take-off and requested to return to Stansted. I asked him if could he accept radar vectors to land on Runway 22 or did he require an immediate return. He stated he could accept vectors, he required to hold for 5-10 minutes to complete his checklists. I asked if he could accept a frequency change and he said yes. All departures were stopped, Check All in force. The runway was inspected and declared serviceable. The Watch Manager requested all arrivals to be stopped so one aircraft was broken off approach. The aircraft landed normally at 2011, vacated at LR and did not require further assistance. The runway was declared serviceable and the Captian contacted the Fire Service on 121.6 when on Taxiway Hotel. Full Emergency cancelled at 2014. □</p> <p>Supplementary 31/07/14: □</p> <p>Aircraft on departure experienced an engine failure. The aircraft was transferred to Director after coordination with the Tower. The aircraft informed me that he had shut down the engine and, after completing his checks, would like to return. He anticipated a normal approach and landing. Second aircraft was broken off the approach at the Tower's request and, after a slight delay, vectored back round to land ahead of the emergency traffic.</p>
201410879	15/08/2014	Passenger	Accident	EGCN : DONCASTER SHEFFIELD	Landing roll - on ru	Unknown	<p>UK Reportable Accident: Left main gear collapse after landing. Three POB, no injuries. Damage to left main landing gear, propeller, wing and fuselage. Subject to AAIB Field investigation.</p>	<p>Supplementary 09/10/14: □</p> <p>The aircraft's left main landing gear failed shortly after it landed on Runway 20. The left main landing gear detached from its mounts and the aircraft slid along the runway on its remaining landing gear, left wingtip and luggage pannier before veering off the runway and coming to rest on the adjacent grass. The single passenger and the flight crew vacated the aircraft without injury. Preliminary findings indicate that the failure was initiated as a result of stress corrosion cracking in the forward yoke pintle at the top of the left landing gear leg. Further analysis is required to determine the precise details of the failure, however, the preliminary findings are of significance because the same aircraft, operating under a different registration, was involved in a similar accident in 2012 during which the right main landing gear failed. The subsequent investigation identified intergranular corrosion / stress corrosion cracking of the forward yoke pintle at the top of the main landing gear leg as the cause of that failure. Two Safety Recommendation, nr 2014-038 and 2014-039 both addressed to the European Aviation Safety Agency. AAIB Special Bulletin S5/2014.</p>
201411857	03/09/2014	Passenger	Serious incident	En route	Normal descent	Unknown	<p>Serious Incident: Pilot reports and emergency calls during descent and approach due electrical system problems. Subsequent full evacuation. POB to be confirmed. AAIB Field investigation.</p>	

201415371	31/10/2014	Passenger	Serious incident	EGKK (LGW): London/Gatwick	Cruise	None	Serious Incident: Overwing escape slide deployed in flight and detached from aircraft. 237 POB, no injuries. Damage to be assessed. Subject to AAIB Field investigation.	
201415420	30/10/2014	Training/check	Incident	EGBE (CVT): Coventry	Normal descent		UK AIRPROX 2014/210 - PA28 and an A109, 4nm Northeast of Coventry in Class G airspace. PA28 pilot subsequently reported being lost and required ATC assistance with a position fix. Traffic info and avoiding action given.	
201417047	07/12/2014	Passenger	Accident	EGSS (STN): London/Stansted	Taxi	None	UK Reportable Accident: Aircraft impacted passenger steps on LH side whilst taxiing onto stand. 182 POB, no injuries reported. Damage to outboard leading edge slat. Subject to AAIB AARF investigation.	
201417225	09/12/2014	Passenger	Incident	EGHC (LEO): Land's End/St. Just	Landing		Aircraft bounce landed resulting in runway excursion.	On landing on runway with a crosswind I misjudged the flare and the aircraft bounced. I took the view that the landing was recoverable and touched down again, but the aircraft bounced again and settled on the third touchdown on the right side of the runway, but aligned with the runway. I selected full reverse, applied opposite direction rudder and into-wind aileron, and some differential braking but was unable to maintain directional control as the aircraft weather cocked towards the wind. I took the view that the ground speed was too fast to safely use the nose wheel steering to regain the centreline and with the knowledge that there were no significant obstacles to the right, let the aircraft roll off the runway into wind. Once the aircraft slowed we taxiied back onto the runway and to stand. We landed the aircraft in almost identical weather conditions in the day without incident. I believe that a combination of unfamiliarity with landing the aircraft type at night coupled with the crosswind conditions and the brightness of the runway edge light caused me to misjudge the flare and destabilise the landing. □ Supplementary 09/12/14: □ Due adverse weather DATCO requests a weather standby, RFFS responds, suitable AGL on am intensity. Captain opts for crosswind runway due low cloud on active runway, runways are damp. Aircraft lands on runway, bounces and leaves the runway on to the grass.

