CONVERSATION AVIATION

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STARTING POSITIVE CONVERSATIONS ABOUT SAFETY

EASA
European Union Aviation Safety Agency

together 4safety

Contents

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EASA, T-C Alliance, Krisztian Zajak (Ground Operations and Security Director, CMA CGM Air Cargo)

Foreword by **Florian Guillermet**

EASA Executive Director

There are 3 important things this New Year's edition of Conversation Aviation focuses on that I would like to bring to your attention.

Firstly, safety is something we can only do "Together". It does not belong to one single group of people acting alone. From how information flows between regulators and the industry; to how concerns travel up and across organisations; to how decisions are made under pressure; to how willing people feel to speak up, slow down, or say "this doesn't feel right".

Secondly, the need to beware of complacency. The absence of major accidents can create psychological complacency, making it difficult to recognise that serious failures remain possible. It's something that grows quietly. Through small deviations that "work out fine"; weak signals that go unchallenged; warnings that feel theoretical; assumptions that "someone else is looking after that". Over time, the extraordinary becomes ordinary and the ordinary becomes invisible.

Somehow the current safety records has removed many of the dramatic cues that once told us we were in danger. This makes weak signals more important than ever. The main safety battlegrounds today are subtle trends, minor anomalies, uncomfortable questions, early signs of procedural drift and human performance under pressure.

Finally, the importance of purposeful Management Systems becomes critical. Not something we build for auditors, but a living system—one that ties everyday work to real risk, surfaces what we would rather not see, challenges complacency born of success, and acts on weak signals before they become events.

At EASA, our role is to provide the regulatory framework, guidance, oversight and the strategic safety direction. We focus on the top safety topics, but we do not "own" safety.

Safety lives in cockpits and control rooms, hangars, operations offices, on the ramp, in training centres, boardrooms and briefing rooms. It lives in the decisions people make when no one is watching. And it lives where organisations create environments that make slowing down acceptable, speaking up rewarded and conservative decisions respected.

We should be proud of how safe European aviation is. But we must never become comfortable with it because safety is not a permanent state.

It is a relationship — between people, technology, organisations, and culture — that must be renewed every day.

The greatest threat to that effort is not lack of knowledge, lack of technology, or lack of rules.

It is forgetting that success itself can make us vulnerable.

COMMERCIAL AIR TRANSPORT:

Safety Priorities for a High-Performing System

Our aviation system is at a high-level of maturity. Traffic levels have recovered and exceeded pre-pandemic levels, fleets are modern, and serious accidents remain rare. Yet the EASA Annual Safety Review (ASR) 2025 reminds us of an important truth:

“The absence of accidents does not mean the absence of risk.”

From Nuno, our Safety Manager

When we look beyond outcomes and examine occurrence and hazard data, risk assessments and the potential for hazards to escalate, a clear set of safety priorities emerges for Commercial Air Transport (CAT) operations with complex aeroplanes.

These priorities matter precisely *because* the system performs well.

From “What Happened” to “What Could Have Happened”

A key strength of the EASA Annual Safety Review is that it uses the European Risk Classification Scheme (ERCS) and links data analysis to the Key Risk Areas (KRAs). Rather than focusing only on accidents, it asks a more important question:

"If this occurrence had escalated, what type of accident could it have become?"

When occurrences are analysed through this lens, three KRAs stand out as the highest safety priorities for commercial operators:

- Aircraft upset (loss of control)
- Airborne collision
- Collision on runway

This ranking is not driven by fear — it is driven by data, probability, and potential severity.

Priority 1: Aircraft Upset Rare, But High Consequence

Aircraft upset has emerged as the highest-risk KRA for CAT operations.

These occurrences involve unintended aircraft states, such as:

- excessive pitch or bank
- energy management
- degraded situational awareness
- automation surprises

What makes aircraft upset particularly concerning is that:

- it does not happen often
- but when it does, the margin for recovery is small

Upset scenarios are strongly influenced by human-system interaction, including:

- mode confusion
- degraded manual flying skills
- high workload
- unexpected weather or automation behaviour

This is not a technology problem alone. It is a training, monitoring and resilience challenge.

Priority 2: Airborne Collision Managed, But Never Eliminated

Airborne collision remains one of the most frequent KRAs, although its overall risk score is lower than aircraft upset due to generally effective mitigations.

However, this is precisely where complacency can creep in.

TCAS, ATM systems and procedural barriers work well — until:

- traffic density increases
- complexity rises
- assumptions replace active monitoring
- or humans over-trust automation

The ASR shows that airborne collision risk is not disappearing — it is being actively managed, and that management must remain vigilant. EASA also have various initiatives with the General Aviation, Rotorcraft and Drone communities to ensure these domains can be seen and be aware to minimise the risks, particularly around smaller airports.

Priority 3: Collision on Runway A Shared Risk Space

Runway collisions remain a significant KRA, spanning:

- flight crew actions
- ATC clearances
- aerodrome layout
- ground handling activity
- vehicle movements

What makes this risk particularly important is that no single actor controls it.

Runway safety is created:

- at interfaces
- across organisations
- through shared mental models

As traffic grows and time pressure increases, the risk shifts from technical failure to coordination failure. EASA has a task force on Runway Safety and mitigations will come out of that.

What the Data Is Really Telling Us

Across these priorities, a pattern emerges:

- The highest risks are systemic, not individual
- They sit at interfaces, not in isolation
- They are shaped by normal work under normal conditions
- They are vulnerable to success-driven complacency

This is why modern safety management cannot focus only on rules, checklists and outcomes.

It must focus on how work is actually done.

Why This Matters Now?

Traffic is increasing. Complexity is increasing. Automation is evolving.

At the same time:

- accident numbers remain low
- systems appear stable
- and confidence is high

This combination is powerful — and dangerous.

The safety priorities identified in the Annual Safety Review are not warnings of imminent failure. They are signals of where attention must remain sharp.

From these KRAs, EASA is also working on a list of Top Safety Topics that will help to the industry to further focus our efforts on the most important safety challenges.

It will come from **paying attention while things still look normal.**

Safety Map

Mindset

Strong performance can hide vulnerability. Risk still exists even when accidents are rare.

People

Human-system interaction, training quality and shared situational awareness remain central to risk control.

Equipment

Automation is a safety enhancer — but only when its behaviour is understood and monitored.

Compliance

Rules provide structure, but real safety depends on how procedures are applied under pressure.

Risks

Aircraft upset, airborne collision and runway collision remain the dominant CAT risk areas.

Learning

Occurrence data and risk classification allow us to act *before* accidents happen.

Summary

Call to Action

For other safety managers, it is important to compare these priorities with your own operations.

Ask:

- Do we know the top risks to the safety of our operation?
- Do our training programmes address these risks realistically?
- Are our interfaces strong — or assumed?
- Are we managing complacency, or benefiting from it?

Because the next safety improvement in commercial air transport will not come from reacting to accidents.

ORGANISATIONAL COLLABORATION:

Where Safety Is Really Made

From Milena, our CEO

In aviation, safety is rarely lost because one person makes a bad decision.

It is lost when good decisions don't connect.

Modern aviation organisations are made up of highly competent people working in specialised roles:

- flight crew
- cabin crew
- dispatch and OCC
- engineering and maintenance
- ground handling
- training
- safety and compliance
- management and leadership

Each of these functions perform well in isolation. And yet, when things go wrong, investigations repeatedly uncover the same underlying issue:

The system did not fail, the interfaces did.

The Illusion of Coordination

In a mature organisation, collaboration often *looks* healthy.

Meetings are held. Emails are sent. Responsibilities are defined. Processes are documented.

But real operational collaboration is not about structure, it is about shared understanding. Complacency creeps in when organisations confuse:

- communication with comprehension
- coordination with connection
- responsibility with ownership

And when everyone believes they are doing their part, it becomes harder to see the gaps between parts.

Safety Lives Between the Boxes

Most safety management systems are designed around functions. But most safety events happen between functions; at handovers; at shift changes; at organisational boundaries; at moments where assumptions replace confirmation.

Consider how often safety depends on:

- One department realising the downstream impact of its decision.
- Another department noticing that something has changed.
- Someone feeling confident enough to challenge "business as usual".

When collaboration weakens, risk doesn't increase suddenly — it accumulates quietly.

When No One Is Wrong and Something Still Goes Wrong

The most difficult safety events to understand are those where procedures were followed, competence was high, intent was good and outcomes were still poor

These are not failures of individuals. They are failures of alignment.

Each part of the system acted rationally, based on the information, priorities and pressures it could see. What was missing was a shared picture of risk.

Familiar Patterns of Collaboration Failure

Note: The following examples are fictional, but deeply familiar.

> ***We Thought They Knew***
>
> Engineering identifies a recurring technical issue assessed as non–safety-critical. The issue is recorded, monitored, and deferred in accordance with established limits. Operational teams are not fully briefed on the basis that no immediate action is required.
>
> Over time, the unresolved issue contributes to increased crew workload during a high-demand phase of flight.
>
> All actions were compliant and individually reasonable. However, the operational relevance of the information was not effectively communicated, and the risk only emerged through the accumulation of small decisions across time and functions.

> ***That's Not Our Decision***
>
> A frontline team raises a concern that doesn't clearly sit in any single department.
>
> Operations sees it as a technical issue. Engineering sees it as an operational issue. Safety sees it as insufficiently defined.
>
> The issue stalls, not because of disagreement, but because ownership is unclear.
>
> Eventually, the concern fades away. So does the opportunity to learn!

Collaboration in a High-Performance System

In high-performing organisations, collaboration risks are harder to see.

Why? Because things usually work, trust is high and failure is rare.

Ironically, this success makes it harder to challenge assumptions. People hesitate to ask:

- "Who else needs to know this?"
- "What happens downstream?"
- "Are we relying on luck here?"

Complacency thrives when collaboration is assumed rather than tested.

"Together" Is a Design Choice

Working *together* is not a cultural aspiration.

It is a design requirement. It requires organisations to:

- Deliberately design interfaces.
- Stress-test handovers.
- Clarify ownership of cross-cutting risks.
- Reward escalation, not silence.
- Create space for inconvenient questions.

True collaboration is visible when:

- Information flows faster than hierarchy.
- Concerns travel across silos.
- Safety decisions are shared, not delegated.

Safety Map

Mindset

Safety is created between roles, not within them.

People

Good people working in isolation can still create unsafe systems.

Equipment

Technology connects systems — but people connect meaning.

Compliance

Defined responsibilities matter, but shared ownership matters more.

Risks

Handover failures, silo thinking, assumption-based decisions, and unclear ownership.

Learning

Most collaboration failures are visible long before they cause harm — if we choose to look.

Summary

Aviation does not fail because people stop caring.

It fails when:

- Information doesn't travel.
- Assumptions replace dialogue.
- Collaboration becomes implied instead of intentional.

Call to Action

This week, identify one interface you rely on for safety.

Then ask: "How do we know this works — and how would we notice if it didn't?"

Because safety is not something we deliver individually. It is something we create — together.

RUNWAY SAFETY:

Focusing Effort Where Risk Is Highest

From Rachel, Pilot, Safety Captain

Runway safety remains one of aviation's most persistent safety challenges. This was brought into sharp focus in January 2024 with the Tokyo Haneda accident. There have been many level actions over the past years. The most recent example from October 2025 is EASA SIB 2025-07 on the continuous use of runway stop bars.

Despite various actions, modern aircraft, advanced surveillance, and mature procedures, *runway incursions continue to occur*, often without injury or damage, but with significant potential for escalation and sometimes with minimal safety barriers in place.

For airline safety teams, the challenge is not just to be aware that runway safety risks exist, but *to know where to focus your efforts as an operator*.

Why Runway Risk Is Different

Unlike many operational risks, runway safety is different from many of the other risks that you have to manage as an operator. The reasons for that include:

- It can be highly **location-dependent.**
- Shaped by **local infrastructure and procedures.**
- Influenced by **traffic mix and complexity.**
- Shared between multiple organisations.

As an airline you operate safely at hundreds of airports, yet you may only experience an elevated runway safety risk at only a small number of them.

This makes runway safety a *prioritisation problem,* not a generic one.

Step 1: Identify Where Runway Risk Is Concentrated

The first question for any safety team is not just "Do we have runway risk?" but to ask *"At which airports does runway risk matter most to us?"*

Some useful indicators to help with that decision making include:

Operational Data

- Runway incursion reports (internal to your airline and externally from Accident Investigation Boards and other sources).
- Intelligence from your flight crews based on their routine experience.

Environmental Factors

- Complex runway layouts.
- Intersecting or converging runways.
- Contaminated runway exposure (snow, ice, standing water) and other weather factors.

Traffic & Use Patterns

- Mixed traffic (CAT, GA, helicopters, vehicles).
- High night-time operations.
- Frequent runway configuration changes.
- Language or phraseology complexity.

The goal is not to create a perfect ranking — but to *identify a manageable set of "runway risk hotspots"*.

Step 2: Look Beyond Accidents

Many runway safety issues never result in damage.

They show up as confusion, hesitation, last-second corrections, unexpected instructions and high workload moments.

These **precursors** matter more than accident statistics and this is where intelligence from your crews really helps.

A runway that "has never had an accident" may still be one where:

- Crews frequently query clearances.
- Taxi instructions are misunderstood.
- Go-arounds occur late.
- Braking margins are routinely small.

These are signals, not noise. The challenge is how to pick up these signals.

Step 3: Decide Where Your Efforts Adds Value

As an airline safety team, particularly with a large network, it is impossible to be deeply involved everywhere you fly.

So, the key question becomes:

"Where can our involvement make the biggest difference?"

High-value opportunities often exist where:

- The airline has the greatest exposure through high movement volumes.
- Multiple fleet types operate at particular airports.
- Seasonal operations increase complexity.
- Infrastructure changes are planned.
- Previous safety concerns already exist.

At these locations, your crews can provide operational insight to highlight fleet-specific risks, share real crew experience and help influence mitigations before incidents occur.

It is also important to be aware where major works might be taking place so you can be informed and potentially play in role in mitigating the risk to your operation and those of others.

Step 4: Engage with Local Runway Safety Teams

The majority of airports have *Local Runway Safety Teams* or equivalent groups.

These teams typically include aerodrome operators, air navigation service providers, operators, ground handling organisations and even sometimes national authorities.

For you as an airline safety team, effective engagement means the following:

- Attending consistently, not occasionally.
- Bringing data and examples, not just opinions.
- Sharing trends, not individual blame.
- Listening to other operators' concerns.
- Helping turn discussion into action.

This is not oversight of the airport, it is *collaboration.*

Step 5: Close the Loop Internally

External engagement only works if learning comes back into the organisation.

Effective airline safety teams do the following:

- Feed outcomes from local runway safety teams into training and briefings.
- Update airport notes and guidance.
- Tailor simulator scenarios where appropriate.
- Communicate changes clearly to crews.
- Monitor whether mitigations actually work.

Runway safety is not improved by meetings alone. It improves when *shared understanding changes behaviour.*

The Complacency Trap

Runway safety is especially vulnerable to complacency because the majority of events don't lead to bad outcomes and often go unreported. There are also many different technological systems that intervene in time.

This creates the feeling that someone else is managing all the risks at a specific airport location. Sometimes we might think "That situation was close, but it always is, everything is under control."

The role of the safety team is to challenge this normalisation and ask "What would it take for this not to end well?" and what can we do in our airline to play our part in mitigating runway safety risks.

Safety Map

Mindset

Runway safety risk is local — and unevenly distributed.

People

Pilots, controllers, ground staff and drivers all shape runway risk together.

Equipment

Lighting, signage, surveillance and technical systems play a key role but do not replace understanding and situation awareness.

Compliance

Rules define minima; local knowledge defines margins.

Risks

Runway collision risk increases when local complexity, mixed traffic, time pressure and assumption-based coordination combine at shared runway interfaces.

Learning

Precursors and near-misses are the best indicators of where to act.

Summary

Runway safety improves when effort is **focused, informed, and shared**.

Not every airport carries the same risk. Not every risk needs the same response.

Call to Action

Identify your top runway risk locations.

Then ask:

- Are we involved in the local safety conversation?
- Do we understand what worries others at this airport?
- Are we feeding learning back to our crews?

Because runways are where aviation systems meet — and safety there is always a **team outcome.**

FATIGUE RISK MANAGEMENT:

Designing the System, Not Just the Roster

From Gunnar, our HF Expert

Why Fatigue Matters

Strong safety performance across the European aviation system can create the illusion that human performance risks like fatigue are "solved."

They are not. Fatigue is often most dangerous when:

- People work within legal duty limits but are still tired.
- Normalised schedules (e.g., night operations) erode alertness over time.
- Organisations focus on compliance, not performance.
- People feel hesitant to report fatigue because the organisation thinks it's the person's fault and won't do anything to help the situation anyway.

It is quiet, cumulative, invisible - and precisely because it doesn't often lead immediately to dramatic failure, it is easily ignored.

The Reality of FRM

A robust FRM system goes beyond the basics of the Flight Time Limitations. It also thinks about fatigue for everyone, not just flight crew.

It's a proactive, systemic approach that recognises:

- Fatigue affects cognition, decision-making and reaction time.
- It can *accumulate* over days, not just hours.
- Legal limits are necessary, but not sufficient.
- Operational context (weather, delays, night work, turnaround pressure) matters.
- Personal life factors (sleep quality, commute, social responsibilities) influence alertness.

A true FRM is not a roster, a roster check, or a tick-box compliance exercise. It is a continuous process that integrates:

1. Risk identification.
2. Monitoring and data collection.
3. Controls and mitigations.
4. Measurement of effectiveness.
5. Feedback loops and learning.

In other words: it's a living system, not a static policy.

Where Organisations Fall Short

Despite best intentions, fatigue still slips through organisational defences when:

Systems Are Designed for Schedules, Not People

Many fatigue programs focus on duty cycles, hours of rest, turnaround minima and roster legality.

But human alertness does not operate on paper schedules alone. Operations that *technically comply* with duty limits can still produce fatigued crews, especially when circadian rhythms are disrupted, or sleep is fragmented.

Warning Signals Are Normalised

Crew may say “I’m a bit tired” in the briefing, and managers may respond “Everyone’s in the same boat.”

This is the classic complacency trap. When fatigue is seen as normal rather than *systemic*, it loses visibility as a risk.

Reporting Culture Is Weak

Fatigue occurrence reporting may exist, but if individuals fear reprisal, inconvenience or stigma, they simply won’t report.

No reports. No data. No organisational learning.

Organisational Focus Is Reactive

Many FRM processes are triggered only *after* an incident or deviation.

True fatigue management anticipates, it doesn’t wait to be surprised.

What Good Looks Like

A mature FRM system integrates fatigue into daily decision-making at every level of the organisation:

1. Senior Leadership Commitment

Leadership must set the tone that:

- Fatigue is a safety issue, not a performance issue.
- Reporting fatigue is valued, not penalised.
- Data matters more than compliance alone.

This reduces the subtle cultural message that “pushing on tired is just part of the job.”

2. Monitoring Real Fatigue, Not Just Rosters

FRM should draw on lots of things, including workload patterns, fatigue reports, event and occurrence data, fleet movement patterns, night activity clustering and science.

This tells you *where* the risk actually exists, not just where the rules say it should.

3. Shared Responsibility

Fatigue is not just a flight crew issue.

Fatigue affects everyone:

- Dispatch.
- Maintenance planning.
- Ground operations.
- Cabin crew.
- Management decisions.
- Scheduling teams.

Organisations succeed when they build cross-functional FRM ownership, not siloed pockets.

4. Early Identification & Mitigation

Good fatigue management includes:

- Adjusted rosters before fatigue becomes entrenched.
- Strategic use of breaks and rest opportunities.
- Proactive reassignments when risk signals appear.
- Recognition of circadian effects.
- Deliberate rest environments for crews.

Fatigue management isn’t just clinical science, it’s *operations science*.

5. Training and Awareness

This topic isn’t just about hours either, it’s about *how people experience those hours*.

Effective training covers:

- Physiology of sleep and circadian rhythms.
- Signs of fatigue and countermeasures.
- Organisational context of fatigue risk.
- How to use fatigue reporting systems.

Training is not a one-off checkbox, **it is *continuous reinforcement*.**

Safewings Occurrence Example

We noted a cluster of flight operations reports indicating delayed reactions in late-night sectors. Initial investigation found all crew were within legal duty limits.

However:

- Many sectors finished after circadian lows (after midnight).
- Rosters had back-to-back night duties.
- Sleep quality reports were seldom shared.
- Fatigue reports were minimal, due to staff concern about being perceived as “not coping”.

To help the situation we introduced:

- Shared fatigue dashboards.
- Protected rest blocks between night sequences.
- Mandatory fatigue briefings for late-night operations.
- Anonymous reporting options.

Within three months, fatigue reports increased (indicating reduced stigma), and discussions with pilot representatives identified a general increase in alertness.

Safety Map

Mindset

Fatigue is a system design challenge, not an individual shortcoming.

People

Everyone plays a role, flight crews, dispatch, schedulers, maintenance and managers.

Equipment

Tools that monitor duty cycles and sleep data must integrate with real operations.

Compliance

Legal duty limits are the starting point, not the finish line.

Risks

Unmonitored circadian effects, night duty clusters, normalised tiredness, delayed reporting, and reactive mitigation.

Learning

Early identification and cross-organisational feedback loops reduce latent fatigue risk before it contributes to errors.

Summary

Fatigue is quiet, pervasive, and insidious — especially when systems perform well. The organisation that thinks *compliance equals safety* will be caught off guard when human performance falls short.

Call to Action

This week, review one part of your operation with elevated night work or back-to-back duty sequences. Ask:

- Who feels tired most often?
- What reports exist — and which don't?
- How do we mitigate before it becomes a problem?

Because fatigue doesn't need an accident to be real, it only needs to be *ignored*.
Additional tactical actions to build in more safety margin:

- Appoint a fatigue coordinator.
- Launch an anonymous fatigue survey.
- Create soft rules for rostering.
- Create Fatigue SPIs to monitor challenge areas.

AIRBORNE COLLISION RISK MANAGEMENT:

Seeing and Being Seen Together

When we think about collision risk in commercial aviation, our minds often go to congested hubs, runways, complex approaches and high-density terminal areas. Collision risk in those environments is controlled through multiple overlapping layers of protection: TCAS/ACAS in the air, STCA on the ground, clearances from ATC, strict procedural adherence, and robust surface surveillance.

From Cate, ATC Controller

But when those layers exist, when technological barriers are the norm, the greatest remaining risk often shifts elsewhere.

To places where:

- Traffic is *mixed* (airliners, GA, helicopters, gliders, balloons and even drones).
- Not all aircraft are equipped with the same conspicuity and avoidance equipment.
- Situational awareness depends more on see-and-avoid than automation.
- Airspace design and visual cues vary widely.

In other words: smaller aerodromes, uncontrolled airspace, places where there are local flying communities and potentially also passing traffic.

This article focuses on how airlines can identify, prioritise and engage other stakeholders on airborne collision risk, especially where protective systems are less complete. As an operator, it can be easy to assume others "own" the risk and are taking action but there are many situations where cross-community collaboration can help reduce risk for *everyone* in the sky.

Why Airborne Collision Still Matters

Airborne collision risk, at its core, is about perception, time and distance.

Even with the best systems, humans still need to *detect* threats early and that is harder when:

- Aircraft lack transponders or ADS-B equipment.
- Visual scan is disrupted by glare, weather, or fatigue.
- Patterns of flight are unpredictable.
- Controllers and pilots of different aircraft types do not share common mental models.
- Small-aircraft pilots may be focused inwardly on navigation.

What does not always show up in statistics, but does show up in interactions with different stakeholders, is that near misses in mixed traffic environments are under-reported and under-analysed, because they often don't result in formal occurrences.

Yet they are *precursors* to much more serious risk.

The Hub vs Non-Hub Risk Landscape

At larger controlled airports, collision risk is mitigated through a number of different factors:

- TCAS/ACAS — on-board alerting for conflicting traffic.
- STCA — ground-based tactical conflict alerts.
- Robust ATC surveillance.
- Structured departure and arrival flows.
- Frequent training and standardisation.

For this reason, true airborne collision risk *within controlled airspace around major hubs* is statistically low and is one of the success stories of modern aviation.

However, collision risk is not only about incidence rates. It is also about *potential severity* and *probability under specific operational conditions*. That's where the risk picture becomes more complex at:

- Smaller airports.
- Visual flight rule (VFR) corridors.
- Mixed equipage airspace.
- Glider and ultra-light flight clusters.
- Helicopter training areas.

In these environments, protective layers are thinner, see-and-avoid is still essentially visual, and the traffic mix makes things less predictable.

Prioritising Risk for the Airline

For an airline safety team with limited resources, the key question is "Where should we focus our attention to reduce airborne collision risk most effectively?" This starts with data and operational context:

Operational Exposure

- Which airports and routes have the highest proportion of operations in mixed traffic environments?
- Do these include VFR corridors near departure or arrival paths?
- Are there *known GA flight paths* near your regular traffic flows?

Traffic Mix Identification

- Which aerodromes near your network have significant non-TCAS traffic?
- Do these facilities host GA clubs, helicopter operators, glider fields, airshows or other specific activities?

Historical Precursors

- What kind of TAF/NOTAM filtering shows the potential for traffic conflicts?
- Do internal or external reports show *close calls* that didn't become incidents?

Local Airspace Characteristics

- Are there plateau approaches, visual reporting points, scenic VFR holding areas that intersect with your approach or climb profiles?
- Are there adjacent uncontrolled zones your crews transit regularly after departure or before arrival?

Actions - Engaging with Local Flying Communities

Once priority locations are identified, the next step is partnership, not observation. Smaller aerodromes and GA communities often operate with:

- Local procedures.
- Culturally established patterns.
- High familiarity with local conditions.

Airlines do not need to impose; they need to collaborate. Effective engagement includes:

1. Shared Dialogue: Get out and engage with:

- Local GA clubs.
- Flight schools.
- Helicopter operators.
- Aerodrome managers.
- Private operators.

Listen to *their* perspectives on traffic patterns, blind spots, and near misses. These communities often have insights that never make it into formal reporting systems, but absolutely matter operationally.

2. Mutual Awareness Sessions: Hosting shared safety days or webinars where:

- Airline crews describe their radar-equipped environment.
- GA pilots explain patterns of local visual traffic.
- Controllers describe the challenges they face to keep everyone apart.

All groups discuss perceptual limitations. This bridges cognitive models across groups.

3. Operational Sharing: Sharing data and information where possible:

- Common reporting channels.
- Coordinated traffic patterns.
- Pattern recognition briefings.

This strengthens shared situational awareness.

EASA's Role: Conspicuity and Shared Responsibility

EASA recognises that airborne collision is not a challenge for commercial operators alone.

The General Aviation conspicuity initiative (including the ADS-L coalition and the *iConspicuity* Declaration) is designed to help General Aviation:

- Be Seen: By equipping GA aircraft with technology (such as ADS-B, FLARM, transponders) that enhances detectability.
- Be Aware: Through training, campaigns, and shared education.
- Understand collision risk: Through guidance that aligns GA behaviour with commercial and ANSP expectations

Aviation is safest when all parties understand the *shared risk space*.

Airlines can be powerful partners in this work by endorsing local conspicuity campaigns, sharing insights with aerodromes, reinforcing common dark-area avoidance tactics and supporting coalition-based awareness tools

This is a practical extension of the Together theme, recognising that GA and CAT do not operate in parallel skies, but shared ones.

Occurrence Example

A European airline regularly uses a regional aerodrome near a popular glider site. On numerous flights, briefing packages note significant GA traffic under VFR, but pilots report *very limited visual contact* with gliders during climb and descent.

A near-miss is reported when an airliner descending through 3,500 ft and a glider crossing that altitude (without a transponder) converge within visual range with minimal time to react.

Investigation highlighted that:

- No local guides about typical glider crossing altitudes.
- No shared traffic information between GA and airline communities.
- Airline crews assumed local GA pilots "would see them".

No collision occurred. But the risk gap was real.

The airline subsequently:

- Shared its risk analysis with the local GA clubs.
- Co-hosted a safety evening on see-and-avoid limitations.
- Promoted ADS-L and FLARM adoption among local GA and glider pilots.
- Updated briefing material to include local traffic insights.

Safety Map

Mindset

Collision risk is not only a technical problem — it is a shared perceptual and information problem.

People

Pilots, GA operators, controllers, dispatchers and ground crew all contribute to the collision picture.

Equipment

Surveillance aids (TCAS, ADS-B, FLARM, ADS-L) help, but only when both sides use and trust them.

Compliance

Rules matter, but responsibility extends beyond compliance into how crews visualise risk and share traffic awareness.

Risks

Mixed equipage, visual scanning limits, unnoticed low-level traffic, diverse flight patterns at uncontrolled aerodromes.

Learning

Engaging across communities reveals latent patterns much earlier than isolated reporting.

Summary

Airborne collision risk is not evenly distributed.

When airlines assume that TCAS and ATC protect them everywhere, they risk overlooking the places where those protections thin and where visual traffic matters most.

Call to action

- Identify the aerodromes and airspace segments in your network where mixed traffic and limited surveillance intersect.
- Engage with local flying communities — listen before you act.
- Share data that helps *both* sides see and be seen.
- Support EASA's conspicuity work — because collision risk belongs to everyone in the sky.

Aviation safety isn't a solo performance - It's a shared horizon.

APPROACH PATH MANAGEMENT:

Keeping the Aircraft Where It Needs to Be

From Claudio, our Safety First Officer

Approach and landing remain among the most safety-critical phases of flight.

Despite modern aircraft, advanced automation, and mature procedures, approach path management (APM) continues to feature prominently in accident precursors and high-risk occurrences. As part of EASA's SRM process, it was an important topic at EASA's last SAFE360 Conference and work on APM confirms a familiar but uncomfortable reality:

Most approach path management events do not begin with loss of control, they begin with mismanaged aircraft energy, degraded monitoring, and late decisions.

APM is therefore not about precision flying alone. It is about anticipation, coordination, and timely intervention by both flight crews and the wider system that supports them.

What the Data Is Telling Us

EASA's Safety Issue Assessment for APM analysed 44 occurrences (2016–2020) using a bow-tie methodology. Two higher-risk threat scenarios emerged repeatedly:

- Poor weather and runway conditions
- Non-standard runway configurations, including displaced thresholds due to works

In many cases, the aircraft was technically capable, the crew were experienced, and procedures existed, yet safety margins eroded because barriers were weak, late, or bypassed.

This aligns with a broader industry pattern: approach instability is rarely sudden. It is usually *progressive*.

The Anatomy of an Unstable Approach

Approach Path Management is about controlling three things simultaneously:

- Lateral path.
- Vertical path.
- Energy state.

EASA CAT.OP.MPA.115 defines clear stabilisation criteria, including configuration, speed, descent rate, thrust and lateral/vertical tolerance, with stabilisation required at a predefined height above the threshold.

Yet the SAFE360 work highlights that meeting stabilisation gates is not the same as managing the approach well.

Crews may technically stabilise late, or momentarily, while task saturation increases, monitoring degrades and go-around decisions become psychologically harder.

When the System Adds Pressure

The APM challenge is not confined to the cockpit. From an ATM perspective, vectoring practices, late descent clearances, speed control, and traffic sequencing all could influence energy management. Regulatory updates in Regulation (EU) 923/2012 - SERA, Regulation (EU) 2017/373 ATM/ANS Provision of services and Regulation (EU) 2015/340 ATCO reinforce that obstacle clearance, position information, standardised phraseology and training on a "Stabilised approach" are critically important when aircraft are vectored off published procedures

When clearances, vectors and expectations change late, it directly impacts a crew's ability to do things like set up the FMS, manage speed and maintain stabilisation

APM is therefore a shared responsibility, not a cockpit-only problem. It comes back again to our wider theme of "Together".

This was not a failure of skill; it was a mismatch between training assumptions and operational reality.

Learning from a Real Go-Around

A Safewings case study illustrates this perfectly.

During an ILS approach into an airport the aircraft ended up above the glideslope and behind slower traffic. The aircraft was fully configured, speed brakes extended and thrust at idleHowever, when ATC instructed a go-around due to reduction of separation, the crew encountered faced significant workload, configuration changes, retraction of the speed brakes as well an unexpected and an autothrottle disconnection that was not immediately noticed. This resulted in a momentary low-speed warning.

The go-around was ultimately safe but the investigation highlighted that while go-around training often focuses on the PF, real-world go-arounds generate significant PM workload and monitoring effectiveness can degrade at precisely the wrong moment.

Changing Behaviour, Not Just Rules

Other studies and analysis show that approach instability is as much behavioural as technical.

Common contributors include:

- Underestimation of risk ("I can fix this").
- Anticipation bias (VMC expectations in IMC).
- Cognitive lock-up and continuation bias.
- Social pressure inhibiting challenge by the PM or FO.

Addressing these requires the following:

- Clear stable approach policies.
- Strong PM training to prompt, direct, and intervene.
- Event management that focuses on learning rather than blame.
- Safety promotion that reinforces early, confident go-around decisions.

The key message is simple: You have control — but only if you act early.

Emerging Concepts: Supporting the Crew Earlier

SAFE360 discussions also explored whether new concepts could support crews earlier in the approach, such as expansion of the stable approach criteria before and actually defined stable approach gates (before 1000ft and past 50ft or flare height), enhanced use of distance-to-touchdown or track-mile awareness when being vectored, better alignment between ATM clearances and flight crew energy management needs.

The central question remains:

Does this help the crew do the right thing, at the right time, under real-world pressure?

Safety Map

Mindset

Approach stability is not a target to "achieve" it is a condition to *protect* early.

People

Effective APM depends on PF–PM coordination, confident challenge, and shared situational awareness.

Equipment

Automation and alerting help but cannot compensate for late energy management or degraded monitoring.

Compliance

Stabilised approach criteria are essential but only effective when combined with timely decision-making.

Risks

Continuation bias, late vectoring, mismanaged energy, high PM workload during go-around, and normalisation of late stabilisation.

Learning

The safest go-around is the one initiated early, before workload and ambiguity peak.

Summary

Approach Path Management is where small delays become big risks.

It is shaped by factors including cockpit behaviour, training assumptions, ATM practices and organisational attitudes toward go-arounds.

Call to action:

Review your unstable approach data and go-around events.

Ask:

- Where do crews first lose energy control?
- When does monitoring start to degrade?
- Are we supporting early decisions — or rewarding late fixes?

Because in approach path management, earlier is almost always safer.

OCCURRENCE REPORTING:

From Obligation to Organisational Insight

From Nuno, our Safety Manager

Occurrence reporting is not only one of the most powerful safety tools in European aviation, it is also one of the most misunderstood.

OCCURRENCE RISK CLASSIFICATION

For many organisations, reporting is still seen primarily as these 3 things:

- A regulatory obligation.
- A timeline to be met.
- A form to be completed.

Yet Regulation (EU) 376/2014 was never designed just to create databases full of events. The Regulation's full title is "the reporting and follow-up of occurrences in civil aviation". Far too often the "follow-up" part is missed - and with it an opportunity to draw lessons is missed. The reality is that Regulation (EU) 376/2014 was designed to create a better understanding of safety risk.

Safety does not improve simply by identifying *what* happened; safety improves when we have a clearer understanding of the sequence of events along with an understanding why the people chose to do what they did at the time. It is also important to understand more about the role of the organisation in the situation.

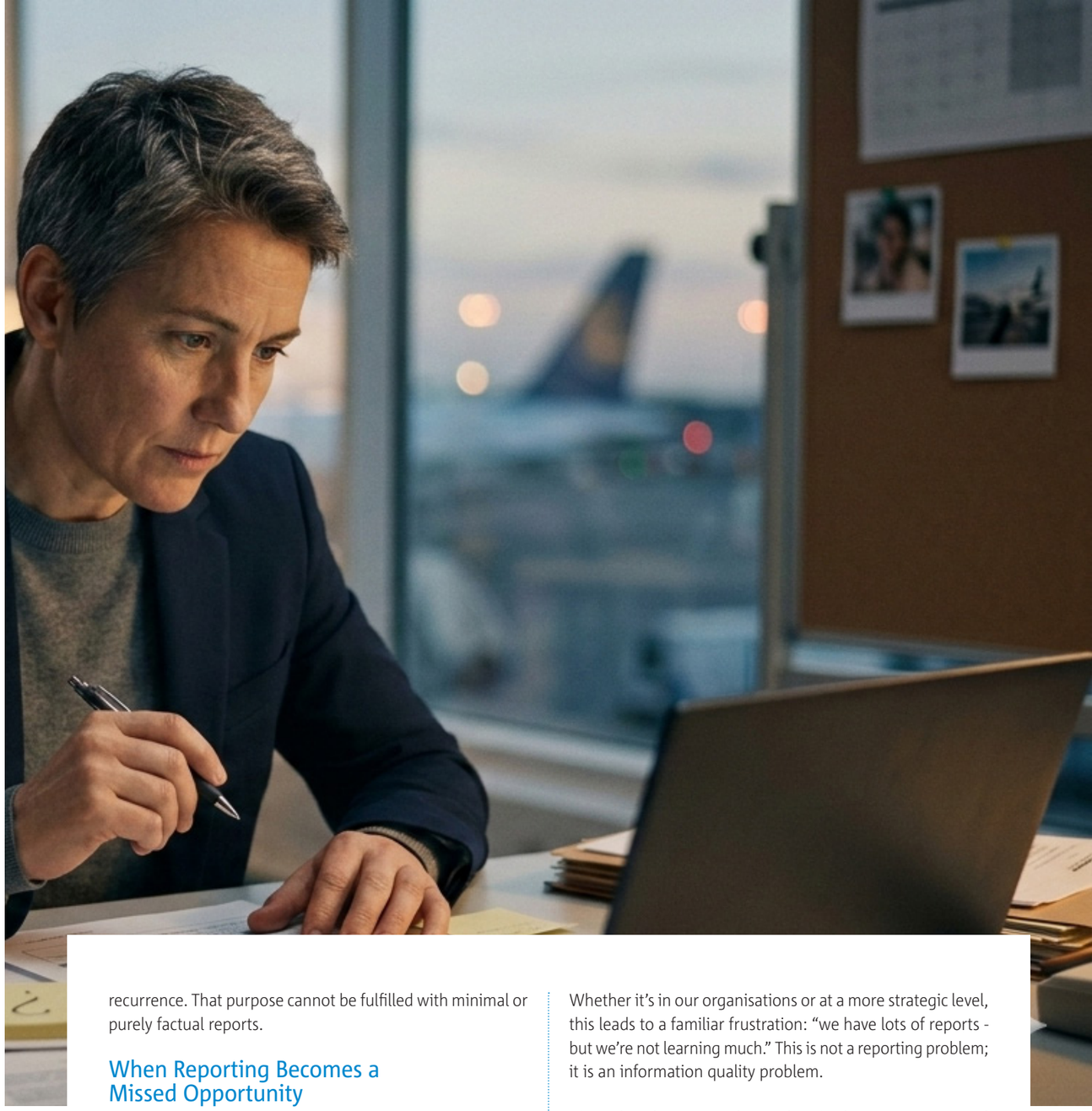
What the Regulation Really Requires

Regulation (EU) 376/2014 establishes a clear framework for occurrence reporting across European aviation.

At its core, the Regulation requires organisations and individuals to:

- Report defined occurrences that may endanger safety.
- Submit reports within required timelines (typically, within 72 hours of becoming aware).
- Ensure reporters are protected under the principles of Just Culture.
- Analyse occurrences to identify the real risks so that they can be mitigated.
- Share relevant safety information within the European aviation system.

Compliance with timelines and categories is, however, only the beginning. The regulation is explicit about the purpose of reporting, such as to improve aviation safety and prevent recurrence. That purpose cannot be fulfilled with minimal or purely factual reports.



When Reporting Becomes a Missed Opportunity

In many organisations, occurrence reports often contain the following statements:

- "Aircraft unstable on approach."
- "Procedure not followed."
- "ATC instruction misunderstood."
- "Human error."

Such statements describe outcomes and don't get into any detail about potential root causes; they really don't provide tangible information to support either the management of the risks in day-to-day operations or cross-organisational learning.

Whether it's in our organisations or at a more strategic level, this leads to a familiar frustration: "we have lots of reports - but we're not learning much." This is not a reporting problem; it is an information quality problem.

Given that the reports that end up in the European Central Repository (ECR) are then used as part of the European Safety Risk Management (SRM) process; this type of information (i.e. outcomes, not causes) doesn't help with system-level and system-wide lesson identification, learning and occurrence prevention.

What “Good” Looks Like in Occurrence Reporting

High-quality occurrence reporting has three defining characteristics:

1. Explains Context, Not Just Events

Good reports answer questions, such as:

- What was the operational environment like?
- What pressures were present?
- What information was available or missing?
- What assumptions were being made?
- What alternatives were considered?

Context turns an event into a learning opportunity. Without context, an occurrence report is simply a data point without meaning.

2. Describes Decision-Making, Not Just Deviations

The most valuable part of a report is often not *what went wrong,* but *why the action made sense at the time*.

For example:

- Why did the crew continue the approach?
- Why did the controller issue that clearance?
- Why did the engineer defer the defect?
- Why did the dispatcher believe the information was adequate?

Capturing this kind of information does not apportion blame, it can reveal how the system behaved under real conditions.

3. Looks Beyond the Individual

Regulation 376/2014 deliberately supports a Just Culture approach. That means recognising that:

- Individuals operate within organisational constraints.
- Performance is shaped by procedures, tools, training, workload and culture.
- “Human error” is a *starting point*, not a conclusion.

Good reports explore things like organisational factors, interface issues, latent conditions and normalised practices. Open, contextual occurrence reporting is how individual events can become system-level and system-wide lesson identification, learning and occurrence prevention.

Fitting in with the wider theme of “Together”, when it comes to reporting and data collection, we really are all in this together.

Imagine coming back from holiday and showing your friends all your holiday photos but they were all blurry like the one on the left. That’s like our organisation trying to make decisions with insufficient information.

At a European level, we all have our pieces of the risk picture, so we need to play our respective parts in making those pieces as clear as possible.

Timeliness Matters, But So Does Maturity

Meeting occurrence reporting timelines matters.

In the first instance, early occurrence reporting helps to preserve memory, captures nuance, allows early risk assessment and, where appropriate, supports the development of timely mitigation(s). Speed must not, however, come at the cost of quality.

The most effective organisations:

- Submit initial reports promptly.
- Then update them as understanding develops.
- Treat reports as living records, not one-time submissions.

This approach aligns fully with the intent of the regulation and significantly improves analytical value.

Why “Why” Matters for Long-term Safety

EASA’s system-wide analyses depend not just on counts and categories, but on patterns of contributing factors.

When reports consistently capture decision drivers, organisational influences and human-system interaction, it becomes possible to detect emerging risks, identify common vulnerabilities, prioritise safety actions and support evidence-based rulemaking and guidance.

When reports do not offer such detail, risk(s) can remain fragmented and hidden.

A Practical Example

An airline submits multiple reports of unstable approaches at the same airport. Early reports state:

- “Unstable approach - crew continued.”

Later reports begin to include:

- Frequent late descent clearances.
- Speed constraints conflicting with energy management.
- Expectation of visual conditions that did not materialise.
- Reluctance to go around due to perceived traffic impact.

Suddenly, the issue is no longer “crew decision-making”. The inclusion of more systemic factors (i.e. context) means that lessons can be identified and shared and risks better managed for everyone. Things like:

- Approach design.
- ATM interaction.
- Cultural pressure.
- Training emphasis.

Now the organisation and the wider system can benefit and act.

Safety Map

Mindset

Occurrence reporting is a learning tool, not a judgement one.

People

Honest occurrence reporting depends on trust, protection and psychological safety.

Equipment

Occurrence reporting tools should support narrative, context and updates, not just tick boxes.

Compliance

Timelines and categories matter, but purpose matters more.

Risks

Superficial occurrence reports, outcome-only descriptions, and “human error” conclusions can serve to hide systemic risk.

Learning

Understanding why it made sense at the time is the key to preventing recurrence.

Summary

Occurrence reporting is where safety intelligence begins.

Every report is an opportunity to either learn deeply, or move on unchanged.

Call to action

Review one recent occurrence report in your organisation. Ask yourself:

- Does it provide/explain the context?
- Does it describe decision-making?
- Does it look beyond the individual(s)?

If not, the next safety improvement isn’t a new rule or system, it’s better questions.

Aviation safety does not improve when we report more, it improves when we understand more.

ARTIFICIAL INTELLIGENCE FOR REPORTING AND SAFETY MANAGEMENT:

Insights from the Front Line

From Nuno, our Safety Manager

As with any powerful tool, however, early experience shows that the true safety value of AI comes not from the tool itself, but how organisations adopt and integrate it into safety workflows.

What AI Is Helping With Now

1. Better Report Triage and Prioritisation

Increasingly, AI tools are used to read large volumes of occurrence reports, identify keywords, themes and trends, prioritise reports with higher escalation potential and to flag similar events across fleets, bases or time periods. Consequently, this allows safety teams to spend less time sorting data and more time understanding risk.

Crucially, many organisations report that AI is most valuable when it helps answer the question “where should we look first?”

2. Pattern Detection Beyond Human Capacity

Humans are excellent at understanding context, but not at scanning thousands of reports. AI excels at clustering similar events, identifying weak signals, spotting slow-burn trends, while linking operational, technical and human factors data.

Several organisations report that integrating AI into their human driven processes has helped them to highlight patterns that may have previously been seen as previously seen as isolated events, crossed departmental boundaries or that wouldn’t have triggered attention individually. This in turn brings more insight to support the human decision making in their organisational management system.

3. Improving Report Quality

Some organisations are using AI to prompt reporters for missing context, encourage narrative explanations rather than tick-box entries, standardise terminology without removing nuance and support non-native language reporting.

When used carefully, AI can improve information quality, not just quantity.

Where Caution Is Needed

Early adopters of AI also report important limitations. Some examples include:

Automation Bias

There is a risk that AI outputs are accepted without challenge, treated as conclusions rather than indicators or prioritised over frontline insight.

AI can suggest *where* to look, but it cannot decide *what matters*. It is important to consider AI as a support to the work people do and not as a replacement.

Data Quality Still Matters

AI reflects the quality of the data it receives. If reports lack context, decision-making rationale and/or organisational/human factors then AI will simply process incomplete understanding at scale.

This reinforces a key message from Regulation 376/2014: Better reporting enables better learning, with or without AI.

Trust and Transparency

Safety teams report that trust matters. So, the key questions are "How does the AI prioritise?", "What assumptions does it make?", "How can results be better explained to humans?"

Black-box outputs can undermine confidence and, in turn, discourage use.

What "Good" Use of AI Looks Like

Across early implementations, common success factors emerge:

- AI is used as a decision-support tool, not a decision-maker.
- Human judgement remains central.
- Outputs are readily explainable and reviewable.
- Safety experts remain responsible for interpretation.
- AI is embedded into existing management system/SMS processes and systems, not bolted on or used on the side.

In short, AI works best when it supports curiosity, not certainty.

AI and the "Together" Theme

AI has demonstrable value in breaking down silos. AI does this by connecting operational data, technical reports, human factors narratives, training outcomes and lots of other types of information.

AI can help organisations to identity system-wide risk, rather than isolated events. But collaboration still depends on people agreeing what to act on, sharing insights across departments and closing the learning loop.

AI can connect data, but people connect meaning.

Safety Map

Mindset

AI supports safety thinking; it does not replace it.

People

Human expertise, challenge and judgement remain at the heart of your management system.

Equipment

AI tools should be integrated parts of your safety systems and tools, not simply a bolt-on.

Compliance

Regulatory reporting requirements remain unchanged, but AI can enhance their value.

Risks

Automation bias, over-trust in outputs, poor data quality, and opaque algorithms mean that introducing AI into your management system introduces additional risks that must be understood and managed.

Learning

AI can accelerate learning only when organisations remain curious and reflective.

Summary

AI is already improving how aviation organisations manage safety data. AI's greatest value, however, is not efficiency, but the insight AI can provide.

Call to action:

If you are using, or considering using, AI to support your management system:

- Ask what questions it helps you ask.
- Ensure humans remain accountable for decisions.
- Invest as much in report quality as in technology.

In safety management, tools don't think, people do and AI works best when it helps us think together.

CARGO OPERATIONAL RISKS:

Safety Happens Together

The world of cargo and freight transportation is something most people never see. Warehouses and cargo aprons are usually separated from passenger terminals, and freighters only appear in the public eye during peak seasons - or when something goes wrong.

Yet, cargo operations are an essential part of the Safewings system, and they bring a distinct set of operational safety risks. These differences stem from the nature of the payload, the operating environment, and in some cases the aircraft themselves. While many risks are shared with the passenger side of things, managing these risks effectively requires an understanding of the specific context of cargo and freight operations.

The key message is simple: cargo safety is as much a team effort as any other safety operation. Every part of the aviation system can influence the outcome; we are in this “together”.

To better understand how, let’s follow the airfreight journey end to end.

From just a commodity to aircraft operating around the world

It all starts with what is being transported.

Mis-declared or hidden Dangerous Goods present a risk across aviation, but cargo aircraft often carry larger quantities and higher concentrations, increasing the potential severity.

Lithium batteries are a clear example. Even when properly declared, *thermal runaway* can occur due to overcharging, short circuits and/or mechanical damage. Other forms of special cargo - from live animals to oversized or heavy items - bring their own hazards. While multiple controls exist during acceptance, handling, and loading, these only work when everyone plays their part consistently.

Warehouse and ULD Build-Up

The first major compliance barrier is the warehouse.

The build-up and manipulation of Unit Load Devices (ULDs) demand situational awareness, discipline, and teamwork, very similar to ramp operations.

Well-built ULDs must meet contour limits, weight distribution rules, segregation requirements, netting and strapping standards, and protection against moisture. Accurate weighing is essential, as this data feeds directly into load planning and mass & balance calculations downstream.

A weakness at this early stage often propagates silently until it manifests as an in-flight risk.

Mass & Balance: a Critical Cargo Risk

Mass and balance errors remain one of the most significant threats in cargo operations.

Unlike passenger aircraft with standard seating and predictable baggage (i.e. weight) distribution, cargo aircraft deal with dense, irregular loads and larger ULDs.

Unchecked errors can result in tail strikes, rotation difficulties, structural damage, or even loss of control in flight. These risks are rarely the result of a single mistake, they emerge from misalignment between warehouse data, load planning, and cockpit verification.

Ramp Operations in Challenging Conditions

Cargo loading often takes place at night, in poor lighting, under time pressure, and with heavy equipment and ULD trains moving in close proximity. Preventing injuries and aircraft damage requires heightened coordination and communication across teams.

Ground Service Equipment (GSE) damage is common, but in cargo operations the risks extend further: main deck pallets built out of contour can damage cargo doors, frames, and internal panels. These are not cosmetic issues - they can compromise an aircraft’s structural integrity and safety margins.

Securing the Load – No Second Chances

Once on board, load security becomes critical. Floor locks, nets, and straps must ensure that cargo cannot shift during flight. For oversized or non-ULD cargo, proper strapping is essential.

A cargo shift can lead to centre-of-gravity changes and/or structural damage - both potentially catastrophic. This challenge is amplified in smaller aircraft and in older cargo aircraft still widely operated worldwide.

After Landing: The Loop Must Close

Following arrival, unloading and warehouse breakdown can reveal irregularities that were not apparent earlier. Safety reporting at this stage is just as important as during loading or flight.

If issues are not reported, the system cannot learn and the same risks can return on the next rotation.

Human and Organisational Challenges

Cargo operations are demanding on human physiology. Night flying, circadian disruption, long exposure to extreme weather, and extended turnarounds all increase fatigue risk. Robust fatigue risk management and a genuine concern for wellbeing are essential.

Cargo operations also frequently occur in challenging geographic and infrastructural environments. These risks are not always obvious, which is why open safety conversations and shared learning matter so much.

Finally, we must acknowledge the reality of ageing cargo fleets. While major carriers benefit from robust organisational structures, some operators face financial pressures that increase reliance on older aircraft. In these cases, maintenance quality becomes even more critical: lives depend on it.

Safety Map

Mindset

Cargo safety emerges from interactions, not individuals. Assumptions and silos can be the enemy.

People

Warehouse staff, loaders, planners, engineers, flight crew - each sees a different part of the risk picture. Safety depends on sharing those perspectives.

Equipment

ULDs, floor locks, nets, straps, GSE, and ageing aircraft structures must all perform as designed - every time.

Compliance

Dangerous Goods, mass & balance, load restraint and maintenance rules are non-negotiable. Deviations accumulate quickly.

Risks

Mis-declared cargo, load shifts, fatigue, ramp damage, and ageing aircraft can combine into high-severity events.

Learning

Reporting at every stage, from acceptance, loading, flight, right through to unloading is essential to stop risks repeating.

Summary

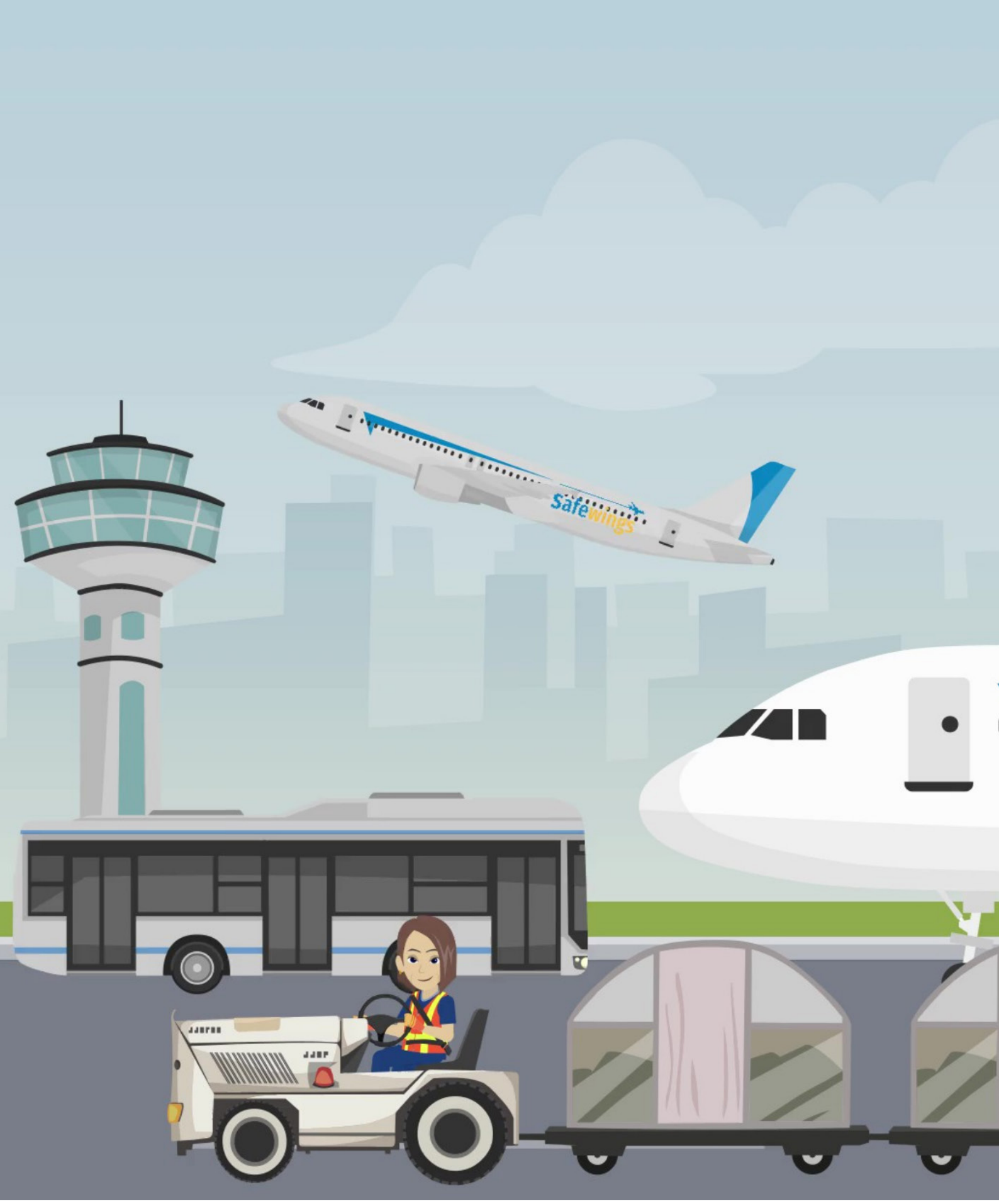
Cargo operations are not inherently less safe than passenger operations, but often involve more variables, fewer buffers, and potentially higher consequences if things go wrong.

Safety in cargo does not sit with one function or one organisation. It depends on how well we work together, how honestly we report issues, and how seriously we treat early warning signs.

Call to Action

- If you see something that doesn't feel right - report it.
- If data doesn't align - stop and check.
- If pressure is building - slow the system down.

Cargo safety is a system outcome, and systems only work when we protect them - together.



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