CONVERSATION AVIATION

#03 2026

STARTING POSITIVE CONVERSATIONS ABOUT SAFETY



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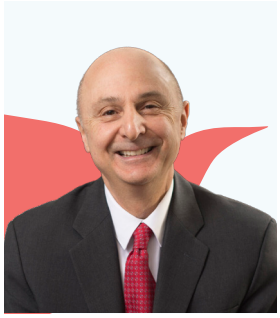
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SAFETY LEADERSHIP

My Conversation with Florian Guillermet

Earlier this year, around the time Flight Safety Foundation introduced its *Seven Essential Principles of Aviation Safety Leadership,* I sat down with Executive Director Florian Guillermet for a fireside chat on aviation safety. We discussed runway incursions, innovation, international cooperation, emerging risks, and the future of regulation. The theme that connected all of it, however, was safety leadership — not as an abstract concept, and not as a list to be explained one principle at a time, but as the discipline of making safety real in everyday decisions.

The principles begin with visible commitment, trust, accountability, strategy, prevention, learning, and engagement. Those words matter, but only if they show up in how leaders behave. Aviation has built an extraordinary record through standards, systems, training, and collaboration. Yet, every one of those strengths depends on leadership. Leaders decide what receives attention, what is funded, what is measured, and what is allowed to interrupt the normal flow of business. In those moments, organizations discover whether safety is truly embedded or merely stated.

That is why runway safety offers such a powerful example. It is not a new risk and the industry has no shortage of reports, task forces, or recommendations. The challenge is different: turning what we already know into action that lasts. Florian captured this well when he spoke about moving recommendations into concrete implementation. For me, that is one of the clearest tests of safety leadership. The question is not whether we can identify the right lessons; the question is whether those lessons survive the next meeting, the next budget cycle, and the next operational disruption.

More broadly, the same is true of safety priorities. Plans can become long catalogues of worthwhile concerns, but when everything is listed with equal weight, urgency disappears. This is where leadership links governance, strategy, and prevention. It means narrowing the field with courage: what can hurt us most; what is changing fastest; what weak signals are we overlooking; and, where can our next practical action make the greatest difference?

Safety leadership also begins with a realistic view of people.

Aviation professionals are adaptable, inventive, and often the last line of defense when conditions change. People are also fallible, which is why strong systems, procedures, and barriers matter. A human-centered approach holds both truths

> *Taking the decision to stop an aircraft sounds simple, but it relies solely on trust and engagement*

together: it not only provides people with structure, but it also protects their judgment, voice, and authority to act.

One phrase from our conversation stayed with me: the ability to "stop the aircraft." Taking the decision to stop an aircraft sounds simple, but it relies solely on trust and engagement — it means that a pilot, controller, mechanic, dispatcher, cabin crewmember, or manager can raise a concern and trust that the system will listen, support and respond. That confidence does not appear in the moment of risk. Leaders build it long before, through what they reward, what they tolerate, and how they respond when someone speaks up.

This is where credibility matters.

People notice whether safety is part of the real conversation. They notice whether it appears on agendas, dashboards, and investment decisions. They notice whether the safety function has access to the top of the organization or is buried so deeply that its voice is softened before it reaches decision-makers. What leaders choose to discuss tells the organization what receives oxygen — and what doesn't.

Learning is much broader than investigating failure.

My conversation with Florian also reminded me that aviation is very good at studying what went wrong, but we must look wider. We must be just as curious about why things went well: why a weak signal was caught; why a team adapted; and, why a good decision was made under pressure. Successful recoveries are not incidental, they are evidence of strengths we should understand, reinforce, and teach.

Innovation makes this even more important.

Data tools and artificial intelligence can help us identify trends, detect weak signals and support better decisions, but technology cannot replace leadership. Leaders must ensure that innovation strengthens safety barriers rather than quietly changing them, and that regulators and industry are prepared to integrate new tools with discipline and competence.

Nor can safety leadership stop at organizational borders.

Aviation is global by design. Risks move among operators, airports, manufacturers, authorities, and air navigation service providers. On the fundamentals of safety, the system needs alignment. That does not require uniform thinking on every issue, but it does require a shared commitment to identify risk honestly and act collectively.

"Walk the talk"

Near the end of our discussion, I asked Florian where aviation leaders should focus first. His answer was direct: "walk the talk." It is a familiar phrase, but in aviation it carries real weight. There is nothing more corrosive than saying the right things on paper while making choices that tell a different story. Safety leadership is not proven by statements of commitment. It is proven by consistency.

That is the purpose of the Seven Essential Principles. They are not intended to be a script or a checklist. They are a compass that connects commitment to trust, trust to reporting, reporting to learning, learning to prevention, governance to decision-making, strategy to investment, and engagement to action.

The real measure of safety leadership is not whether we can explain these principles. It is whether we create the conditions for the right call to be made when the pressure is real.

WINTER STARTS BEFORE THE SNOW:

Preparing for the Season's Biggest Operational Risks



From Nuno, our Safety Manager

Every year, there is a moment when winter suddenly seems to arrive.

The first frost. The first contaminated runway report. The first morning when several aircraft need de-icing and the schedule immediately starts slipping. But winter safety cannot start on that morning.

At Safewings, our preparations begin much earlier. We review, and analyse what happened last winter, examine our occurrence data, talk to our operational teams and work with airports and service providers across our network.

The question I want us to answer isn't simply "*are we ready for winter?*".

The *questions* must be much more specific:

- *What lessons did we identify from last winter?*
- *What could go wrong this winter?*
- *What controls should stop these events happening?*
- *How confident are we those controls will work when we need them?*

While winter hazards provide the context, *it's people working together who provide the solution*.

What Incidents Are We Trying to Prevent

Winter brings plenty of hazards: ice and snow, slippery surfaces, darkness, poor visibility, freezing precipitation and rapidly changing runway conditions. Add disruption, delays and operational pressures and the margins we normally rely upon can quickly be eroded.

As Safety Manager, however, simply listing winter hazards isn't enough.

I want to understand *where those hazards could take us in our daily activities*. What controls and barriers should stop them turning into a more serious situation and whether those controls will still work when the operation is cold, dark, disrupted and under pressure.

At Safewings, we focus our winter preparations around four outcomes that we actively want to prevent (these are the EASA ECCAIRS Taxonomy Key Risk Areas – KRAs):

- **Damage and Injuries on the Ramp**. Slippery surfaces, poor visibility, cold conditions, vehicle and equipment movements, and human actions under operational pressure can combine to cause injuries or damage to aircraft and/or equipment.
- **Loss of Control Following Aircraft Contamination**. Frost, snow and/or ice remaining on critical aircraft surfaces can significantly affect aerodynamic performance, which could have potentially catastrophic consequences.
- **Collisions and Incursions on the Ramp and Manoeuvring Area**. Darkness, snow, fog and/or precipitation can combine to obscure aerodrome signage and markings, in turn, reducing situational awareness for flight crews, drivers and/or other personnel operating on or around the ramp and manoeuvring areas.
- **Runway and Manoeuvring Area Excursions**. Snow, slush, ice or water can reduce braking action and directional control, particularly when conditions change or the reported runway conditions differs from those used for performance planning.

Four outcomes. Many contributing factors. Multiple organisations. That's where our winter preparation starts.

Damage and Injuries on the Ramp

Take something as apparently simple as an icy aircraft stand. The immediate hazard might be obvious: somebody could slip and fall.

But look a little wider.

A baggage tractor could lose traction. Ground equipment could slide into an aircraft. A ramp worker concentrating on keeping their footing might have less attention available for everything happening around them. Cold can affect dexterity and performance. Tasks take longer and, as the turnaround starts to fall behind schedule, pressure can build to recover the lost time. The outcome could be an injured colleague, damaged equipment or a damaged aircraft.

So, our question shouldn't just be *"has the stand been treated?"* We should also be asking whether deteriorating conditions are being identified and reported, whether vehicles are being operated appropriately, whether people have suitable equipment and whether someone has the confidence and authority to stop an activity when conditions become unsafe. Most importantly: does that information travel?

The airport might be responsible for treating the surface. A ground handler may be the first to notice that conditions have deteriorated. A contracted provider may damage an aircraft. A Safewings engineer or flight crew may identify that damage.

These aren't separate safety systems. **The risks cross organisational boundaries, so the controls must cross them too.**

Loss of Control Following Aircraft Contamination

Here, the outcome we are trying to prevent is particularly clear. An aircraft must not depart with frost, snow or ice contamination that could adversely affect the aircraft's aerodynamic performance. De-icing and anti-icing provide critical barriers against that outcome. But having a de-icing truck or a pad available isn't enough.

Think about everything that must work.

The right equipment and fluids must be available. Personnel need to be trained and current. The aircraft needs to be configured correctly. Communication between the flight crew and de-icing personnel must be clear. Weather conditions need to be understood and monitored. Applicable holdover times need to be considered.

Even the environment in which people are working matters. **Can they see what they're trying to remove or what they are applying to the aircraft?**



Poor lighting during darkness or adverse weather can make contamination and the effectiveness of treatment more difficult to assess. A stand that looks perfectly adequate on a summer afternoon may be a very different working environment at 05:30 on a freezing winter morning.

That's exactly the kind of vulnerability we should be identifying now — not discovering when the first aircraft is waiting for de-icing — **and don't overlook configuration**.

Aircraft configuration during de-icing can sometimes feel like a procedural detail. It isn't.

Different aircraft types can require specific configurations or precautions involving engines, APU, air-conditioning systems, control surfaces and/or other systems. The procedure is one barrier. The flight crew is another. The de-icing team is another. **Communication connects those barriers.**

If somebody sees something unexpected, do they speak up? If there is uncertainty about the aircraft configuration, does everyone understand who needs to resolve it? And when the aircraft is already late and another ten are waiting behind it, are we still prepared to stop and check?

That's when good procedures, communication and safety culture matter most.

Collisions and Incursions on the Ramp and Manoeuvring Area

Winter doesn't just change the condition of the airport surface. It can change what people can see and how easily they can work out where they are.

Longer hours of darkness often combine with snow, fog, precipitation and poor visibility. Snow or standing water may make aerodrome markings harder to distinguish. Signs and lighting can become more difficult to identify. A familiar airport can suddenly look very different.

For flight crews and vehicle drivers, that can reduce positional and situational awareness. On the manoeuvring area, the potential consequences can be severe.

Again, this is not a risk that belongs to one organisation. The airport is responsible for its infrastructure and winter operations. ATC has its picture of aircraft and vehicle movements. Flight crews need to understand their position and clearance. Drivers and ground personnel need to know exactly where they are permitted to go — and not go. **Each sees a different part of the operation.**

So, if something isn't clear, **don't fill the gap with an assumption**. **Stop. Check. Ask and clarify if needed.**

Sometimes the most important winter safety action is simply acknowledging: "*I'm not completely sure where I am*".

Runway excursions

The final outcome brings us to one of the most familiar winter challenges: contaminated runways.

Snow, slush, ice and/or water can affect braking action and directional control. Our previous winter guidance highlighted the importance of using the Global Reporting Format and reassessing conditions after events such as snow clearing or temperature changes. But, the safety barrier isn't simply obtaining a runway condition code.

Think about the information chain. The airport assesses the runway. The information needs to be communicated. Airline systems and operational personnel need to receive and use it correctly. Flight crews need to understand it and relate it to the conditions they actually encounter.

And all that needs to happen while the conditions themselves may still be changing.

Precipitation changes. Temperatures cross freezing. A cleared runway can become contaminated again. Traffic itself can change surface conditions.

That creates a simple but important challenge: **the runway you planned for may not be the runway you get.**

A perfectly correct performance calculation based on information that no longer represents the actual conditions isn't much of a safety barrier.

Preventing an excursion therefore depends not only on good performance calculations, but also on good observation, timely information, communication and decision-making across the whole system.

Look across the network

For me, one of the most important parts of winter preparation happens away from the aircraft. It happens in our safety data. I want to know where we experienced problems last winter.

Did we receive repeated reports about slippery stands at particular airports? Were there problems with lighting during de-icing? Did crews encounter difficulties with winter markings or maintaining situational awareness? Were there locations where runway conditions changed rapidly or information didn't reach crews as effectively as it should have?

Then, I want to go one step further.

Which of our four outcomes could those events or identified hazards have led to?

One report might describe a local event or a hazard. A series of reports can reveal a pattern.

That's why our SMS is designed to ensure we focus not just on **reporting what happened, but to changing what happens next**.

If several crews report the same problem at one airport, the answer isn't necessarily another notice reminding our crews to be careful. There is a lot more we can coordinate already.

Talk to the airports in our network, our handling agents, the de-icing providers; understand what each organisation is seeing and what can be changed before winter returns.

Winter hazards have an inconvenient habit of recurring, but past events don't have to.

Prepare for Pressure and the Weather

There is one factor running through all four outcomes that deserves particular attention: **operational pressure**.

Weather deteriorates. Aircraft need de-icing. Turnarounds take longer. Slots are missed. Passengers become frustrated. Crews approach duty limits and the schedule starts to unravel.

Suddenly, five extra minutes feels very expensive.

That pressure can influence decisions anywhere in the system: on the ramp, during de-icing, while taxiing or when deciding whether the available runway information is good enough to continue.

We cannot remove operational pressure from winter operations, but we can prepare our people to manage it.

Procedures need to remain usable when the operation is disrupted. People need confidence to stop when something doesn't look right. Supervisors and managers need to support decisions that protect safety even when those decisions affect punctuality.

The safest winter operation isn't necessarily the one that avoids disruption, **it's the one that manages disruption without allowing pressure to erode the barriers that exist to keep us safe.**

Winter starts before the snow

So, before the first snow appears on the forecast, there are some questions I want us asking across Safewings:

- *What did we learn last winter?*
- *Where were our recurring problems?*
- *Which of our four outcomes could they have led to?*
- *Have the problems actually been fixed?*
- *Have we spoken to the airports and providers involved?*
- *Do our people know what has changed?*
- *And are the barriers still going to work when the operation becomes cold, dark, disrupted and under pressure?*

Damage and injuries on the ramp, loss of control following aircraft contamination, collisions and incursions on the manoeuvring area and runway excursions don't belong to one person, department or organisation.

Nor does preventing them.

That's why winter preparation starts long before the first snowflake falls, and it's why winter operations are such a good example of **Going Safe Together When It Matters Most.**

WINTER STARTS BEFORE THE SNOW

Preparing for the season's biggest operational risks

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GO SAFE TOGETHER WHEN IT MATTERS MOST

COMMUNICATE COORDINATE COLLABORATE PROTECT

Winter increases complexity. Together, we keep it safe.

THE HIDDEN RISK OF SUCCESS:

When Safety Looks Easy



From Milena, CEO, Safewings

Safewings has had another good year: our operation is growing; our people are delivering; customers are choosing to fly with us; and, most importantly, we continue to operate safely.

Rightly, those things belong in the same sentence. I don't see business performance and safety performance as competing priorities. A safe airline is the foundation of a successful airline; but success brings its own risk.

When serious accidents are rare and our safety performance is strong, it becomes very easy to believe that everything is working exactly as it should.

That's when we need to be at our most vigilant.

The Success Paradox

There is a strange paradox in aviation safety: when safety works, very little happens. There is no accident. No damaged aircraft. No serious injury. No disruption splashed across the news. That's exactly the outcome we want.

Conversely, it also means that much of the work that created that outcome could become less visible.

The occurrence that was reported and investigated. The trend somebody spotted in the data. The difficult conversation with a supplier. The procedure that was changed. The extra training. The safety action that prevented something happening months or years later.

Success can, therefore, create the conditions for complacency: "We're safe. Why do we need to keep spending so much time on safety?"

For me, the question should be exactly the opposite: **"We're safe. What are we doing that is helping to keep us that way?"**

Safety is Productive Work

This matters when we talk about resources. Safety teams across aviation are being asked to do more. New regulations arrive; new technologies create opportunities and risks; operations grow; data increases; and, organisations change.

It would be tempting to respond by simply adding another task, but there are still only so many hours in the working day.

If we want our safety people to analyse reports properly, understand why events happen, identify emerging risks, engage with operational teams and work with other organisations, we need to give them the time to do it. Critically, that isn't time taken away from running the business or operation, it must be a fundamental part of it. The same applies beyond the Safety Department.



A pilot taking time to write a useful occurrence report, an engineer stopping to investigate something unusual, a manager joining a safety review or a ground handler raising a concern are all contributing to the resilience of the operation.

Safety isn't an additional activity we perform when the "real work" is finished. Safety is part of the real work, for everyone, every day. Don't measure safety only by what didn't happen but by the risks that we have effectively managed.

This is where leadership matters.

If our only measure of safety is the absence of accidents, we can easily reach the wrong conclusion.

No Accidents Does Not Necessarily Mean No Risk

No accidents certainly doesn't mean there is nothing left to learn. A healthy organisation should still be finding things to learn from.

People should still be reporting mistakes, hazards and weak signals. Investigations should still challenge assumptions. Safety reviews should still uncover uncomfortable questions.

In fact, I become more concerned when everything looks perfect. A strong safety culture doesn't necessarily produce a clean dashboard. Sometimes it produces more information about where the organisation is vulnerable; that's useful information.

The truth is valuable even when it's inconvenient

As CEO, I need people to tell me what is really happening in our operation. Not what we hope is happening. Not what the procedure says should be happening. And not simply what makes the performance dashboard look good.

That means creating an organisation where people can raise concerns, report mistakes and challenge decisions without believing that delivering uncomfortable information makes them the problem.

It also means being willing to hear that something needs more resources, more time or a different approach.

That doesn't mean every safety request automatically receives unlimited resources. Every organisation has to make choices.

Those choices should, however, be informed by a genuine understanding of the risk - not by the assumption that yesterday's success guarantees tomorrow's safety.



Invest in What Keeps You Successful

Perhaps the biggest danger of a good safety record isn't complacency itself, it's forgetting why the record is good.

Our procedures, reporting systems, training, safety specialists, operational expertise and willingness to learn all contribute, but, ultimately, it comes back to people.

People noticing. People reporting. People asking difficult questions. People being given enough time to understand the answers. And leaders listening when they do.

That is not safety competing with business success. That is safety protecting it.



WHEN SAFETY FALLS DOWN THE GAPS:

Why Safety Doesn't Belong to One Department

When we visit airlines, airports, training organisations and/or maintenance facilities, I often hear people talk about "the Safety Department."

"That's a safety issue."
"The Safety Department will look at it."
"Safety owns that risk."



From John, the Regulator

But it's important that we view things differently. Safety doesn't belong to one department.

In fact, some of the most important lessons have very little to do with technical failures, equipment malfunctions and/or non-compliance. Instead, they have everything to do with the spaces between people, teams, organisations and domains.

Safety doesn't usually fail inside a department; it falls down the gaps between them.

Everyone Did Their Job: So, What Went Wrong?

A few years ago, I was discussing an occurrence involving emergency equipment in an aircraft cabin. The equipment itself wasn't faulty. The aircraft met the approved configuration. Maintenance had completed its work, and the aircraft was technically serviceable.

Yet, when the cabin crew carried out their checks, they identified a problem. The equipment couldn't be reached easily in an emergency. Nobody had deliberately created an unsafe situation. Nobody had ignored a procedure. Nobody had knowingly accepted additional risk.

Instead, a series of small decisions had been made by different people, in different teams, for perfectly understandable reasons.

The problem wasn't within one department. The problem existed between departments, which made it so difficult to identify.

Aviation Doesn't Operate in Departments (Or In Organisations Alone)

Think about how most organisations are structured. There are specialists responsible for Flight Operations, Cabin Operations, Maintenance, Ground Handling, Engineering, Training, Commercial Operations, Safety and other areas as well.

That structure makes perfect sense. Aviation is a highly specialised industry, and expertise matters; but, risk doesn't follow organisational charts.

- A maintenance decision can affect cabin operations.
- An airport infrastructure change can affect ground handling.
- A training decision can influence how a crew responds during an emergency.
- A commercial decision can influence operational pressure.
- And, a seemingly small change in one area can create an entirely unexpected consequence somewhere else.

Safety issues don't stay neatly inside the boxes we create; safety issues move across the system, and our communication needs to move with them.

WHEN SAFETY FALLS DOWN THE GAPS

EVERYONE DID THEIR JOB.
SO WHAT WENT WRONG?

SAFETY DOESN'T USUALLY FAIL INSIDE DEPARTMENTS.
IT FAILS BETWEEN THEM.



> Safety belongs to all of us.
> And when safety falls down the gaps,
> the solution is rarely another procedure.
> It's usually a better conversation.

The Danger of Assumptions

One of the biggest risks I see is the assumption that someone else has already thought about something. We assume another department has already considered the operational consequences. We assume somebody else has already checked. We assume information has already been shared. We assume that, if a process is documented, it must also be working in practice.

Assumptions, however, are remarkably effective at hiding risk. The most dangerous gaps are often invisible because nobody realises they exist. That's why one of my favourite questions during safety discussions is surprisingly simple: "who else needs to know this?"

Not: "*Who owns this process?*", but who else interacts with it?

That small change in perspective often reveals people, departments and organisations that were never part of the original conversation.

Cross-pollination Creates Better Safety

One of the most effective ways to improve safety is to bring different perspectives together. Invite cabin crew into discussions that traditionally involve only flight operations. Include maintenance representatives in operational safety reviews. Bring airport and ground handling partners into safety conversations earlier. Share occurrence reports across departments. Review investigations with the people who actually perform the work.

Because something interesting happens when people step outside their normal area of expertise.

They ask different questions: questions that challenge assumptions; questions that identify practical difficulties; and questions that expose the difference between a procedure and the reality of performing that procedure during a busy operation.

Sometimes, the most valuable person in the room is the person who wasn't supposed to be there.

Safety Information Is Only Useful If It Moves

As regulators, we often focus on occurrence reporting and for good reason. The real value of reporting, however, isn't simply recording what happened, it's understanding how information moves through the system.

A good occurrence report doesn't just tell us that something went wrong, it helps us understand:

- Who knew about the problem?
- Who should have known about it?
- Where did communication break down?
- Which departments were involved?
- What barriers failed?
- What can we change before it happens again?

One report might describe an event. Several reports might reveal a trend, but only if the information reaches the right people.

Winter Reminds Us Why Working Together Matters

This edition of *Conversation Aviation* focuses on the theme "Working Together When It Matters Most".

Winter operations provide a perfect example. Airports, airlines, air traffic controllers, maintenance teams, de-icing providers, dispatchers, cabin crew, ground handlers and flight crews all contribute to safe operations.

No single organisation controls the entire process and that's true far beyond winter operations. The same principle applies every day.

Incidents and accidents don't always happen because people fail to do their jobs. Sometimes incidents and accidents happen because everybody was doing their own job correctly, but nobody connected the information between them.

A Regulator's Perspective

As a regulator, I don't want organisations to build bigger safety departments. I want them to build stronger connections.

I want to see safety managers talking to operational teams. I want to see airlines learning from airports. I want to see maintenance organisations understanding operational consequences. I want to see occurrence reports shared more widely. And I want people to feel comfortable asking questions outside their own area of expertise.

Safety isn't owned by a department. It isn't owned by a regulator, and it certainly isn't the responsibility of one person.

Safety belongs to all of us. When safety falls down the gaps, the solution is rarely another procedure; it's usually a better conversation.

Safety Starts Before the Passengers Board



From Gemma, Operations Control, Safewings

The phone always rings in Operations Control.

A passenger with a complex medical condition needs to travel.
A last-minute seat change has been approved.
Special assistance hasn't arrived.
The flight is already boarding.
The cabin crew have questions.
The dispatcher needs a decision.
The airport has changed the gate.
The turnaround is running late.

Suddenly, everyone is looking at Operations Control for an answer. But by the time the phone rings, many of the safety-critical decisions have already been made.

Safety Starts a Long Time before the flight itself

When we think about operational safety, we often think about pilots, cabin crew, engineers and ground handlers. But many of the decisions that influence safety happen much earlier and often in departments that don't traditionally see themselves as part of the operational safety system.

Sales teams decide what products and services are offered. Customer service teams manage passenger requests. Commercial teams make decisions about schedules and turnaround times. Human resources teams influence staffing. Airport teams manage gate allocations. Special assistance providers coordinate support for passengers who need additional help.

Individually, none of these decisions may appear *safety-critical*. Collectively, however, they can fundamentally change the operational picture. And when all those decisions finally converge, they usually converge in one place: **Operations Control.**

The Invisible Safety Chain

Consider a passenger with a complex medical condition. The ticket is sold, a request for assistance is submitted and information is transferred between different systems. Ground staff prepare for boarding, cabin crew receive information and the flight crew are briefed. Operations Control coordinates any changes.

Now add a few more variables.

Perhaps there isn't just one passenger requiring additional assistance, but a group of ten. Perhaps the right information isn't transferred and a special assistance request doesn't reach the gate. Perhaps a last-minute aircraft change alters the seating configuration. Perhaps nobody confirms that an important message has been received.



None of these situations is particularly unusual; they happen every day across the aviation system.

The challenge is that modern aviation operations are highly interconnected. A single passenger journey can involve airlines, airports, ground handlers, customer service teams, special assistance providers, dispatchers, cabin crew, flight crews and Operations Control.

The risk doesn't arise because one person makes a mistake. The risk arises when a series of perfectly reasonable decisions become disconnected from one another.

Building Resilience Before the Operation Becomes Busy

Winter often makes these situations more challenging. Disruption increases. Aircraft substitutions become more common. Delays become more frequent. Gate changes happen at short notice. Resources become stretched. The entire operational system becomes less predictable.

Under pressure, even relatively small communication failures can become much more significant.

I, however, don't think the answer is simply to ask people to work harder. Resilient organisations don't expect frontline teams to solve every problem themselves. Instead, resilient organisations build systems that support people when operational complexity increases.

Resilient organisations create clear processes for sharing information and they make sure that different departments understand how their decisions affect others. Resilient organisations design procedures that remain practical when operations become disrupted and they create enough flexibility within the system to absorb change without transferring all of the pressure to the people at the sharp end.

Resilience Isn't Built in Operations Control

There is something I've learned over the years: by the time Operations Control becomes involved, many of the important decisions have already been made.

Operations Control doesn't create resilience but reveals whether resilience already exists. The key questions are these. Has the right information been shared? Have the operational consequences been considered? Do different departments understand how their decisions affect the wider operation? Do the right people have the information they need to make good decisions? These are organisational questions, not operational ones. Answering them before

disruption occurs is one of the most important things an organisation can do.

Questions Every Organisation Should Be Asking

Before winter begins, ask yourself:

- Which departments make decisions that influence operational safety?
- Do those departments understand their role within the wider safety system?
- How is safety-related information transferred between departments?
- Where are the communication gaps?
- Which decisions create additional workload for operational teams?
- Does Operations Control receive the right information at the right time?

Working Together When It Matters Most

The safest organisations don't simply react to problems, they recognise that safety begins long before an aircraft pushes back from the gate.

From a passenger's perspective, there is no distinction between airline, airport, assistance provider, ground handler or operations centre. There is simply one journey - their journey.

The challenge for us all is ensuring that our organisations work in the same way.

Not as separate departments handing work from one team to another, but as a connected system designed to support people, share information and adapt when things change.

Passengers don't experience separate organisations, they experience one journey.

That journey is only as safe as the conversations, decisions and relationships that connect us all.



BREATHING UNDER PRESSURE:

When Training Matters More Than Equipment

A cabin fire. Smoke in a lavatory. A burning lithium battery. Toxic fumes from an unknown source. These are situations that every cabin crew member hopes they will never experience, yet they are also the situations that demand the highest level of performance.



From Sven, Cabin Operations Manager, Safewings

When faced with an emergency, it is natural to look towards the equipment designed to protect us. We trust that the firefighting equipment will work, that the procedures are correct and that our Protective Breathing Equipment (PBE) will provide the protection we need while we manage the situation. But equipment alone does not create safety. People do. And people can only perform effectively if they understand both the capabilities and the limitations of the equipment they are using.

EASA published a Safety Information Bulletin highlighting the use of PBE and drawing attention to an important issue: many crews may not fully understand the limitations of the equipment they are expected to use. The bulletin also encourages operators and training organisations to review their procedures and training programmes to ensure that they accurately reflect both the equipment installed on the aircraft and the environment in which it may be used.

What Happens When the Cabin Environment Changes?

PBE is designed to protect crew members from smoke, carbon dioxide and other harmful gases while they deal with an emergency. PBEs may be used during firefighting activities where smoke or gases are present, particularly in confined areas such as lavatories. They may also be used when crews are attempting to locate the source of smoke, during fume events or when dealing with the spillage or leakage of dangerous goods.

In principle, the concept is straightforward. The equipment provides a breathable atmosphere for a limited period of time, allowing crew members to continue working safely while they manage the event. However, once the oxygen supply is exhausted, the PBE should no longer be used. Continuing to wear it can expose the user to hypoxia, elevated carbon dioxide levels or other hazardous contaminants. This may sound like a simple operational consideration, but emergencies are rarely simple.

Smoke reduces visibility. Communication becomes more difficult. Adrenaline affects decision-making and can distort our perception of time. Tasks that appear straightforward during a classroom demonstration can become much more challenging when crews are working in a confined environment while wearing unfamiliar equipment.

This is one of the key messages behind the Safety Information Bulletin. The document is not simply a reminder that PBE exists. It is a reminder that understanding how equipment performs under real operational conditions is just as important as knowing where it is stored.

The Problem isn't the Equipment. It's the Assumptions we Make About it.

One of the most important points raised in the bulletin is that not all PBEs are the same.

Different aircraft fleets may use different models, with different packaging, activation methods and operating characteristics. A crew member who is completely familiar with one type of equipment may encounter another that behaves differently. This is why EASA requires that training programmes cover all PBE types used within an operators fleet rather than assuming that experience with one model automatically transfers to another. This is something that our National Authority checks during their audits.

The bulletin also addresses several common misconceptions.

A PBE should not be considered a first-aid oxygen supply. It is not a supplementary oxygen system and it should not be used as a substitute for an oxygen mask during a depressurisation event. These distinctions matter because assumptions made during an emergency can quickly become operational risks.

The bulletin also highlights several practical considerations that training programmes should address, including how to retrieve the equipment, remove it from its packaging, activate it correctly, recognise that it is functioning normally, communicate while wearing it and identify when the oxygen supply has been exhausted. It also highlights the importance of understanding when, where and how the equipment should be removed.

These may seem like relatively small details until you remember the circumstances in which the equipment is likely to be used.

Training for reality, not simply for compliance

Cabin crew members know where PBE are located and they are trained to use them when needed.

The biggest challenge of course is whether training prepares them for the environment in which they will actually use it during an emergency situation. Can they retrieve it quickly in a smoke-filled cabin? Can they remove it from vacuum-sealed packaging while dealing with a fire? Can they recognise whether it has activated correctly? Can they continue communicating effectively with other crew members while wearing it? Can they recognise when the oxygen supply is coming to an end?

These are precisely the areas that EASA recommends operators include within their training programmes. Training cannot simply demonstrate a piece of equipment. It needs to recreate the operational environment in which that equipment will actually be used. This means moving beyond a simple compliance exercise and creating realistic scenarios that allow crews to experience the practical challenges they may face during an emergency.

Organisational resilience starts long before an emergency

One of the themes running throughout this edition of Conversation Aviation is that organisations create the conditions that allow people to perform effectively. Protective Breathing Equipment is an excellent example.

By the time a cabin crew member opens a PBE during an emergency, the organisation has already made hundreds of decisions that will influence the outcome.

- Manufacturers have designed the equipment and determined how it should be operated.
- Operators have developed procedures and incorporated them into their Operations Manuals.
- Training departments have decided how the equipment will be introduced, demonstrated and practised.
- Instructors have shaped how crews understand the equipment and when they should use it. Again, this is something that is a important role for our National Authority.

Safety managers have reviewed previous events and identified opportunities to improve.

Successful use of a PBE during an emergency does not begin when the packaging is opened. **It begins months, and sometimes years, earlier.**

That is why the recommendations in the Safety Information Bulletin extend beyond cabin crews and include operators, training organisations, competent authorities and manufacturers. The focus is not simply on the equipment itself. It is on the entire system that supports its safe use.

Working together when it matters most

Winter operations inevitably bring additional pressures. Aircraft are fuller, disruptions become more common and operations can become less predictable. When an emergency occurs, there is very little time to stop and think about procedures or equipment.

Crews rely on the knowledge, skills and practical experience they have already developed. The lesson from the latest EASA guidance is not that we need more equipment. It is that we need a better understanding of the equipment we already have.

That means reviewing procedures, testing assumptions and ensuring that training reflects operational reality rather than simply satisfying a regulatory requirement.

Because when people are breathing under pressure, preparation remains one of the most important safety barriers we have.

BREATHING UNDER PRESSURE

When smoke fills the cabin, there isn't time to learn.



EQUIPMENT

The right Protective Breathing Equipment to protect us from smoke and toxic fumes.



PROCEDURES

Clear instructions on when and how to use the PBE – and when to remove it.



TRAINING

Realistic practice so we can use our equipment confidently when it matters most.



THE RIGHT EQUIPMENT. | CLEAR PROCEDURES. | REALISTIC TRAINING.

PREPARATION HAPPENS LONG BEFORE THE EMERGENCY BEGINS.



Getting De-icing Right Every Time

There is a phrase I hear every winter that always makes me smile: “We’ve been doing de-icing for years. We know what we’re doing.”

From Callum,
Ground Operations Manager,
Safewings

It’s true, most of us do know what we’re doing. The challenge is that winter operations rarely fail because people don’t understand the basic principles; winter operations fail because winter rarely gives us ideal operating conditions.

Aircraft arrive late. The weather changes faster than expected. A stand becomes unavailable. The taxi route changes. Visibility deteriorates. A departure slot appears unexpectedly. Ground equipment is repositioned. A delay pushes an aircraft beyond its expected holdover time.

Suddenly, a straightforward de-icing operation becomes something much more complicated. That’s why I don’t think of de-icing as a technical procedure. I think of it as a team activity.

A clean aircraft isn’t the result of a single action by a de-icing operator. It’s the result of good planning, effective communication and shared situational awareness across multiple teams. Meteorologists, dispatchers, operations controllers, flight crews, ground handlers, de-icing providers, air traffic controllers and airport operators all contribute to the same outcome: an aircraft that remains free from contamination until it is safely airborne.

That’s exactly why de-icing fits so well within this year’s “Working Together When It Matters Most” theme.

De-icing Doesn’t Start at the Aircraft

One of the biggest misconceptions in winter operations is that de-icing begins when the aircraft arrives at the de-icing pad. The de-icing process starts much earlier.

Long before the aircraft pushes back, people are already making decisions based on weather forecasts, precipitation type, expected taxi times, runway availability, stand allocation and aircraft scheduling.

Those early decisions influence everything that follows.

- Will a one-step or two-step process be needed?
- Which fluid is most appropriate?
- Will the expected taxi time remain within the protection offered by the selected fluid?
- Will the aircraft be de-iced on stand or at a remote facility?
- Will weather conditions remain stable?

Every answer depends on information being shared across different teams.

The Right Fluid for the Right Conditions

Every de-icing fluid has a specific purpose.

- Type I fluid is designed primarily to remove existing contamination from the aircraft.
- Type II and Type IV fluids provide additional anti-icing protection by creating a protective layer that delays the accumulation of further contamination.

Selecting the correct fluid isn't simply a technical choice, it requires an understanding of the current and forecast conditions.

A short taxi route in light snowfall presents a very different operational picture from a long taxi during freezing precipitation. Using a fluid because it's immediately available rather than because it's appropriate to the current and forecast conditions can create unnecessary risk.

The question shouldn't be "What fluid do we normally use?" The question should be "What conditions are we operating in today?"*

Holdover Time Is Guidance, Not a Guarantee

Holdover time is one of the most valuable tools available during winter operations, but it is often misunderstood.

Holdover time provides an estimate of how long a de-icing or anti-icing treatment may remain effective under specific environmental conditions. Holdover time isn't a promise, it isn't a target and it certainly isn't a guarantee that an aircraft will remain contamination-free until departure.

Weather conditions can change unexpectedly. Snowfall intensity can increase. Taxi routes can become congested. Departure delays can extend beyond what was originally planned.

That's why holdover time should support decision-making rather than replace it. The clock matters, but what matters even more is what is actually going on in the operation and the real aircraft state.

Communication Prevents Winter Surprises

The most effective winter operations I've experienced weren't necessarily the fastest. They were the operations where everyone shared the same picture. The flight crew understood the expected taxi time. The de-icing team understood the departure sequence. Operations control understood the weather forecast. Ground handlers understood any changes to the stand or pushback plan.

Nobody was working in isolation.

The moment information stops moving between teams, assumptions begin to replace facts and assumptions have very little place in winter operations.

There Should Never Be Pressure to Continue

Winter operations create commercial pressure. Passengers are waiting, aircraft are delayed, connections are at risk and everyone wants to get moving again.

One principle, however, should always remain unchanged: if there is any doubt about the effectiveness of the de-icing treatment, stop and reassess. Requesting another treatment isn't a failure, nor is delaying a departure or rechecking the aircraft. Those decisions demonstrate good operational judgement.

The Real Lesson from Winter Operations

Every winter, we analyse reports involving aircraft contamination, holdover time exceedances and operational disruptions. The same lesson appears repeatedly.

Technology helps, procedures help and training helps, but the strongest defence against winter hazards is still people working together.

Getting aircraft de-icing properly isn't simply about selecting and applying the right fluid, it's about sharing information, challenging assumptions and making sure everyone involved is working from the same operational picture and that's what keeps aircraft safe when winter is at its most demanding.

THE CONVERSATIONS THAT KEEP US SAFE:

Making Better Use of Briefings and Debriefings

Safe operations depend on good conversations.



From Gunnar, our HF Expert

That may sound obvious, but in aviation it is easy for briefing and debriefing to become routine. A briefing becomes something we complete because the checklist says we should. A debrief becomes a quick exchange at the end of a duty, or disappears completely when everyone is tired and wants to go home.

The danger is that we start treating these conversations as administrative tasks rather than critical safety tools.

A good briefing helps a team build a shared picture of the operation before the work begins.

A good debrief helps the organisation understand what actually happened afterwards, including what went well, what changed, where people had to adapt and what might be worth doing differently next time.

Used properly, the two belong together: one helps us prepare, the other helps us learn.

Creating a Shared Operational Picture

The purpose of a briefing is not simply to pass information from one person to another, it is to make sure that those involved have a shared understanding of the situation. That matters because aviation operations are dynamic.

Weather changes. Passengers require additional assistance. Equipment becomes unavailable. A stand changes. A defect appears. A delay creates new pressure. A route or runway changes. Staffing changes. A turnaround that looked straightforward at the start can become quite different twenty minutes later.

A useful briefing, therefore, does more than describe the plan, it highlights the things that could affect the plan.

- For flight crew, that might mean discussing weather, threats on the route, aircraft status and/or operational constraints.
- For cabin crew, it might include passenger needs, turbulence, equipment issues and/or anything unusual about the flight.
- For ground teams, it might include stand conditions, loading challenges, de-icing requirements, time pressure and/or equipment availability.

The context changes, but the principle is the same: *"what do we need everyone to understand before we start?".*

Make Briefings Specific Enough to be Useful

One of the weaknesses of routine briefings is that they can become generic: "be careful", "watch the weather" or "let's have a safe flight".

There is nothing wrong with those messages, but they do very little to prepare a team for the actual operation in front of them. A stronger briefing is specific.

Instead of saying:

> *"Weather could be difficult."*

Say:

> *"We are expecting moderate turbulence in the early stage of the approach, so let's secure the cabin earlier than usual and keep each other updated if conditions deteriorate."*

Instead of:

> *"The turnaround is tight."*

Say:

> *"We have a late inbound and a short turnaround. If we start losing time, we will protect the safety-critical tasks first and coordinate before changing anything else."*

Specific briefings help people understand not only what is expected, but also what should happen when the original plan starts to change.

Briefing is a Conversation, not a Broadcast

The best briefings are rarely one-way. If the person leading the briefing does all the talking, there is a risk that important information remains hidden.

The engineer may know about a technical limitation. The cabin crew may know about a passenger issue. The ground handler may know that equipment is unavailable. A colleague who worked the previous sector may have already encountered the problem you are about to face.

Good briefings give people permission to add information, question assumptions and/or raise concerns.

That doesn't mean every briefing needs to become a long discussion. In most operations, time is limited. It does mean creating enough space for people to say: *"there is one thing you should know".*

Sometimes that sentence is the most valuable part of the briefing.

Debriefing Closes the Loop

If briefing helps us prepare for what we expect, debriefing helps us understand what actually happened. Those two pictures are rarely identical.

Perhaps the weather developed differently from forecast. Perhaps a procedure worked particularly well. Perhaps a task took much longer than expected. Perhaps two departments interpreted the same information differently. Perhaps a team found a simple workaround that made the operation safer or more efficient.

Without a debrief, those lessons often stay with the people who experienced them. That is a lost opportunity.

A useful debrief does not need to be formal or lengthy. In many cases, five minutes is enough.

The important questions are usually simple:

- What went well?
- What was different from what we expected?
- Where did we have to adapt?
- Was there anything that made the job harder than it needed to be?
- Is there something the next team should know?
- Does anything need to be reported or followed up?

The aim is not to search for mistakes. It is to capture useful operational knowledge while it is still fresh.

From Team Learning to Organisational Learning

This is where debriefing becomes more than a crew or shift activity. If the same issue appears repeatedly, the organisation needs to know about it. A debrief may reveal that a procedure is unclear. Several debriefs may reveal that the procedure is consistently difficult to use.

One team may notice a recurring issue with a stand, an airport, a piece of equipment or a process. If that information remains within the team, the organisation cannot act on it.

That is why briefing, debriefing and occurrence reporting should support each other.

Not everything discussed during a debrief needs a formal safety report; but, when something has potentially wider safety relevance, the pathway from operational conversation to reporting and organisational learning needs to be clear.

The organisation then has a responsibility to complete the loop by analysing the information, sharing lessons and, where necessary, changing the system.

Otherwise, people quickly learn that there is little value in speaking up.

Good Practice for Better Briefings and Debriefings

There is no single format that will work for every operation, but a few principles consistently help. Keep the briefing relevant. Focus on the risks, changes and operational factors that matter today rather than repeating information everyone already knows.

Make it two-way. Give everyone an opportunity to contribute, particularly those who may hold different parts of the operational picture.

Be specific. Talk about the actual risks and decisions that may arise, not simply generic reminders to "be safe".

Agree what happens if the plan changes. Teams perform better when they already understand the triggers for stopping, reassessing or asking for support.

Debrief close to the event. Useful detail disappears quickly. A short conversation **immediately afterwards can capture more than a formal review days later.**

Look for what worked as well as what went wrong. Organisational learning is not only about failures. Successful adaptations can be just as valuable.

Know when to escalate. If the discussion identifies something with wider safety relevance, make sure it reaches the reporting or safety-management process.

Feed learning back. People are far more likely to keep contributing when they can see that their information has led to action.

The Conversation is Part of the Operation

Briefings and debriefings are sometimes described as "soft" safety tools. I don't think they are. They are practical ways of building shared situational awareness, identifying threats before they become problems and turning operational experience into learning and they become even more valuable when operations are disrupted, complex or under pressure.

The strongest organisations do not simply tell people what to do, they create regular opportunities for people to understand the operation together, talk about what actually happened and share what they have learned.

The conversations before the operation help us manage the risks we can see, and the conversations afterwards help us understand the risks we didn't.

SEEING AND BEING SEEN:

How Airlines, General Aviation and Local Communities Can Work Together to Reduce the Risk of Mid-air Collisions



From John, the Regulator

When most people think about mid-air collision risk, they picture two aircraft unexpectedly occupying the same piece of sky. In reality, the challenge is much more complex.

Different types of aircraft operate at different speeds, altitudes and for different purposes, often sharing the same airspace while having very different pictures of what is happening around them.

For General Aviation (GA), mid-air collision remains one of the key safety risks. Across the EASA Member States, there are on average six fatal mid-air collisions involving GA aircraft each year, resulting in around 13 fatalities. EASA's "*¡Conspicuity*" initiative is intended to help address that risk through a straightforward principle: *Be Seen and Be Aware*.

Naturally, much of that initiative's work is directed towards the GA community, but I think there is an important question for the commercial air transport world too.

What Is the Role of an Airline in Helping to Prevent Mid-Air Collisions?

Imagine a Safewings crew conducting a scheduled passenger service into a smaller regional airport. At the same time, the surrounding airspace could contain training aircraft, private pilots, helicopters conducting utility or emergency medical operations, gliders, parachuting activity and/or drones surveying a farm or industrial site.

Everyone may be operating legitimately and appropriately, but they may not all have the same information or the same awareness of each other.

Preventing mid-air collisions cannot, therefore, rely on a single barrier. Separation, air traffic services, airborne collision avoidance systems, electronic conspicuity and visual acquisition all have roles to play. Just as importantly, we need to create a better shared understanding of the local operating environment.

Find the Places Where the Risk is Greatest

Not every airport presents the same risk of collision, so it makes little sense for an airline to apply the same approach everywhere.

For example, at a major hub, commercial traffic generally operates in a highly structured and closely monitored



environment. Conversely, at a smaller regional airport, the picture may be quite different. The smaller airport might handle only 10 or 20 commercial movements during particular periods of the day while being surrounded by active flying clubs, training areas, helicopter routes or other aerial activity.

Airlines can use their own safety data and operational knowledge to identify the locations where those interactions are most likely. Indicators might include significant flight-training activity, busy GA communities, nearby gliding or parachuting sites, helicopter operations, drone activity, mixed or less-controlled airspace and particular seasonal patterns.

The objective is to identify where focused collaboration with specific ANSPs and local flying communities could help to increase the strength of the existing safety barriers.

Be Seen and Be Aware

This is where EASA's existing work with the GA community is particularly relevant.

The *¡Conspicuity* concept is based around two complementary ideas. The first is *Be Seen*: encouraging GA airspace users to become electronically conspicuous through compatible technology such as ADS-L. The second is *Be Aware*: combining information from available tools with effective visual scanning and good situational awareness.

ADS-L is a GNSS-based electronic conspicuity solution intended to make a wide range of airspace users electronically visible. EASA is working with industry and user associations through the ADS-L Coalition to support the development and adoption of ADS-L, with the broader objective of improving situational awareness both in the air and on the ground.

That matters to airlines, because better visibility of smaller airspace users can contribute to a better overall traffic picture. Where the relevant infrastructure and services support it, increased electronic conspicuity may also help air traffic services units to develop a fuller picture of the prevailing traffic situation, in turn, allowing more information to be available to those who might need it.

Technology alone, however, should not give us false confidence. Not every aircraft will necessarily be visible electronically, and EASA's guidance specifically emphasises that electronic tools complement rather than replace effective visual scanning.

A screen full of traffic information can itself draw attention inside the cockpit, so pilots still need to balance technological assistance with looking outside and maintaining a complete picture of the surrounding airspace.

The aim isn't to replace the concept of *see and avoid*; the aim is to make *see and avoid* more effective.

Local Knowledge Can Be One of Our Strongest Safety Tools

Technology is only part of the solution. Some of the most effective collision-prevention initiatives can begin with something much simpler: a conversation.

Imagine an airport with only a handful of scheduled passenger services each day. Perhaps, most arrive and depart between 07:00 and 09:00 and again between 17:00 and 19:00.

That information is useful for the local aviation community.

If flying clubs, training organisations, helicopter operators and other local airspace users understand when commercial traffic is most likely to arrive and depart, they can factor that knowledge into their own planning. That doesn't mean closing the airspace or telling people when they can and cannot fly. It simply means giving everyone a better understanding of when potential interactions are most likely.

The information should also flow both ways.

Airlines and their crews can benefit enormously from local knowledge. Where are the normal training areas? Are there common helicopter routes? Where are gliders normally encountered? Are there seasonal activities that change the traffic picture? Are there locations where pilots regularly report seeing conflicting traffic?

Airlines Have a Bigger Role Than We Sometimes Realise

It's easy to think of this as primarily an issue for GA organisations, airports or air navigation service providers. Airlines can make a meaningful contribution too.

An airline safety team could identify the airports in its network where mixed traffic presents the greatest potential risk and then work with those airports to understand the local environment. That could lead to engagement with flying clubs, helicopter operators, training organisations and other local groups; targeted promotion of electronic conspicuity; sharing of commercial traffic patterns; participation in relevant local safety forums; and better exchange of occurrence and safety information.

It doesn't have to become a huge safety campaign at every airport. In fact, the opposite approach may be more effective.

Target the places where the risk is greatest and work with the people who actually operate there.

A local flying club may be much better placed than an airline safety department to explain the message to its members. An airport may already have relationships with drone operators or helicopter organisations. ATC may know where recurring traffic conflicts are appearing. Airlines can bring their own operational data and the perspective of their crews.

Put those pieces together and not only does the local picture becomes considerably stronger, but relationships within the aviation community also strengthen.

One Shared Airspace - Sharespace

The growth in the use of drones makes this collaboration increasingly important. Think of it as sharespace rather than just airspace.

EASA's *¡Conspicuity* work recognises that GA pilots are sharing airspace with an increasing range of air vehicles, including drones, conducting activities - such as search and rescue, medical deliveries, aerial work and cargo operations. Electronic conspicuity has an important role to play in enabling those different airspace users to operate safely alongside each other.

That brings us back to the wider theme of this edition of *Conversation Aviation*: Working Together When It Matters Most.

An airline alone cannot solve the risk of mid-air collision. Neither can a flying club, an airport, ATC, a helicopter operator or a drone operator.

What we can do is identify the places where our operations interact, make ourselves easier to see, improve our awareness of one another and create the local relationships that allow information to flow.

Whether you are flying an Airbus full of passengers, a training aircraft, a helicopter, a glider or a drone, we are all ultimately using the same thing: one shared airspace - keeping it safe requires all of us.

WHEN A DEFECT CHANGES THE OPERATION:

Looking Beyond Airworthiness to Understand the Wider Safety Impact of Deferred Defects



From Helena, Engineering, Safewings

In Engineering, we spend a lot of time answering an important question: can this aircraft be safely dispatched?

The Minimum Equipment List (MEL) helps us answer that question when something isn't working as intended. The MEL establishes which items may temporarily be inoperative and the associated operating conditions, limitations or procedures.

There is another question, however, that matters just as much: *what does this defect change for the operation?*

That distinction is important.

The MEL is an established safety tool, developed from the Master MEL (MMEL) and adapted by operators to their particular aircraft and operation. An aircraft dispatched correctly in accordance with the MEL isn't an unsafe aircraft.

An inoperative item, however, can change the capabilities available to the crew, restrict where or when the aircraft can operate, increase workload or remove one of the layers of resilience normally available when something else goes wrong.

This is where Engineering, CAMO and Operations need to look beyond the defect itself and consider the operation around it.

A Good Example: Weather Radar

Imagine an aircraft with an inoperative weather radar.

Depending on the aircraft and the applicable MEL, dispatch may be permitted subject to specific conditions. EASA's MMEL guidance, for example, includes relief where operations are conducted in daylight VMC or where thunderstorms and other potentially hazardous weather detectable by the system are not forecast along the intended route, including relevant diversions.

The engineering question may, therefore, be relatively straightforward; the operational questions aren't.

Where are we flying? What weather is forecast? What are the alternates?

Could conditions deteriorate? What capability has the crew lost if the actual weather differs from the forecast?

The answers to these require information from outside Engineering: and, that's the point.

The MEL tells us the conditions under which dispatch *may* be permitted. Managing the operation safely within those conditions requires Engineering, CAMO, Operations and the crew to understand the same picture.

To Dispatch, or Not to Dispatch, That Is the Question - Which Deferred Items Should Make Us Think Harder?

There isn't a universal list of the "most challenging MEL items" because their significance depends on aircraft type, MEL, route and operating environment. I would, therefore, avoid presenting a league table.

There are, however, some useful categories where the connection between technical condition and operational risk is particularly obvious.

Weather and environmental systems are perhaps the clearest example. Weather radar, predictive windshear functions and equipment associated with icing operations can affect the conditions in which an aircraft can be operated and the information available to crews. The EASA MMEL material explicitly links weather-detection relief to the weather conditions expected along the route.

External and cockpit lighting provides another good example. An inoperative landing light may be permitted under particular conditions, but daylight and night operations present very different risk pictures. Wing illumination lights can also have specific implications for operations at night and/ or in icing conditions.

Navigation, communication and surveillance equipment can affect the airspace, routes, approaches or operational procedures available to a crew. A defect that has relatively little consequence in one operating environment could be much more significant in another.

Then, there are cabin and passenger-related items. These are interesting because their impact can be less obvious. EASA's MMEL guidance recognises that some items associated with passenger convenience, comfort or entertainment - such as galley equipment - may be considered non-safety-related. That doesn't mean, however, that their operational consequences should always be ignored.

One inoperative oven might simply change the service. Several pieces of galley equipment unavailable on a full sector could change how cabin crew organise their work. An unavailable toilet might have little significance on a short flight with a light passenger load but could create a much bigger operational challenge on a long, full sector, particularly if another toilet subsequently becomes unavailable.

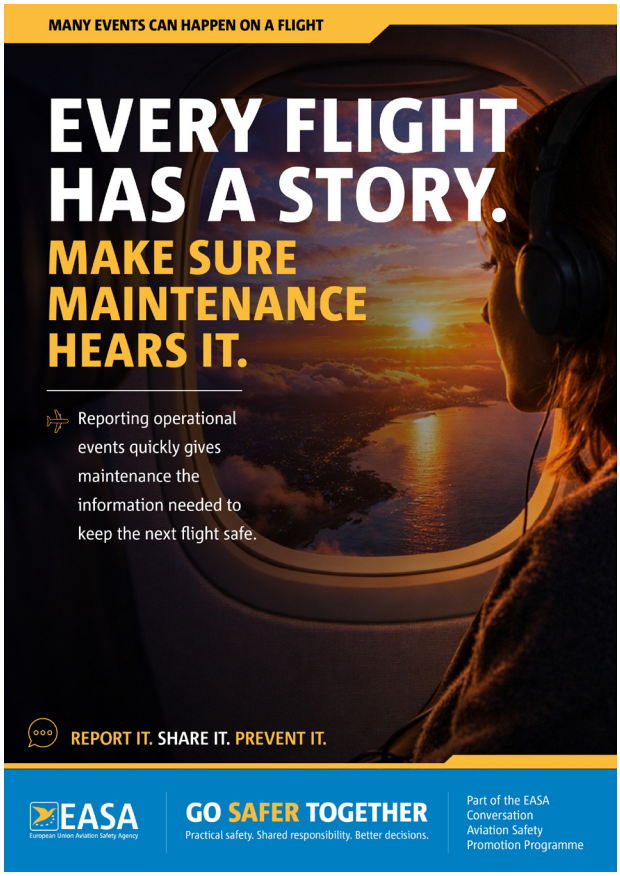
The important question is not simply "how safety-critical is this component?" The important question is also "what does this loss mean to the operation we are planning today?"

One Defect Can Also Change the Significance of Another

This becomes particularly important when several items are deferred at the same time.

Each individual defect may satisfy its respective MEL requirements, but the combined operational effect needs consideration. EASA's MEL framework specifically requires operators to establish procedures for managing multiple unserviceabilities.

Imagine, for example, an aircraft operating in poor winter weather with a technical limitation, an unrelated cabin defect and a delayed departure. None necessarily presents an unacceptable risk by itself, but together they may increase workload, reduce flexibility and leave fewer options if conditions deteriorate.



WHEN A DEFECT CHANGES THE OPERATION

LOOKING BEYOND AIRWORTHINESS TO UNDERSTAND OPERATIONAL SAFETY



EXAMPLE DEFECT: WEATHER RADAR INOPERATIVE

Dispatch permitted under MEL conditions (e.g. Day VMC or no relevant hazardous weather forecast)

MAINTENANCE
(ENGINEERING / PART-145)

The technical view

- Nature of the defect
- Applicable MEL relief and conditions
- Maintenance status and rectification interval
- Other open defects that may interact

CAMO

The continuing airworthiness view

- Overall airworthiness status and trend
- Interaction between open defects
- Regulatory compliance and oversight
- Liaison with Operations and Part-145

OPERATIONS

The operational view

- Route, airspace and alternates
- Weather and airport forecasts
- Crew and cabin considerations
- Operational limitations or pressures

ITEMS THAT OFTEN NEED EXTRA OPERATIONAL ATTENTION

- **Weather & environmental systems** e.g. weather radar, windshear, icing equipment
- **External & cockpit lighting** e.g. landing lights, wing illumination
- **Navigation, communication & surveillance** e.g. radios, transponders, ADS-B
- **Cabin & passenger-related items** e.g. galley equipment, ovens, toilets
- **Multiple deferred items** – consider the combined operational effect

MEL RELIEF IS TEMPORARY, NOT THE NEW NORMAL

- Every day an item remains open is a day with reduced capability.
- Prompt rectification restores barriers and makes us more resilient.
- Don't let "permitted to dispatch" become "normal configuration".
- Close MEL items sooner when practicable.

ONE AIRCRAFT. ONE OPERATION. ONE SHARED PICTURE.
TALK. UNDERSTAND. MANAGE THE RISK TOGETHER.

SAFEWINGS
PEOPLE CREATE SAFETY

Share information | Ask the questions | Understand the bigger picture | Make better, safer decisions

This is where simply asking whether each individual item is "within the MEL" isn't enough. Someone needs to see and consider the combined picture.

The MEL Should Be Temporary, Not the New Normal

There is another important human and organisational dimension.

When an aircraft operates successfully for several days with an MEL item open, people naturally adapt. Crews become familiar with the associated procedure, planners incorporate the limitation and the degraded configuration can gradually start to feel normal.

That's why the Airbus Safety First article "*Closing MEL Items: Why Sooner is Better*" is such a useful complement to the regulatory material. The article reminds us of the importance of rectifying deferred items rather than treating the MEL simply as a convenient way of continuing operations.

The EASA framework reinforces that principle by defined rectification intervals: MEL relief permits items to remain temporarily inoperative, subject to the applicable conditions, but rectification remains the objective.

From a safety management perspective, there is another reason to close items promptly. Every restored capability gives the operation another barrier back.

Our Management Systems Need to Talk to Each Other

This brings us to the wider issue. Engineering, CAMO, Part 145, Flight Operations, Cabin Operations and Operations Control may have different responsibilities, but they are *not* managing separate aircraft.

A maintenance organisation may understand the technical consequences of a defect better than anyone else. Operations understands the environment in which the aircraft is about to be used. Crews understand the practical effect on workload and procedures. CAMO sees the developing continuing-airworthiness picture, while Safety may identify patterns across multiple events or aircraft.

The strongest decisions come when those perspectives meet.

That means maintaining effective communication between the operator, CAMO and Part-145 organisation, particularly where maintenance is contracted. It also means recognising that the output of one organisation's management system can become an input to another's risk assessment.

This shouldn't require a meeting every time an oven stops working.

It does, however, require clear triggers for recognising when a technical issue has wider operational consequences and making sure that information reaches the people who need it.

Move the Conversation Beyond "Can We dispatch?"

The MEL remains one of the important tools that allows airlines to operate safely and practically when equipment becomes temporarily unavailable. The challenge is to use it as intended.

For me, that means moving the conversation beyond simply "can we dispatch?" and asking a few additional questions: What capability have we lost? What does that change for today's operation? Could this defect interact with another limitation or operational pressure? Does everyone who needs to understand the consequences have the same information? And is there an opportunity to rectify the item sooner rather than simply waiting for the permitted interval to expire?

That is where maintenance and operational safety come together.

The aircraft may be technically acceptable for dispatch, but the people operating it still need to understand what has changed.

The MEL gives us the framework, but good communication helps us manage the operation around it.

SAFE PEOPLE MAKE SAFE DECISIONS:

Looking After People Isn't Separate from Safety — It's Part of How We Create It



From Milena, CEO, Safewings

Every day at Safewings, we ask people to make decisions on our behalf.

Most of those decisions are routine. Others are made under time pressure, during disruption, in difficult conditions or when something unexpected has happened. Occasionally, the decision somebody makes in a few seconds can have significant consequences for our passengers, their colleagues and our organisation.

If we expect our people to make good decisions for us, we have a responsibility to put our people in the best possible position to do so.

That is why wellbeing matters to me as a CEO. Not as something separate from safety or business performance, but as part of both.

People Don't Leave Their Lives at the Door

In aviation, we talk a lot about being *fit for duty*. Fatigue is an obvious part of that conversation, and rightly so, but being ready to perform safely is much broader than whether somebody has had enough sleep.

People come to work carrying their lives with them.

Someone may have been awake half the night with a sick child. They may be worried about an elderly parent, struggling with a relationship or dealing with financial pressure. They may be recovering from a difficult event at work or simply reaching the end of a demanding period where work and life have both asked too much of them.

Most of the time, our people cope remarkably well, but they are still the same people we ask to communicate clearly, notice when something isn't right, challenge when necessary and make good decisions under pressure.

EASA's guidance on flight-crew support programmes recognises this explicitly, referring to both job stressors and life stressors, as well as mental fitness and mental health. The emphasis is on prevention, early support and creating an environment where people can seek help before a problem becomes more serious.

There is a wider lesson in that for all of us.



We shouldn't have to decide whether someone's problem is sufficiently "aviation related" before we care about it. If something affects the person, it can affect how they experience and perform during their working day.

Our Job is Not to Make People More Resilient to a Bad System

When we discuss wellbeing, the solution can too easily become another list of things we expect individuals to do: sleep better, manage stress, eat well, exercise, recognise their limitations, speak up and ask for help.

Those things can all be useful, but they are only one part of the picture.

We cannot remove every pressure from people's lives, and no employer should try to. What we can influence is the environment people encounter when they come to work.

We influence how work is organised. Whether workloads are realistic. Whether people have time to recover. How managers behave when the operation becomes difficult. Whether colleagues treat each other with respect. Whether somebody can say *"I'm struggling today"* without immediately worrying about what that admission might mean for their career.

Good procedures, equipment, training and staffing all help people perform well. So do supportive colleagues, good leadership and an organisation that listens.

The objective isn't an organisation where nobody ever has a bad day. That's impossible.

The objective is an organisation where having a bad day doesn't have to become a safety problem.

Sometimes the First Conversation Is the Most Important

Formal support matters.

For flight crew, European rules require operators to enable, facilitate and ensure access to a proactive and non-punitive

support programme. EASA's associated guidance places considerable emphasis on confidentiality, mutual trust and appropriately trained peers, supported where necessary by mental-health professionals. The guidance also notes that operators can extend such programmes to other safety-sensitive personnel, including cabin crew and maintenance staff.

Peer support can be particularly valuable because sometimes the easiest person to talk to is someone who understands the job.

That doesn't make a peer an amateur psychologist. Their role is not to diagnose or solve somebody's problems, but they can listen, understand the operational context and help someone find the appropriate support.

We shouldn't wait for a formal support programme before we start looking out for each other.

Sometimes it begins with a colleague noticing that somebody who normally contributes has gone quiet. A supervisor realising that a normally patient team member seems unusually frustrated. Or somebody simply asking: *"how are you doing?"* And being prepared to listen to the answer.

Trust is a Safety Resource

Of course, none of this works unless people trust the organisation around them.

We can publish policies saying that people should speak up. We can provide support programmes and tell everybody that help is available. People's willingness to use those systems, however, will ultimately depend on what they see happening around them.

What happens when somebody says they aren't fit for a particular task today?

How does a manager respond when somebody asks for help?

When a team says its workload is becoming difficult to manage, do we listen and understand what is happening, or simply remind them of the target?

When someone makes an honest mistake, do we look at the circumstances that shaped their actions, or immediately start looking for someone to blame?

These everyday experiences tell people much more about an organisation's real culture than any policy or poster.

Respect is part of this too. People who believe their expertise is valued are more likely to contribute it. People who believe their concerns will be taken seriously are more likely to raise them. People who feel part of a team are more likely to look out for one another.

That makes trust, respect and psychological wellbeing more than "people issues", they are part of our safety capacity.

The People Who Deliver Safety Also Create Our Success

There can sometimes be a temptation to put wellbeing, safety and business performance into different boxes. However, it could be argued that these 3 elements are critical success factors in any business or operation.

The same people who create safety also create our operational performance. They recover disrupted operations, solve technical problems, look after passengers, maintain aircraft and make thousands of small decisions every day that keep Safewings moving.

When experienced people leave, we don't simply lose an employee. We lose knowledge, judgement, relationships and experience. When people disengage, we lose ideas and information and when people don't feel able to speak openly, we lose an important part of our safety intelligence.

There is a direct connection here with the Truth Paradox we discussed earlier in this edition. Safety capacity isn't just procedures, systems and budgets. Much of that capacity resides in the knowledge, experience and judgement of our people and in their willingness to contribute those things to the organisation. Looking after that capacity matters to the future of our industry too.

Aviation is competing for skilled people. The next generation has choices about where they work and what kind of employer it wants to work for. If we want talented people to join aviation and experienced people to remain, we need workplaces where people feel respected, supported and able to contribute.

That isn't a trade-off between looking after people and running a successful airline.

It's part of running a successful airline.

Looking After the People Who Look After the Operation

At Safewings, we need professional support programmes, trained peers and appropriate pathways for people who need additional help. We need to manage fatigue properly and make sure our people are fit to perform their safety-critical tasks.

But none of those systems can replace the culture around them. Ultimately, this comes down to how we treat each other every day.

Do our managers listen? Do our colleagues notice? Can somebody say they're struggling without fearing what happens next? Do we make space for people to recover? And, above all, do people feel that the organisation genuinely values them rather than simply the job they perform?

If we want people to care about Safewings, Safewings has to care about them.

Every inspection completed carefully. Every concern raised. Every go-around called. Every aircraft stopped when something doesn't look right. Every colleague challenged or supported at the right moment.

All depend on people having the capacity and confidence to make good decisions.

Safe People Make Safe Decisions.

If we want our people to look after the operation, we have to look after our people.



FROM REGULATION TO REALITY:

The new Ground Handling rules are here — now we have to make them work

For a long time, we have talked about the future Ground Handling Regulation. Now it isn't the future anymore.



From Val, Ground Handling, Safewings

The new European Ground Handling Regulations entered into force on 27 March 2025. Existing ground handling organisations may start submitting their declarations to competent authorities from 27 March 2027 but no later than 27 March 2028. This isn't a lot of time really.

There are management systems to develop, responsibilities to clarify, manuals and procedures to review, people to train, reporting systems to strengthen and, perhaps most importantly, relationships between ground handlers, airlines, airports and authorities that need to work differently.

So the conversation has changed.It is no longer *"What will the new Ground Handling Regulation say?"*

It is "What do we need to do to make it work?"

Why ground handling needed its own framework

The starting point is worth remembering. Ground handling sits at one of the busiest interfaces in aviation. Passenger and baggage handling, loading, refuelling, de-icing, aircraft servicing, pushback and towing are just some of the activities covered by the new framework and many of them happen at the same time.

Look around during a busy turnaround and you'll see teams from different organisations, vehicles and equipment moving close to the aircraft, passengers boarding, bags and cargo being loaded, fuel going on and operational decisions being made — often against the clock.

That complexity is important because ground handling risks don't sit neatly inside one organisation.

Safe operations depend on the ground handling organisation, aircraft operator and aerodrome operator understanding what each other is doing and managing the interfaces between them.

The new rules recognise that. They create a common European safety baseline for ground handling across the 30 EASA Member States and place particular emphasis on safety management, competence and training, equipment, reporting and the interfaces between organisations.

So what actually changes?

For ground handling organisations, the regulation brings requirements that will be familiar to many other parts of aviation.

Organisations will need a management system proportionate to their size and complexity, covering areas including safety management, change management, training, compliance monitoring and documentation. They will need safety reporting and Just Culture processes, arrangements to ensure personnel remain trained and competent, maintenance programmes for ground support equipment and appropriate technical documentation and manuals.

But one part is particularly important for this edition of *Conversation Aviation* - Interfaces.

Ground handling organisations must have processes to manage interface risks with aircraft and aerodrome operators, including coordination and the sharing of safety information.

That shouldn't just become another paragraph in a manual. We need to use implementation as an opportunity to look at how the operation really works.

Where do responsibilities change hands? Where do we rely on information from another organisation? Where do different procedures meet? Where are assumptions being made? And when something changes in one organisation, how do the others find out? Those are the places where implementation becomes safety.

Don't just add another layer

There is another opportunity here. Ground handlers already operate within a complicated web of requirements from airlines, airports, customers and industry standards. One of the challenges has been the number of audits conducted on ground handling organisations, sometimes covering similar ground again and again.

The new framework introduces cooperative oversight, particularly for ground handling organisations operating across more than one Member State. Competent authorities will be able to cooperate, share information and oversight responsibilities and work towards common methodologies and oversight tools, reducing unnecessary duplication.

To further reduce the number of audits, GH organisations may share the audit reports from the competent authority oversight with their airline customers, so that airlines can rather focus on aspects that are more relevant for the interfaces, like operational procedures. The amended Air Ops rules enable aircraft operators to adopt a performance-based and risk-based approach in their audits to their providers of ground handling services in the EASA States.

That matters. Implementation shouldn't mean simply putting a regulatory layer on top of everything we already do.

EASA's stated approach is to support implementation without excessive paperwork, using a performance-based approach that also recognises increasing automation and new technologies on the ramp.

For me, that is an important test of whether we get implementation right.

We need systems that help people manage safety, not systems that simply demonstrate that we have systems.

Implementation is a team sport

None of us can implement this alone.

- A ground handling organisation can develop a good management system, but it still has to interface with the airline's management system and the aerodrome's.
- An airline can have excellent procedures, but those procedures must make sense to the people applying them across different aircraft, customers and locations.
- An airport can manage its own risks, but many of those risks are influenced by organisations operating on its apron.
- Authorities need to develop the competencies, tools, information and relationships required to oversee a sector that has not previously been regulated in this way at European level.

This is why implementation needs dialogue rather than a handover of documents.

EASA is coordinating implementation work involving ground handling organisations, aerodromes and aircraft operators specifically to help everyone understand these new interfaces and establish a clear delineation of responsibilities.

That conversation needs to happen locally too. Ground handlers, airlines and airports should already be talking to each other about what 2028 will mean at their stations.

Use what we already know

We shouldn't start implementation with a blank sheet of paper.

We already know many of the things that make ramp operations difficult: time pressure, workload, distraction, equipment operating close to aircraft, inconsistent procedures and communication across organisational boundaries. Weather can make all of those challenges harder.

We also have occurrence reports, near misses, audit findings and the experience of the people doing the job.

The new framework gives reporting an important role within ground handling management systems. That's an opportunity to make better use of what our people tell us — particularly the small events and unsafe conditions that can reveal weaknesses before something more serious happens.

Good implementation should therefore start with questions such as:



- Where are our biggest risks today?
- Where are our most difficult interfaces with other organisations?
- What are our reports and operational experience already telling us?
- What needs to change to meet the new requirements?
- And what are we already doing well that we should keep?

The regulation should help us improve the operation we have, rather than create a parallel regulatory version of it.

EASA is supporting the journey

Implementation is also a learning process for the whole European system.

EASA has already been running a programme of implementation webinars, bringing together industry and authorities to work through the new framework and the practical questions it creates. The implementation material records the webinar series and EASA's continuing work with competent authorities on cooperative oversight, harmonised procedures, inspector competence, training and safety data.

That support will continue as we move towards full applicability. Because success won't be measured by whether everyone reaches 27 March 2028 with the right documents. It will be measured by whether those documents translate into safer operations on the ramp.

From rules to safer turnarounds

For me, that's what the next phase is really about. We've got the regulation.

Now we need to turn it into management systems that help organisations understand their risks; training that prepares people for the realities of the job; reporting that leads to learning; oversight that focuses effort where it matters; and better coordination between the different organisations sharing the ramp. In an environment with significantly high staff turnover, it's important for people working on the apron to understand why it's important to follow the operating procedures and what can happen if they don't.

We have time to do that properly, provided we use it. 2028 is the deadline, it shouldn't be the starting line.

The best implementation will happen when ground handlers, airlines, airports, authorities and, most importantly, the people doing the work use the remaining time to learn together and build something that works in practice.

Because regulation can provide the framework. We make it real on the ramp.



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