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DECEMBER
2024

Safety MATTERS

Providing the Namibian aviation industry and users with vital information on the latest aviation safety statistics and reports for the continuous improvement of safety systems:

Share Knowledge = Improve Safety



www.ncaa.com.na



This monthly publication will keep industry, NCAA, license holders, and the general public updated in terms of what has occurred in safety monthly within the industry. All reports are de-identified and no attempt should be made to identify the reporter in this or any other avenue unless specific authorisation is given.

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We're working hard to make sure there's

NO COUNTRY LEFT BEHIND

when it comes to global aviation standards

SAFETY FIRST



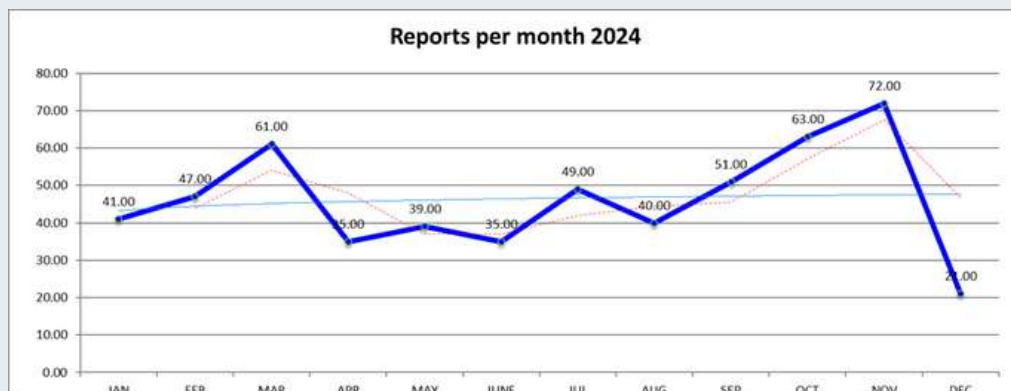
Safety data trending is essential in aviation safety. Only with adequate data on proactive and reactive mechanisms, can we move towards prediction. By analysis of key events and processes through appropriate metrics we can grow and develop - moving closer to achieving our goal of maximum achievable safety levels and minimum undesirable events.

December 2024

After several very positive months of reporting, the relative quiet of the Christmas period set in with only 24 occurrences, movements were slightly lower than normal at 3930, (the average being approximately 4500), resulting in a report rate of 5.598 reports per 1000 movements. The average rate for the year was 10.64.

There were 12 voluntary reports, the remaining 10 being mandatory. There were 301 voluntary reports for the year including 43 hazards. For December there were 3 medium-risk events, and 2 high-risk events event, the remaining 19 events being classified as low-risk. The high-risk events were both extreme low flying, posing a CFIT risk. The year ended with 78.5% low-risk, 18.2% medium-risk, and 3.4% high-risk. There were eight accidents for the year.

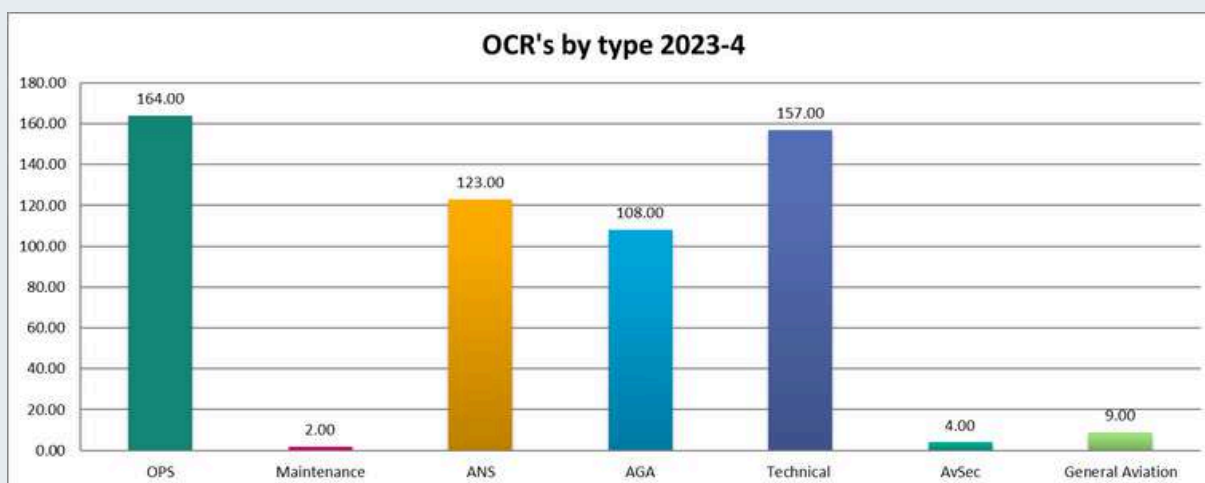
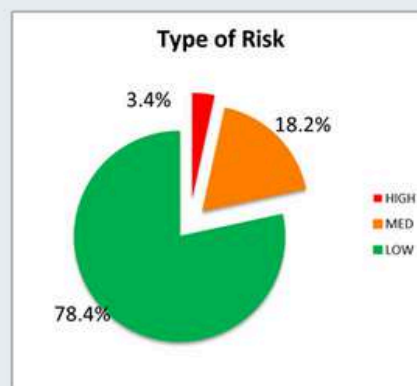
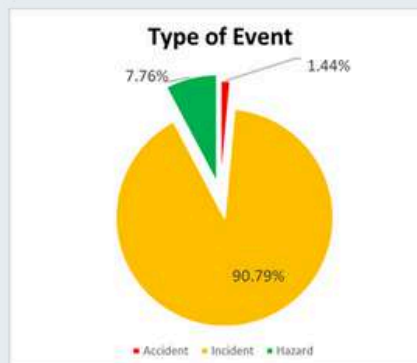
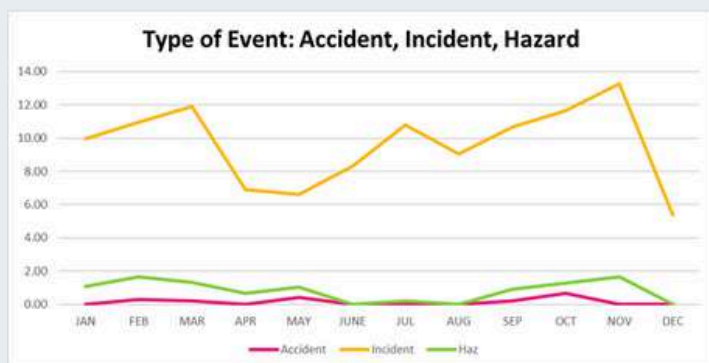
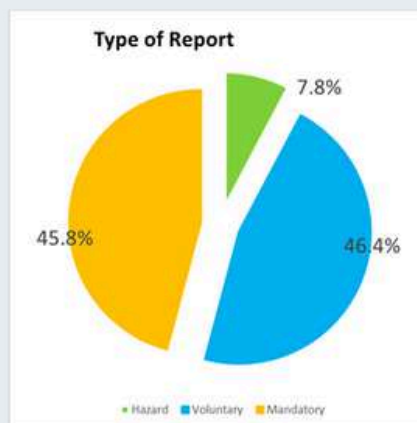
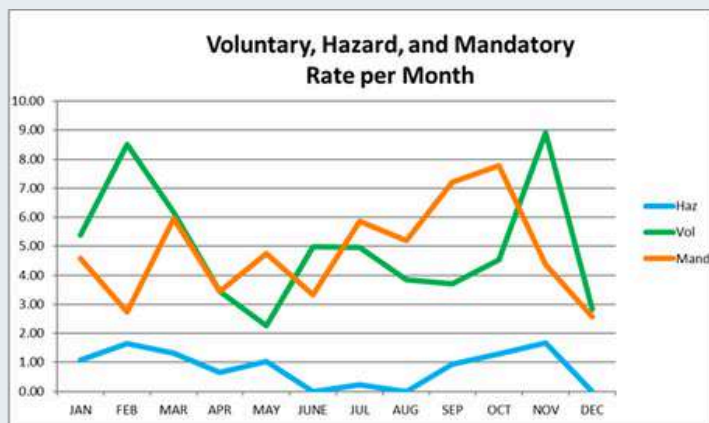
Despite the December low, reporting overall showed an upward trend for the year both in rates and in numbers.



Detailed information is available in the occurrence section, and trends will be reviewed by the State Safety Programme Steering Committee (SSP Steercom) and the SSP Technical Working Group (TWG)

For more about classifications of risk see the definitions in Safety Bulletin 1-22. Graphs included in this document show 12 month rolling figures unless specified.

Safety Statistics



Safety Dashboard

Safety Performance Indicators 2024

December heralded a very quiet month and the high-risk categories of occurrence reflect this. When we review the year past, we again had four of the seven categories below target, and while there is significant trend in CFIR, AirProx, and Runway Excursions, there was only one category breaching an alert, which was for technical events.

Please note the figures are provided as a rolling total.

	AirProx/LOS	CFIT	Rwy Excurs.	Wildlife	LOCI	Rwy Incurs.	Maint & Tech
52535 Average '24	0.269	0.137	0.148	1.258	0.038	0.018	3.035
3917 JAN '24	0.000	0.000	0.000	2.042	0.000	0.000	2.553
3816 FEB '24	0.262	0.000	0.000	0.786	0.000	0.000	3.669
4543 MAR '24	0.440	0.000	0.220	0.660	0.000	0.000	5.063
4642 APR '24	0.431	0.000	0.000	0.431	0.000	0.000	2.585
4844 MAY '24	0.826	0.000	0.000	1.032	0.206	0.000	2.064
4215 JUN '24	0.000	0.000	0.000	2.372	0.000	0.000	1.661
4446 JUL '24	0.225	0.225	0.225	1.799	0.000	0.000	2.699
4419 AUG '24	0.000	0.000	0.226	1.131	0.000	0.000	3.394
4306 SEP '24	0.000	0.697	0.464	0.464	0.000	0.000	4.180
4636 OCT '24	0.216	0.216	0.431	0.431	0.000	0.216	4.098
4821 NOV '24	0.830	0.000	0.207	3.941	0.000	0.000	1.659
3930 DEC '24	0.000	0.509	0.000	0.000	0.254	0.000	2.799
Target 2024	0.248	0.137	0.111	1.615	0.110	0.124	1.958
Avg 2023	0.315	0.192	0.137	1.106	0.094	0.145	2.198
SD 2023	0.279	0.208	0.172	0.599	0.141	0.237	0.719
Three of Alert 3	0.593	0.399	0.310	1.705	0.236	0.382	2.917
Two of Alert 2	0.872	0.607	0.482	2.305	0.377	0.619	3.636
One of Alert 1	1.151	0.815	0.654	2.904	0.518	0.856	4.354



Safety Thought for the Month

"Aircraft don't fly on luck; they fly by focusing on safety in everything we do. Ensure the odds are stacked in your favour."

Anon

Stay Safe!

Reporting

From the ED's Desk:

Toska Sem
Executive Director



As we transition from 2024 into 2025, it is with great pride and gratitude that I reflect over the year past, one of growth, learning, and collaboration for the aviation sector in Namibia. Together, we have continued to uphold our commitment to the highest standards of safety and operational excellence.

December is traditionally a month of quietened activity in aviation within Namibia, and while headquarters took a brief break, we extend our sincere gratitude to the exceptional coordination, vigilance, and professionalism of our ANS team, who, working through the holidays contributed to the safe and efficient handling of operations during this period. Your dedication underscores the resilience and capability of our aviation community.

As we embark on 2025, our focus remains unwavering: to ensure safety, sustainability, and innovation in Namibia's aviation sector. Among our priorities for the coming year are:

- Expanding the use of technology to improve safety oversight and streamline processes.
- Continuing efforts to foster a proactive safety culture where potential risks are identified and mitigated before they can impact operations.
- Supporting regional initiatives like the Single African Air Transport Market (SAATM) and ensuring Namibia's active participation in the broader African aviation agenda.

Safety is a collective responsibility, and every member of our aviation community plays a crucial role in maintaining the integrity of our skies. I urge you to remain steadfast in your commitment to compliance, vigilance, and professionalism. Together, we can ensure that 2025 brings new achievements and even higher standards of aviation safety. Let us continue to aim higher and achieve more.



On behalf of the NCAA, I thank you for your contributions and wish you a prosperous, safe, and successful year ahead.

Yours in safety, Ms Toska Sem, Executive Director



SAFETY MANAGEMENT

Safety Management Systems are both ingrained into many operations and in their infancy in others, particularly AMOs and Part 91 operators. With this in mind we need to continue to learn from each other to ensure safety management is a living breathing organism, growing and maturing with our operations, and continuing to grow and evolve even when established or mature. Safety is about continuous improvement and should not be considered static in any way.

Within our safety management system we have several components that are vital to any living breathing entity. And the body is a very good analogy for SMS:

- Safety culture is like the life blood of the SMS - bringing vital energy into every part of the safety body.
- Reporting and the safety data collection and processing system are like the backbone of the safety body, ensuring that it stands erect and strong.
- Documentation is like the skin that holds the safety body together, resting on the foundation of a strong policy and ensuring everyone knows their role through effective manuals and guidance.
- Safety promotion and training remain the breath and voice of the safety body - bringing the safety management message to all involved.
- Just like the body, there are many more components of safety, including every member of the organisation who can be said to form the different parts of the safety body in their various roles.

Again, like a body your safety management system must grow and learn, and without growth and development, and without each and every component of the system, like the body, it will fail to function at its optimum. Finally, ensure to exercise your safety body by taking a regular inventory to ensure each aspect is performing at its best.

If you have any further suggestions, please do not hesitate to write: spq@ncaa.na



SAFETY OCCURRENCES

DECEMBER 2024



TECHNICAL FAULTS (MANDATORY, **LOW RISK**, AIR/OPS)

There were 10 maintenance events this month, including one medium risk event.

No.	Fault	Type
2	Electrical	turbine, jet
1	Pressurisation fault	jet
2	Flat tyre	piston
1	Rough running engine	piston
1	Door fault	turbine
1	Harness fault	jet
1	Wheel fairing fault	piston
1	Non-specific	turbine

AMO personnel are again reminded of the critical importance of the elements in NAMCATS Part 140 Appendix A, as identification of trends that an individual AMO may not pick up and provides closure to the trends. AMOs, ATOs, AOCs, always submit the closure report from the AMO when there is a technical event, either via the PRAM or directly from the AMO.

SAFETY OCCURRENCES

DECEMBER 2024



WILDLIFE STRIKES (VOLUNTARY, MEDIUM RISK, AGA)

There were no reported bird or wildlife strikes in Namibian airspace in December. There were no more reported livestock events occurred at FYKM, however it is possibly attributed to the rain.

One bird strike was reported in the Gaborone FIR which is not counted for statistical purposes.

The below table shows rates per 1000 movements.

YEAR	JAN	FEB	MAR	APR	MAY	JUNE	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
2024	2.042	0.786	0.660	0.431	1.032	2.372	1.799	1.131	0.464	0.431	3.941	0.000	67
2023	1.346	0.823	1.398	0.696	0.623	0.966	0.471	0.438	0.525	1.192	1.116	0.500	42
2022	0.846	0.739	1.126	1.272	1.308	2.350	1.877	0.219	0.250	0.679	0.684	1.925	50
2021	2.864	7.380	8.123	2.052	3.745	4.223	0.000	2.778	0.000	1.855	0.835	0.000	74

SAFETY OCCURRENCES

DECEMBER 2024



GO AROUNDS AND DIVERSION EVENTS (VOLUNTARY, **LOW RISK**, OPS/ANSSO)

The following table shows go-around and diversion events.

No.	Details	Intended
1	Go Around due to unstable approach	FYWH
1	Go Around due to weather	FYWH
1	Diversion due to weather	FYWE
1	Diversion due to operations (medical)	FYWE

ATS / MET RELATED EVENTS (MANDATORY, **LOW RISK**, ANSSO)

The following Air Traffic Services and Meteorological events occurred.

No.	Fault	Area
1	Main frequency failure	FYOA
1	Weather display unserviceable	FYOA

AERODROME RELATED EVENTS (MANDATORY, **LOW RISK**, AGA)

There was a report of a failure to provide after-hours services as per the Service Level Agreement with an operator. The airport manager was consulted and a standby shift was located and services provided.

The PAPIs at FYWE on runway 19 were reported to be giving false information, they were subsequently calibrated.

SAFETY OCCURRENCES

DECEMBER 2024

PRESSURISATION FAULT (MANDATORY, **LOW RISK**, OPS)

A scheduled overflight suffered a gradual decompression, they followed the QRH and SOP however the situation upgraded to a rapid decompression. The crew declared a MAYDAY, descending to 10,000ft (FL100) and diverted to FYWH. Five passengers and two crew suffered injuries and they requested medical services on arrival. The aircraft landed safely with no further incident.



GLIDER IN CONTROLLED AIRSPACE (MANDATORY, **MEDIUM RISK**, OPS)

A glider briefly entered controlled airspace without a clearance nor any radio contact. This is a second event of such kind in two months. Fortunately, in both cases the glider had their transponder on.

SSN has confirmed that they will require transponders for all gliders to be on at all times from 2025, a great step forward in avoiding collisions.

SAFETY OCCURRENCES

DECEMBER 2024

RECKLESS LOW FLYING (MANDATORY, **HIGH RISK**, OPS)

A non-type certified aircraft reportedly flew extremely low over tourist vehicles on an expedition to sandwich harbour. The witnesses said the aircraft flew so low over the vehicles that the drivers had to take avoiding action through fear of being hit.

If proven it is noted that this type of reckless behaviour is not tolerated and strict enforcement action will be taken, which may include, but not limited to, a significant fine.

Low level flight is not permitted where it poses a risk or nuisance to persons or property and logic would dictate that pilots need to be appropriately trained. Additionally, the flight took place in a national park where the minimum height permitted is 3000ft.

Both OPS and MEFT are investigating the event.



SAFETY OCCURRENCES

DECEMBER 2024

RECKLESS LOW FLYING (MANDATORY, **HIGH RISK**, OPS)

In another event, a non-type certified aircraft reportedly performed low level aerobatics over the built up area of Swakopmund and Rossmund.

Again, if proven it is noted that this type of reckless behaviour is not tolerated and strict enforcement action will be taken, which may include, but not limited to, a significant fine.

The minimum height for aerobatics is 2000ft and aerobatics may not be performed over built up areas.



LOSS OF CONTROL (MANDATORY, **MEDIUM RISK**, OPS)

A gyrocopter overturned on landing in strong winds resulting in substantial damage.

Pilots flying very light aircraft are cautioned to consider wind conditions carefully when departing.

INTERNATIONAL OCCURRENCES

DECEMBER 2024

DEADLY RUNWAY EXCURSION

The B737-800 Jeju Air passenger aircraft crashed while attempting to land at Muan Airport, South Korea, on its return from Bangkok. Witness reports indicate that the plane lost control after seemingly landing with the gear retracted, skidding off the runway and slamming into a concrete barrier. The impact ignited a fierce fire that rapidly engulfed the aircraft, despite 32 fire trucks and helicopters being dispatched, only 2 of the 181 on board could be saved. The cause of the landing gear being retracted is not known, however emergency communication from the cockpit is reported to have happened minutes before landing.



POOR WEATHER AND TECHNICAL DIFFICULTIES

Christmas Day 2024 saw an Embraer ERJ-190AR aircraft operated by Azerbaijan Airlines crash near Aktau Airport in Kazakhstan, killing 38 out of 67 passengers. The flight, which had originated from Baku enroute to Grozny, diverted to Aktau and requested an emergency landing due to technical difficulties and poor weather. After several unsuccessful landing attempts, the aircraft reportedly banked and descended steeply before impacting the ground near the Aktau airport.

December 2024 reported a very sad 34 fatal accidents with 382 fatalities. A stark reminder to continually strive for safety in everything we do.

SAFETY ARTICLE

HUMAN ERROR

"I always learn from my mistakes: I can repeat them perfectly!"

It is essential to remember that the human element is central to accident causation. Whether it is due to organisation factors (attitude or knowledge based errors), maintenance slips or lapses, or direct crew actions or omissions, humans are centric and fallible. When we learn more about human errors we can make conscious efforts to guard against them. Learning more about errors and prevention strategies ensures we DO NOT repeat them!

TYPES OF ERROR

Errors can be broadly classified into slips (an action done incorrectly), lapses (an action not done), and mistakes (an action with unintended consequences).

Slips: DOING something you *DID NOT* mean to do. They may be easy to spot and so recover from with proper procedures, can be reduced primarily by SOPs, but can have more disastrous results if not picked up.

Lapses: NOT DOING something you DID mean to do. Harder to recognise as it is a non-event, difficult to control after the event. It is important to adhere to triggers and safety nets, they can be reduced primarily by proper checklist design and utilisation.

Causes of slips and lapses can be distractions or interruptions, task overwhelm, personal discussion at inappropriate times. physical needs, mental distraction (mind elsewhere), or fixation. Aviation requires our full attention all of the time. Being alert, and present, focused on your job, and applying SOPs/checklists correctly can help avoid slips and lapses. When there is two crew always adhere to appropriate cross checks.



Mistakes: A mistake happens when we do not know or mis-understand required actions or events causing an unplanned result;

INTENTIONAL ACTIONS - UNINTENTIONAL RESULTS

Crew are resistant or unaware of counter-information so actions may continue until it is too late.

Prepared by :

SPQ

SAFETY ARTICLE

HUMAN ERROR - CONT'D

Mistakes can be rule based (applying the wrong rule or using the right rule incorrectly; or knowledge/skill based, incomplete/incorrect knowledge or deficient skill leading to a mistaken routine or action or mis-interpreting the situation because of incorrect/incomplete knowledge. Training/study and currency are the two best defenses against mistakes. Know your equipment and your procedures well.

COGNITIVE BIASES

Another common cause for mistakes is cognitive biases - a systematic deviation from normal judgement or behaviour based on a false sense of belief. Some examples include confirmation, recency, concept shift, and anchoring.

Confirmation Bias: Expectation of particular environmental cues, resulting in a biased search that may overlook truthful contradicting evidence. ("You see/hear what you want to see") (Refer: Air France, Mid-Atlantic, 2009)

Recency Bias: When encountering a new situation, basing decisions on similar information from other events recently encountered. (Refer: British Midlands, Kegworth, 1989).

Concept Shift: Sticking to the original decision despite contradicting evidence. Parameters of a problem change, through confusion or a delay in decision making, the action does not. (Refer: American Airlines, Cali, 1995)

Anchoring Bias: The tendency to rely too heavily—to "anchor"—on one trait or piece of information when making decisions (usually the first piece of information acquired on that subject). Anchoring bias can be also called fixation or focalism. (Refer: Eastern Airlines, Florida Everglades, 1972)



SAFETY ARTICLE

HUMAN ERROR - CONT'D

ERROR PREVENTION STRATEGIES

Some common prevention strategies include:

Mindset: Monitoring and control over your thought processes and habits. (thinking about thinking).

Knowledge/Skill/Situational Awareness: An individual's understanding of the elements of a system/operation/situation/process, applying appropriate interaction.

Vigilance Tuning: Identifying priorities in a situation and providing increased attention to monitoring the more critical.

Teamwork: When working as a functional and competent team you should function better combined than the sum of the parts.

IN SUMMARY:

Know and follow procedures; Know your equipment; Strive for continual improvement (yourself, your team, your environment, and the processes/procedures); Stay current and focused.

Errors are inherent in human nature. The more complex the environment the more prone to errors, and the more serious the consequences. Managing them by improving systems, skills, and methodology is essential in working towards continually reducing accident rates.



HIRM

NCAA again, invites YOU to keep a look out and report any hazardous observation, attitudes, or pre-cursor event. The more awareness of hazards the better our system moves from reactive to predictive. Together we can make the skies safer! And don't forget you can report online or via email.

Updates

Expressions of interest are requested for the upcoming one day free workshops:

1. Safety Performance Indicators (presenter Danielle Bruckert)
 2. Safety Management Systems (presenter(s) various)
 3. SOP design and implementation (presenter Richard Becker)
 4. Human Factors (presenter(s) various)
 5. Quality Management Systems (presenter(s) various)
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Invitation to Contribute

Service providers and users are invited to contribute topics, ideas, articles, or questions to NCAA SPQ department for consideration in our safety publications or safety workshops. Remember the safety system only works with participation and information sharing is key to continuous improvement and achieving our global aviation safety goals.

Further information requests, submissions, or queries can be sent to:

email: spq@ncaa.na
phone: 083 235 2468

