



4 Rudolf Herzog
Street
P/Bag 12003
Ausspannplatz

Safety, Security
Promotion and
Quality Department

spq@ncaa.na
Ph. +264 83 235 2511
or +264 83 235 2468



MAY
2026

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 keeps industry, NCAA licence holders, and the general public informed of safety-related occurrences, recommendations, and initiatives 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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Safety data trending is essential in aviation safety. Only with adequate data on proactive and reactive mechanisms, can we move towards prediction. By analysing key events and processes through appropriate metrics, we can move closer to achieving maximum safety levels and minimising undesirable events.

May 2026

There were 51 occurrence reports in May, an 18% increase over May 2025. The reports included:

- 25 mandatory events, on the 26 voluntary reports, there were 4 hazard reports.
- 16 medium-risk events, including 7 bird strikes, and no high-risk events.
- There were two accidents in May, tragically including one fatal accident. The increasing accident trend remains is under close review with a task force established including teams from DAAI, NCAA, the SSP SteerCom / SSP TWG, and AOPA.

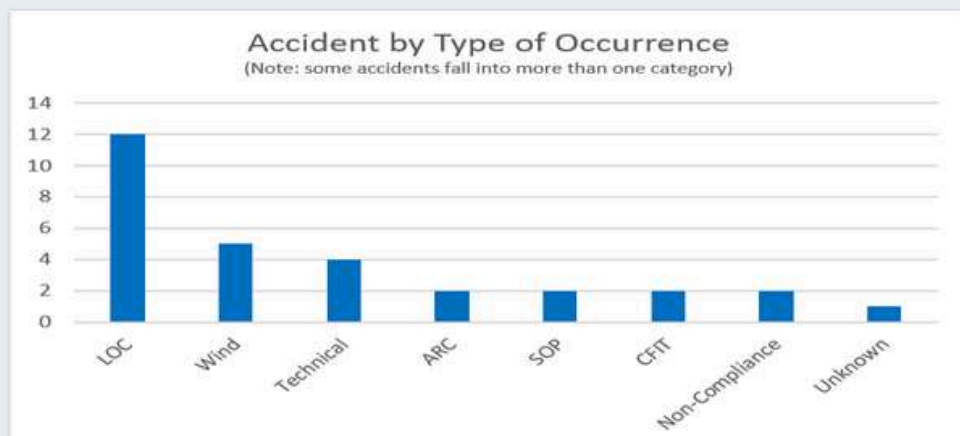
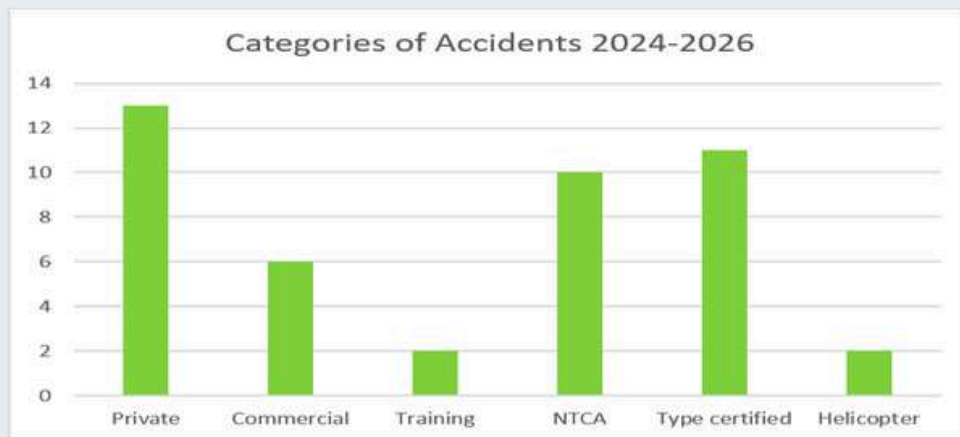
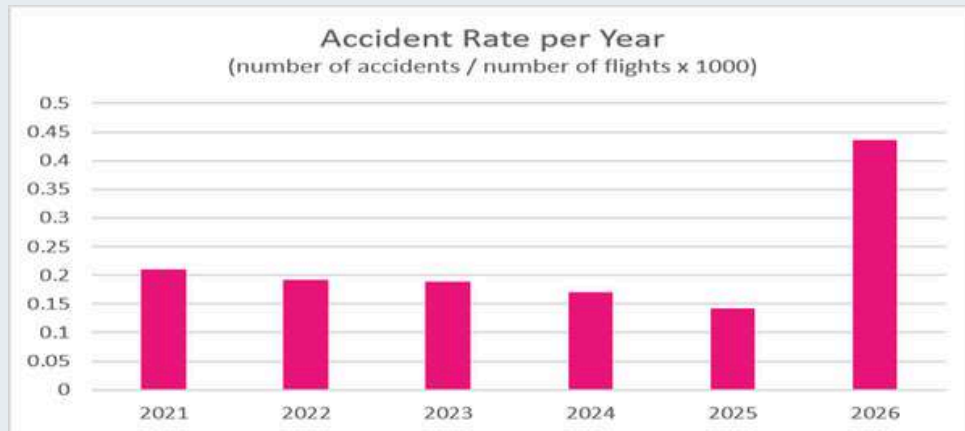


Detailed information is available in the occurrence section, and trends will be reviewed by the State Safety Programme Steering Committee (SSP Steercom) and the SSP Technical Working Group (TWG)

For more information 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

While the accident rate followed a downward trend over the past five years, 2026 has tragically seen a significant increase in accidents, including three fatal.



The graphs above show some of the statistics gathered so far. The matter is being looked into with considerable effort to determine root causes and common factors. Common themes from initial summaries cite LOC and windshear as a recurrent concern, and a pilot proficiency enhancement programme is one proposal currently being considered.

Statistics

Safety Performance Indicators May 2026

Of note this month were a high number of Loss of Separation events. Primarily featured around the closely bunched arrivals of schedules at FYWH where all occurred. VFR traffic is advised to plan around peak times at FYWH and ATS units are encouraged to consider traffic demand and peak arrival periods when scheduling operational breaks.

SPIS

	AirProx/LOS	CFIT	Rwy Excurs.	Wildlife	LOCI	Rwy Incurs.	Maint & Tech
12 mth avg	0.480	0.037	0.059	2.225	0.076	0.188	2.339
JAN '26	0.517	0.000	0.000	4.396	0.000	0.000	1.810
FEB '26	0.272	0.000	0.000	3.541	0.272	0.272	3.814
MAR '26	0.487	0.000	0.000	5.602	0.000	0.000	5.845
APR '26	0.227	0.227	0.227	2.043	0.000	0.454	2.043
MAY '26	1.036	0.000	0.000	2.073	0.207	0.207	1.866
JUN '25	0.718	0.000	0.000	1.196	0.000	0.239	1.914
JUL '25	0.228	0.000	0.000	0.913	0.000	0.000	1.825
AUG '24	0.436	0.218	0.000	1.307	0.000	0.218	1.960
SEP '25	0.223	0.000	0.223	0.893	0.223	0.223	1.117
OCT '25	0.430	0.000	0.000	0.645	0.215	0.430	1.934
NOV '25	0.427	0.000	0.000	1.067	0.000	0.213	1.921
DEC '25	0.756	0.000	0.252	3.023	0.000	0.000	2.015
Target 2026	0.327	0.111	0.100	1.308	0.129	0.120	1.842
Avg 2025	0.363	0.062	0.082	1.460	0.144	0.133	2.047
SD 2025	0.277	0.114	0.121	0.760	0.260	0.150	1.221
Alert 3	0.640	0.176	0.203	2.220	0.404	0.283	3.267
Alert 2	0.916	0.290	0.324	2.980	0.664	0.433	4.488
Alert 1	1.193	0.403	0.446	3.740	0.924	0.584	5.709



Safety Thought for the Month

"There will be old pilots, and bold pilots, but no old bold pilots" - Anon

Stay Safe!

Reporting



Dear Stakeholders,

I regret to begin this message with a sombre tone, however, it is with great sadness that the accident trend continued through May with two more accidents adding to the eight existing making the total ten for the calendar year so far. Our organisation in conjunction with our sister Annex 13 organisation DAAI, are making this an absolute priority to get to the root causes, forming a task force for a deep dive into trends and potential mitigations. My deepest sympathy goes out to the friends, loved ones, and colleagues of the departed.

Another aspect which combats safety concerns is training. A topic close to my heart, hence the endorsement of the twelve safety and quality courses scheduled for this financial year. May continued the training pace with a government safety inspector flight operations training course (GSI-OPS), along with SMS attended by approximately 30 individuals from NCAA, the Namibian Air Force, and from industry. These courses strengthen NCAA's safety oversight and SSP along with enhancing industry skill base. There is still some space in the upcoming months, do register your interest with spq@ncaa.na, and/or enquire about future courses. We will continue to support effective in-house training - keeping down training costs and enhancing capacity as a training partner.

We are pleased to wish a big thank-you to our cabin crew this month with international day of the cabin crew member, an often thank-less job, whereupon constant readiness for emergencies is demanding, while still meeting service needs. I'm pleased to see that two potential cabin crew inspectors attended the first four training events,

May also marked the monumental task of Board handover. I am ever so grateful for the outgoing Board for their steadfast leadership over the past three years. I equally welcome the new Board a very qualified and professional team that I am confident will continue to lead us to new heights in safety oversight and excellence of aviation service provisioning, both internally and through support of our service providers.

Yours in Safety, Ms Toska Sem.

INTERNATIONAL DAY OF THE CABIN CREW MEMBER

Our flight angels work tirelessly to both meet our needs and be prepared to facilitate safe outcomes in the event of an emergency. On the 31st May we recognise their efforts with deep gratitude



The dedication and high standards of our experts in cabin safety does not go unnoticed.



UPCOMING TRAINING

At the time of writing, the first five courses have been completed successfully. There is still some space on Oversight of Aircraft Leasing and Air Cargo Certification, get in touch with spq@ncaa.na if you want to attend. Interested participants may also join the waiting list for the remaining three courses and this will help with planning for 2027.



NCAA Presents



In-house Safety and Quality Training 2026

Course	Dates	Provider	Fee per person (NAD)
Safety Management Systems (SMS)	11 – 15 May 2026	Aviason	12,667
Surveillance of Service Providers	1 – 5 June 2026	Aviason	15,833
Resolution of Safety Concerns	8 – 12 June 2026	CAAS	30,780
Quality Management Systems (QMS)	22 – 26 June 2026	Aviason	12,667
Human Factors	6 – 10 July 2026	Aeroclass	13,680
Air Cargo Certification ✓	27 – 31 July 2026	Aviason	12,667
Oversight of Aircraft Leasing (OPS) ✓	3 – 7 August 2026	Aviason	13,680
Aircraft Accident and Incident Investigation	31 August – 4 September 2026	Aeroclass	15,580
Operational Risk Management	21 – 25 September 2026	Aeroclass	13,680
Cyber Security in Aviation	19 – 23 October 2026	Aeroclass	12,920

Bookings: RSVP to spq@ncaa.na

OPERATIONAL SAFETY MEETINGS

The traditional safety management system has two mandated meetings, namely the safety action group and the Safety Review Board. Sometimes combined in very small organisations. The safety action group (SAG) is composed of operational line management and discusses workplace issues. The Safety Review Board (SRB), normally chaired by the accountable manager discusses policy decisions and matters elevated by the SAG.



However, an equally important meeting, not described explicitly in Part 140, but an essential component of any SMS, is the operational safety meeting.

An operational safety meeting is a front line discussion with operational staff on matters of importance to operational safety. This may be combined with other regular operational staff meetings, but it is essential that it has a specific agenda point and time allocated. Safety discussion in operational safety meetings may include items such as:

- Feedback from occurrence reports;
- Lessons learnt or operational changes brought about by safety risk assessments or investigation reports;
- A case study from a local or international event of significance;
- A key safety message;
- Encouragement to report and emphasis of just culture;
- Shared experiences on a safety matter from operational staff;
- Discussion on hazards identified;
- Open feedback from the operational staff about safety matters that may or may not have been reported;

Feedback from the SRB or SAG.

It is essential that the meeting is operationally focused and provides open feedback on safety issues to/from the Safety Department and to/from operational staff. Information feeding the SDCPS comes from front line staff to the SAG/SRB and it is vital information is fed back to the same.

For incident, accident, and hazard reporting, email both incidents@ncaa.na and daaii@mwt.gov.na. For voluntary, confidential, or anonymous reports, follow the secure [Confidential Reporting Link](#).



SAFETY OCCURRENCES

MAY 2026



WILDLIFE STRIKES (VOLUNTARY, MEDIUM RISK, AGA)

Bird strikes were at lower levels than recent months, while crews, ATS, and aerodromes are advised to utilise avoidance techniques year-round - namely minimise time in the bird strike window, clear runways before arrivals, keep a good lookout at all times.

Wildlife	Events and near misses		
No.	AD	Phase	Details
1	FYDN	Takeoff	Swallow
1	FYWE	Takeoff	Unknown
1	FYWE	Landing	Guinea Fowl
2	FYWH	Landing	Unknown
1	FYWH	Takeoff	Falcon
1	FYOQ	Landing	Giraffe
1	FYLZ	NA	Oryx

An Oryx was sighted entering through a gap in the fence at FYLZ, the gap was immediately and proactively closed with additional mesh after the oryx was escorted off the runway.

The below table shows historical statistical data for wildlife strikes:

YEAR	JAN	FEB	MAR	APR	MAY	JUNE	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
2026	4.396	3.541	5.114	2.043	2.073								72
2025	1.533	1.104	1.505	2.956	1.148	0.957	0.913	1.377	0.447	0.645	1.067	3.023	61
2024	2.042	0.786	0.000	1.615	1.106	0.599	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	1.538	42

SAFETY OCCURRENCES

MAY 2026



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

There were eight technical events reported this month.

No.	Fault	Type
1	Radiator fault	Piston
1	Gear fault	Jet
1	Brake fault	Jet
1	Radio Communications Failure (RCF)	Turbine
1	Flat tyre	Turbine
1	Fuel fault	Turbine
2	Unspecified	Piston

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

SAFETY OCCURRENCES

MAY 2026



ANSP RELATED EVENTS (MANDATORY, **LOW RISK**, ANSSO)

The following four Air Navigation Services events occurred.

No.	Fault	Area
1	Radio fault	FYOA
1	Telephone lines U/S	FYOA
1	Briefing unavailable during HOD	FYWF
1	ATC late to shift	FYWB

There was another event of an operational shift left unmanned due to staffing constraints.. This matter is being prioritised.

Users are reminded to continue to report MET breakdowns or unavailability. Without occurrence data, NMS is limited in its ability to justify additional resources and equipment.

SAFETY OCCURRENCES

MAY 2026



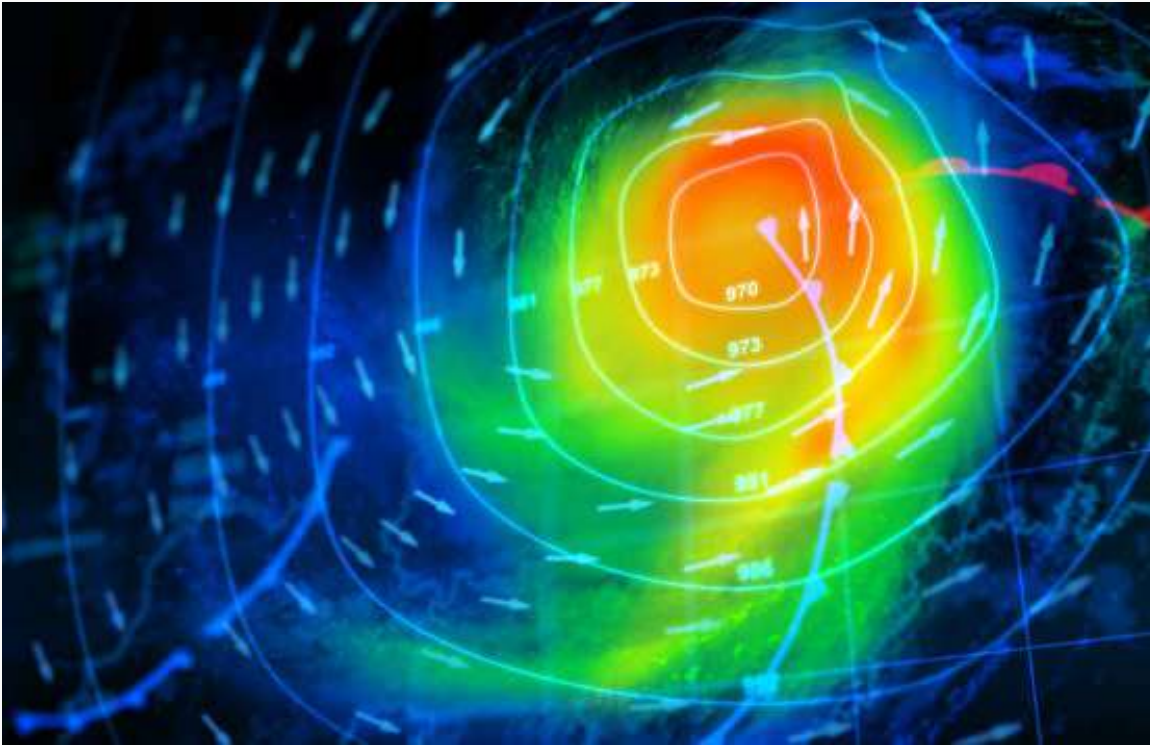
AERODROME RELATED EVENTS (MANDATORY, **LOW RISK**, AGA)

There was one aerodrome related event, whereupon there was a runway incursion by cyclists. The aircraft on approach performed a go around and on the second approach the runway was clear. The lodge owner drove the runway prior to departure to ensure it remained clear. See more under feedback.

A hazard was raised again about location indicators, discussions are underway with AIM and AGA to determine how the locations can be verified.

SAFETY OCCURRENCES

MAY 2026



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

The following table shows go-around and diversion events.

No.	Details	Intended
2	Go arounds due to unstable approach	FYWH
1	Go around due to windshear/tailwind	FYWT
3	Diversions due to weather	FYRW, FYMW

Crews are advised to remain go-around and diversion orientated at all times to counteract the inherent get-there-itis prevalent in our goal orientated make-up, to ensure vigilance against weather and other related hazards.

Always know your weather minima and stick to them.

See more about get-there-itis / press-on-itus on page 27

SAFETY OCCURRENCES

MAY 2026

NOT YET ESTABLISHED (ACCIDENT, **HIGH RISK**, OPS)

A Cessna 210 impacted terrain enroute from FYHK to FYKW, there were no survivors.

The causes are not yet established.

LOC-G (ACCIDENT, **MEDIUM RISK**, OPS)

A tail dragger, while braking on soft sand, nosed over and flipped causing substantial damage. There were no injuries.

This is the second incident with a tail wheel aircraft in as many months, pilots are reminded, that while tail wheel flying is fun, there is a higher skill level needed for operating tail wheels, currency and conditions are essential considerations.



SAFETY OCCURRENCES

MAY 2026

LOSS OF SEPARATION (MANDATORY, MEDIUM RISK, OPS/ANSSO)

The following four loss of separation events occurred:

Wrong Altitude

VFR traffic enroute from FYSM to NND-SRA was cleared to climb to 5000ft. Due to equipment limitations, there was no target on the radar so the ATC did not have confirmation of the height of the aircraft, which had mistakenly climbed to 9500ft. At the same time IFR traffic was cleared to descend 6000ft causing a loss of separation.

Always write down clearances and listen out for other potential conflicting traffic, we are all each other's safety nets.

No Speed Restrictions

During the midday peak traffic period, with two IFR flights inbound at a similar ETA, the first flight was issued a "no speed restrictions" clearance, while the other inbound was not told to reduce speed early enough. The controller assumed no-speed restrictions would result in the aircraft increasing speed, but in fact the aircraft reduced speed. At the time the approach and area positions were combined due to a scheduled break.

It is strongly recommended that breaks are not scheduled during peak times.

Assumptions on IFP

Two IFR in-bounds experienced a loss of separation when the controller assumed the first aircraft would descend to 9000ft and for the second aircraft mistook a fly-by for a fly-over waypoint shortening the separation distance. The first aircraft descended 9500ft, while a following aircraft descended to 10,000ft, where the separation was 500ft and 4.5nm instead of the required 1000ft and 5nm.

The controller is commended for self-reporting.

SAFETY OCCURRENCES

MAY 2026



LOSS OF SEPARATION (CONT'D) (MANDATORY, **MEDIUM RISK**, OPS/ANSSO)

A scheduled IFR aircraft was cleared to climb altitude 10,000ft after departure while a crossing VFR traffic was maintaining 9500ft, causing a loss of separation.

Refer also to the case on the preceding page.

CONFUSING LINE UP CLEARANCE (VOLUNTARY, **MEDIUM RISK**, OPS/ANSSO)

During departure an aircraft was given taxi and takeoff clearance without the runway being specified. They heard traffic on approach and assumed this was the runway in use. The error was picked up when they were given an unusual turn after takeoff and queried the runway in use. The aircraft, which had lined up on the opposite runway to the one ATC intended, turned to line up for the active and departed without further incident.

Remember we are all each other's safety net, always question if something doesn't seem right.

SAFETY OCCURRENCES

MAY 2026

SHIFT UNMANNED (MANDATORY, **LOW RISK**, ANSSO)

An ATC was phoned about a close relative who passed away in the early hours of the morning causing considerable loss of sleep and when they did finally get to sleep it was only a short time before shift began, consequently they overslept. There was no standby available and the controller felt the need to go to work regardless of the emotional stress.

Remember working while dealing with an emotional problem should be avoided at all costs, there is always an alternative.

NO NOTAM (VOLUNTARY, **LOW RISK**, ANSSO)

There were two cases of missing NOTAMs, one for blasting, where a CAUA was not obtained, and a second for fireworks where a CAUA was obtained but the NOTAM request was mistakenly issued for only the concurrent drone activity instead of for both activities.



SAFETY OCCURRENCES

MAY 2026

DRONE SIGHTINGS (MANDATORY, **LOW RISK**, OPS/ANSSO)

One unauthorised drone sighting was reported.

RPAS operators require approval to operate on another person's property, a RPAS Letter of Approval for all operations, and a CAUA to operate in controlled airspace or near an aerodrome. All illegal operations should be reported.



AFTER HOURS REQUEST (VOLUNTARY, **LOW RISK**, OPS/ANSSO)

An after hours request was submitted for local time not UTC and consequently services arrived two hours late.

Operators are cautioned to take care with times both on requests and in reporting and any other matters that may have a critical effect if times are wrong.

SAFETY OCCURRENCES

MAY 2026

UNRULY PASSENGERS (MANDATORY, **LOW RISK**, OPS)

Passengers for a charter flight in a light aircraft became unruly when they were told they would need to leave some of their excess luggage. The guests had three soft bags, three hard cases, and three backpacks.

Operators are reminded to always be very clear with passengers about the allowable luggage when booking tickets. If tickets are booked by a third party always ensure they pass the message along. The pilot is commended for handling the matter diplomatically.

WINDOW OPENED IN FLIGHT (VOLUNTARY, **LOW RISK**, OPS)

At 500ft on approach to land at FYSL, a passenger opened the window, marked clearly “only pilot”. The approach was stable and the pilot was comfortably able to lean over and close the window without further event.

Always brief your front seat passengers about do’s and don’ts very carefully, while remembering passengers can be unpredictable even if briefed well. See also the September edition where a passenger almost caused an engine failure.

MEDICAL EMERGENCY (VOLUNTARY, **LOW RISK**, OPS)

A passenger lost consciousness during a balloon flight. The pilot arranged medical services and executed an emergency landing. The passenger was transported safely to hospital.

SAFETY OCCURRENCES

MAY 2026

IMPROPER MAINTENANCE (MANDATORY, **LOW RISK**, AIR)

An aircraft was released to service with a number of items outstanding on the maintenance release, including maintenance items and documentation.

This matter was a repeat occurrence with the same maintenance service provider. The operator arranged a meeting to discuss shortcomings in the AMO quality system which appeared to be a root cause for these repeat occurrences. The AMO agreed to implement the recommendations to reduce errors.



Namibia **Day** VFR: Visibility & Cloud Requirements

VFR Prohibited Above 3/8 Cover

Identifiable objects on the ground must be visible.



 VFR Prohibited Above 3/8 Cover. Identifiable objects on the ground must be visible.

Airspace	Visibility	Cloud Distance
At/Above 10000 ft	8 KM 	1,500 M Horiz  1000 ft Vert 
Below 10000 ft Above 1000 ft	5 KM 	1,500 M Horiz  1000 ft Vert 
Class F & G (Low Level)	5 KM 	Clear of cloud / Surface in sight 

© NotebookLM

Not adhering to VFR minima is a clear recipe for CFIT.
Know your minima and stick to them, you owe it to your passengers.

- graphics courtesy of M Coetzee, Wilderness Air Namibia

SAFETY FEEDBACK

MAY 2026



RUNWAY INSPECTIONS (HAZARD, **MEDIUM RISK**, AGA/OPS)

Another two wildlife events and a runway incursion by cyclists in this month's bulletin highlight the importance of runway inspections.

While pilots should ideally complete a runway inspection on arrival wherever conditions are not assured, it also assists greatly to ensure the lodge you are visiting is at the airport prior to arrival to clear off any unwanted visitors. AOC holders should brief accommodation operators in runway safety and the importance of clearing the runway prior to an arrival. Where there is more than one lodge being serviced by an airfield it is important they know to coordinate. Lodges should be equipped with a hand-held radio for this exercise and ensure to listen out.

A caution: ground personnel with a radio license may transmit on the frequency, but take care to never give unqualified operational advice, such as "the weather is okay for landing".

Alongside the obvious significant safety considerations of impact with an animal or person, the passengers are often alarmed if more than one approach and go around is needed. For the lodge and AOC holder it makes sense to improve guest experiences.

SAFETY FEEDBACK

MAY 2026



MAGNETIC BEARINGS (HAZARD, **LOW RISK**, ANSSO)

Pilots are warned of the ongoing hazard of a number of airports with incorrect runway vectors. This affects FYOA, FYWE, FYKT, FYLZ, and FYAR among others. Instrument approaches on these airports require a specific risk assessment to ensure application of correct hand amendments and crew briefings. Take note that the process of changing the vectors has begun and appropriate notifications/NOTAMs will follow.

SHORTAGE OF ATS PERSONNEL (HAZARD, **HIGH RISK**, ANSSO)

A number of recent occurrences have been attributed to the shortage of ATS personnel. This matter is being treated as a matter of urgency with the first bursary intake finalised and the recipients departing for their training on the 15th May 2026.



INTERNATIONAL OCCURRENCES

MAY 2026

MAY IN HISTORY - CFIT

On the 31st May 1971 an Indian Airlines B737-200 collided with powerlines on an NDB approach fatally injuring 43 of the 58 passengers and 5 of the 7 crew. The crew descended below the minimum descent height in poor visibility.

On final approach to New Delhi-Palam Airport by night, the crew encountered poor weather conditions. In below-minimum visibility, despite being unable to locate the runway, the captain decided to continue the approach and passed below the glide. With the flaps down to 40°, the aircraft struck power cables and crashed in flames near the district of Vasant Vihar, about 3 km east of the airport. Five crew members and 43 passengers were killed while 17 other occupants were injured.

Operating minima exist for a reason and form part of the regulatory safety framework. Deliberate non-compliance removes critical safety barriers, constitutes all three aspects of a principal of exception, and will result in enforcement action. One flight crew member survived the action and was subject to enforcement action for failing to comply with regulatory requirements.



SINCERE CONDOLENCES

MAY 2026



NCAA would like to express our sincere condolences to the families and friends of the pilot and passengers involved in the tragic accident on the 10th May 2026. Our hearts go out to those grieving and our thoughts are with you.

NCAA is working closely with the Directorate of Aircraft Accident and Incident Investigation (DAAII) to uncover details that will lead us to address any safety considerations related to the accident.

Again, our heartfelt sympathies are expressed to the families and friends affected by this tragic event.

We will communicate further once the facts have been established.



SAFETY ARTICLE

DESTINATION FIXATION: PRESS-ON-ITIS

With a number of VFR into IMC incidents and precursors these past months, and following nicely in the DMM article last month, is review of a psychological phenomenon called press-on-itis - the decision to continue to the planned destination or toward the planned goal even when significantly less risky alternatives exist. Press-on-itis is also known as “get-home-itis,” “hurry syndrome,” “plan continuation” and “goal fixation.” No matter what it is called, press-on-itis can present a serious problem to flight safety. Knowing the causes and recognizing the syndrome developing will allow a pilot to recover before things go terribly wrong.

Examples of press-on-itis include:

- Conducting multiple approaches despite the weather being unlikely to have improved
- Violating MDA/DH minima
- Flying Visual Flight Rules (VFR) into Instrument Meteorological Conditions (IMC) without being appropriately rated and/or without appropriate equipment
- Racing a thunderstorm to a destination
- Landing in a thunderstorm
- Failure to abide by aircraft performance limits
- Failure to go around from an unstabilized approach
- Failure to plan for a go around or diversion.



The Flight Safety Foundation's (FSF) Approach-and-landing Accident Reduction (ALAR) Tool Kit study examined 76 approach and landing accidents and serious incidents and showed the most-frequent causal factor (74 percent) was “poor professional judgment/airmanship”. Press-on-itis accounted for 42 percent of all occurrences in which the crew continued an approach and landing when conditions warranted other action.

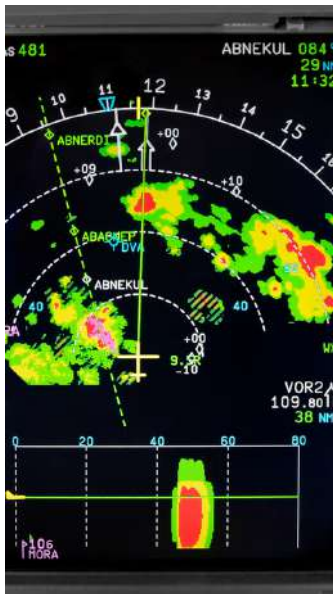
When pilots intentionally deviate from SOPs, it is seldom malicious. In interviews after an accident, they almost always say, “It seemed like the right thing to do based on the information we had at the time.” Assuming that no aircrew deliberately crashes an aircraft, possibly killing themselves and their passengers, why do well-intentioned people make decisions that in hindsight appear grossly inappropriate? The statement, “It would not have happened if they had just followed the rules” is often true, and sometimes the rule that needed to be followed was simply common sense and good airmanship.

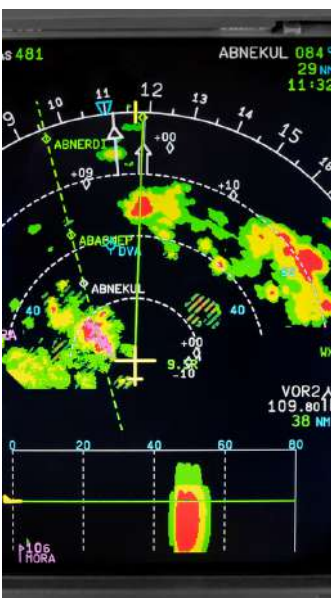
SAFETY ARTICLE

DESTINATION FIXATION: PRESS-ON-ITIS

Aircrews may succumb to press-on-itis for the following reasons:

- They want to “get the job done” (excessive commitment to task accomplishment), often influenced by organisational goals such as on-time arrival, fuel savings, and passenger and crew convenience
- They may be competitive - “if XXX airline/aircraft XXX made it, so can we!”
- Personal ego or saving face that makes the crew reluctant not to achieve their objective of landing at the original destination
- “We are almost there, let's just do it and get it over with”
- “We do not want to divert, with all the associated additional work”
- They may have diverted once when everyone else landed safely and felt somewhat embarrassed about it or were questioned about their decision
- They are over-confident that nothing will go wrong
- They take pride in a chance to demonstrate their skills in challenging situations



- 
- They have a personal commitment/appointment at the completion of the flight, or they may simply want to get to the destination
 - They are fatigued
 - They become task-saturated
 - They focus solely on aircraft flight path control due to turbulence and other distractions
 - They miss the significance of ATC calls of changing winds and runway conditions
 - They lose situational awareness and are not fully aware of the potentially perilous situation
 - They have not set performance limits and trigger gates that require a go around
- They may have poor CRM skills, and, even if one of the crew members feels uncomfortable about continuing, he or she may therefore not speak up
 - They do not conduct a risk assessment or threat and error management based on current and developing (possibly deteriorating) conditions
 - They do not anticipate and plan for things that may go wrong
 - They are not fully aware of their own limitations and/or the aircraft's limitations
 - They feel nothing matters if they can just get it on the runway and get it stopped.

SAFETY ARTICLE

DESTINATION FIXATION: PRESS-ON-ITIS

6 Press-on-itis Prevention Methods

Knowing how press-on-itis can negatively affect aircrew decision making can help lead to recognition of its hazards and, hence, reduced decision errors. The following are ways to prevent press-on-itis:

- The company should commit to safety as a priority and act in such a way that does not contradict that commitment. A company may promote situations where crew diverted, for example, when it was the safe option, reinforcing the message that diverting is a norm.
- The company should have a sound training program about the dangers of press-on-itis and other matters relating to safety, ADM, and human factors. The company should also emphasize the importance of observing the minima and procedures.
- Crews should be indoctrinated in the error-reducing benefits of proper planning. A crew should use “what if?” scenarios that are related to the mission. Preplanning among captain, first officer and dispatcher allows everyone a chance to comment and gain a shared mental model of possible alternate plans.
- Crews should be taught to ask “why?” when they select the more risky of two alternatives, following effective use of a DMM. This can be taught in simulator scenarios/scripts.
- Company policy and crew training should emphasise carrying enough fuel for diversion(s) and/or holding, particularly when conditions are poor.
- Crews should be trained concerning how to select a suitable alternate. This should include not choosing a “close-in alternate” that will be affected by the same weather system (for example FYWE/FYWH).
- Crews should be trained in how to carry out a risk assessment based on crew fatigue level and type of approach (precision, non-precision, etc.). For example, a circling approach at night entails much more risk than flying a precision approach.
- SOPs and training should stress the selection of a runway with vertical guidance even if it is not the noise abatement runway.
- Crews should be trained and required to calculate the increased stopping distance required for a contaminated runway based on the estimated ground speed, Minimum Equipment List (MEL) limits, etc.

SAFETY ARTICLE

DESTINATION FIXATION: PRESS-ON-ITIS

- Training should emphasize the need to:
 - Review and brief the crosswind/tailwind limits for weather and runway conditions.
 - Brief the planned approach including aircraft configuration, navigation and automation procedures.
 - Clearly brief performance limits and minima for approach
 - Review and brief the crosswind/tailwind limits for weather and runway.
 - Be go around orientated. If everything is not within limits, go around.
 - Take the necessary time to re-brief and set up for a new approach if plans change. Do not rush, and do not let ATC pressure you into a rushed approach.
 - Fly the aircraft onto the runway at the proper touchdown point. If the approach does not look right or feel right, then go around.
 - Be mindful of the danger of letting one's own commitments or circumstances or the commitments of the rest of the crew influence your decisions.
 - Conduct a debrief after every flight. Recognise that just because you made it in safely this time does not mean it was a wise decision. Learn from those experiences, recognize the precursors of an accident and divert or go around early.

7 Key Points

- Press-on-itis is a dangerous mental state that can affect even the best and most experienced pilots.
- Many accidents are caused, or suspected to be caused or contributed to by press-on-itis.
- Unreasonable pressure to get to the destination, whether self-generated or externally-imposed, can cause an aircrew to decide to continue to their planned destination despite conditions being unsuitable to do so.
- Company policies must truly place safety first and reward safe decision making.
- Good training that stresses awareness of the dangers of press-on-itis, setting boundaries, sound knowledge of rules and procedures, disciplined adherence to minima and performance requirements, and planning to deal with potential situations will act as defences against unsafe conditions.

ANNOUNCEMENTS

APPOINTMENT OF NEW NCAA BOARD



Welcome to the NCAA Board of Directors

The Namibia Civil Aviation Authority is delighted to warmly welcome its newly appointed Board of Directors:

- Ms. Loide Shaparara – Chairperson
- Ms. Martha Hitenanye – Deputy Chairperson
- Mr. Josef Shipepe
- Mr. Edward N. Kafita
- Mr. John Shimaneni
- Mr. Edson E. Isaaks
- Mr. Sam H. Nekaro

We are truly honoured to have you join the NCAA family at such a pivotal time in our journey. Your diverse expertise, leadership, and commitment to excellence will be invaluable as we continue to strengthen aviation safety, security, and regulatory oversight in Namibia.

As we move forward together, we look forward to your guidance and partnership in shaping a resilient, innovative, and high-performing civil aviation sector. Together, we remain committed to upholding the highest standards and reinforcing the NCAA's position as one of Africa's leading aviation regulators.

We extend our sincere congratulations once again and warmly welcome you aboard.

HIRM

NCAA again invites all stakeholders to keep a lookout and report any hazardous observations, attitudes, or precursor events. The greater our awareness of hazards, the more effectively our system can move from reactive to predictive safety management. **Together we can make the skies safer!** And don't forget you can report online or via email.

Updates

NAMCATS 171 Volumes 1, 2, 3, 172, 174, and 175 updates were approved and uploaded to the website. This update aligns with updates to Annexes 3, 10, 11, and 15 related to air navigation services.

Invitation to Contribute

Service providers and users are invited to contribute topics, ideas, articles, or questions to NCAA SSPQ 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.

Did you have an experience that taught you more about staying safe? Share it with others!

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

email: spq@ncaa.na

phone: +264 83 235 2468



GLOSSARY

Term / Acronym	Meaning / Description	Term / Acronym	Meaning / Description
AGA	Aerodromes and Ground Aids – ICAO-defined sector responsible for the safety of airport infrastructure.	NAMCATS	Namibian Civil Aviation Technical Standards – technical regulatory requirements in Namibia.
AIP	Aeronautical Information Publication – a document published to provide information essential to air navigation.	NAMCAR	Namibian Civil Aviation Regulations – the core aviation law in Namibia.
AMO	Approved Maintenance Organisation – a facility authorised to perform aircraft maintenance.	NTCA	Non-Type Certified Aircraft – aircraft not holding a type certificate under ICAO Annex 8.
ANSSO	Air Navigation Services and Safety Oversight – refers to the oversight of air navigation services.	OCC	Operations Control Centre – typically responsible for dispatch and operational control.
AOC	Air Operator Certificate – certification issued to an airline allowing it to operate commercial air services.	OPS	Flight Operations Section – department overseeing flight safety, compliance, and investigations.
ATO	Approved Training Organisation – an entity authorised to conduct pilot or aviation personnel training.	PRAM	Person Responsible Aircraft Maintenance
ATS	Air Traffic Services – includes services such as air traffic control (ATC), flight information, and alerting services.	QMS	Quality Management System – a structured system for quality assurance and continuous improvement.
AVSEC	Aviation Security – the part of aviation concerned with preventing unlawful interference or acts of sabotage.	RPAS	Remotely Piloted Aircraft Systems – commonly referred to as drones.
CARTAP	Civil Aviation Technical Advisory Panel	SDCPS	Safety Data Collection and Processing System – structured data management tool to support SMS.
CHT	Cylinder Head Temperature	SMS	Safety Management System – a systematic approach to managing safety, including organizational structures and procedures.
CNS	Communication, Navigation, Surveillance – essential infrastructure for air traffic management.	SPI	Safety Performance Indicator – a data-driven metric used to monitor safety performance.
Doc 9859	ICAO Safety Management Manual – foundational guidance for States and service providers on SMS and SDCPS.	SPT	Safety Performance Target – a specific safety goal to be achieved.
HIRM	Hazard Identification and Risk Management – a proactive safety management approach.	SSP	State Safety Programme – the national programme for managing aviation safety.
ICAO	International Civil Aviation Organization – UN body that sets global aviation standards.	TWG	Technical Working Group – an expert team working under the SSP to analyse safety data.
MET	Meteorological Services – aviation weather services.	UTC	Coordinated Universal Time – standard aviation time reference.
MEFT	Ministry of Environment, Forestry and Tourism – required for approvals in protected areas.	WHV	Hosea Kutako International Airport VOR