SAFETY SUMMARY

SUMMER 2025

EVENT DEBRIEF: MISUNDERSTANDING OF "CLEARED TO LAND" VS. "CLEARED FOR THE OPTION"

OVERVIEW:

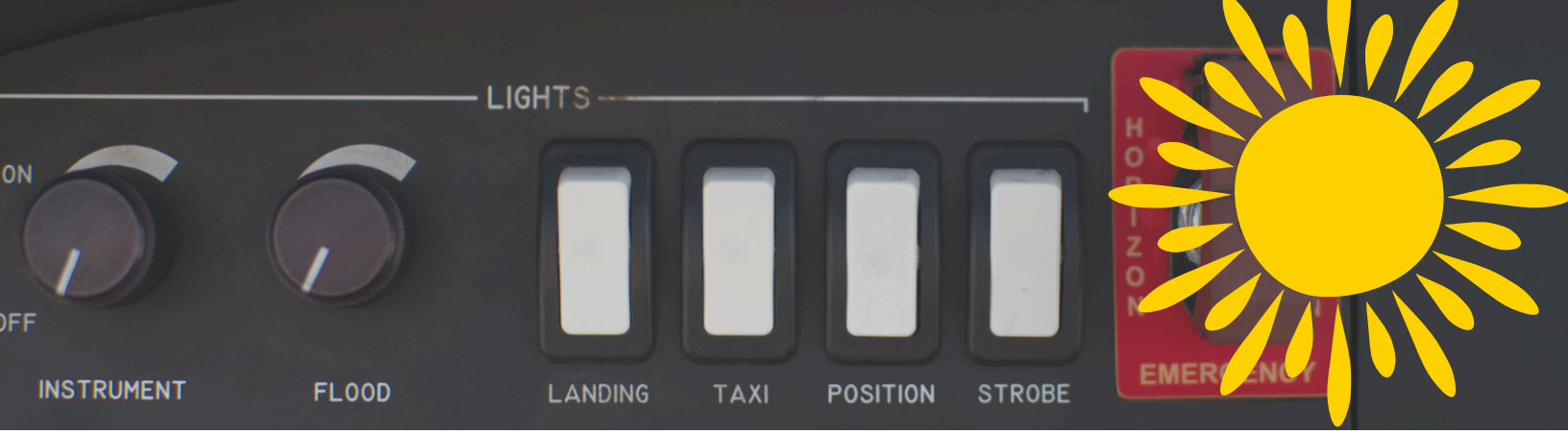
Four separate safety reports were submitted involving different crews operating under various scenarios (IFR/VFR, training flights, instrument approaches). In each case, the aircraft conducted a touch-and-go or go-around after being cleared to land, resulting in a pilot deviation, warning, or informal notification from ATC.

CONTRIBUTING FACTORS:

- Assumption About Phraseology: Pilots assumed that "cleared to land" inherently permitted a touch-and-go or option.
- Unclear Coordination Between ATC Facilities: Crews expected approach controllers to relay operational intentions to tower, which did not occur.
- Confusion Due to Atypical Phraseology: One reporter noted that ATC phraseology was not what they were accustomed to, contributing to overall confusion during the approach.
- Student Training Environment: All events involved instructional flights, increasing workload and potential for miscommunication

REPORTER TAKEAWAYS & LESSONS LEARNED:

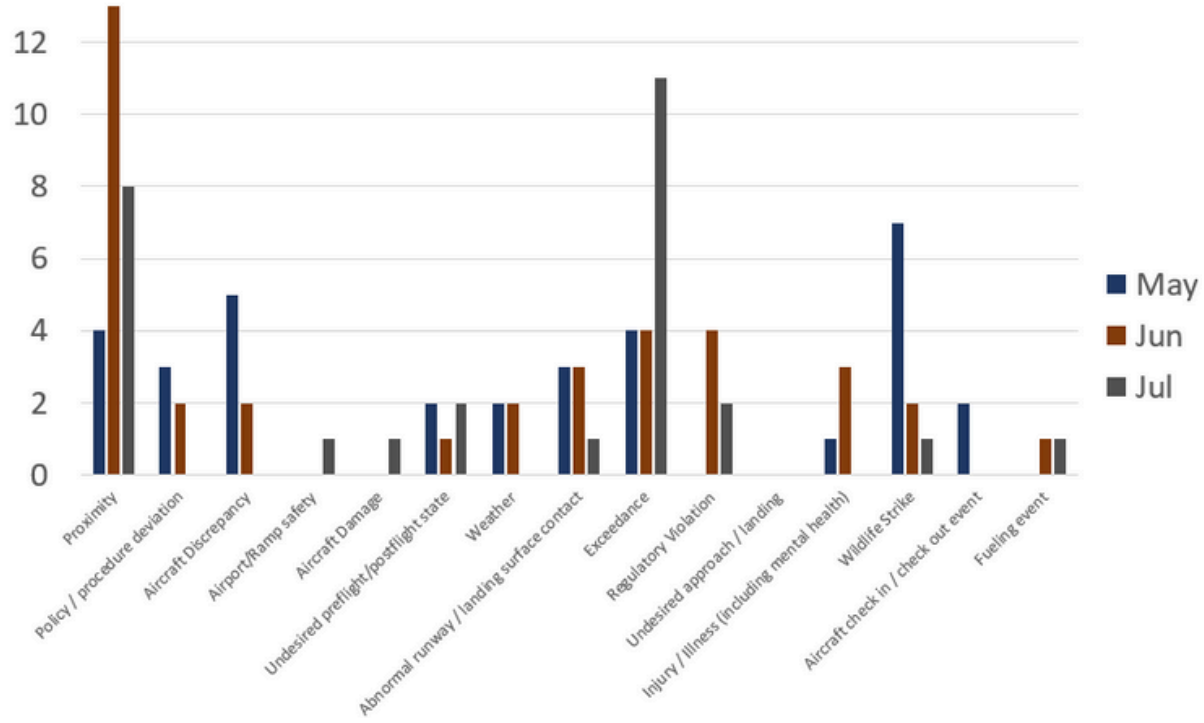
- Do not assume "cleared to land" includes authorization for a go-around or touch-and-go. Always wait for "cleared for the option" **or make a specific request if uncertain.**
- Confirm pattern work or touch-and-go intentions explicitly **with tower, not just with approach.**
- **Clarify expectations** and phraseology with students before entering complex or busy airspace to reduce errors and workload.
- Use this as a teaching opportunity to better understand IFR and VFR communication, inter-facility coordination, and the critical importance of proper clearances.



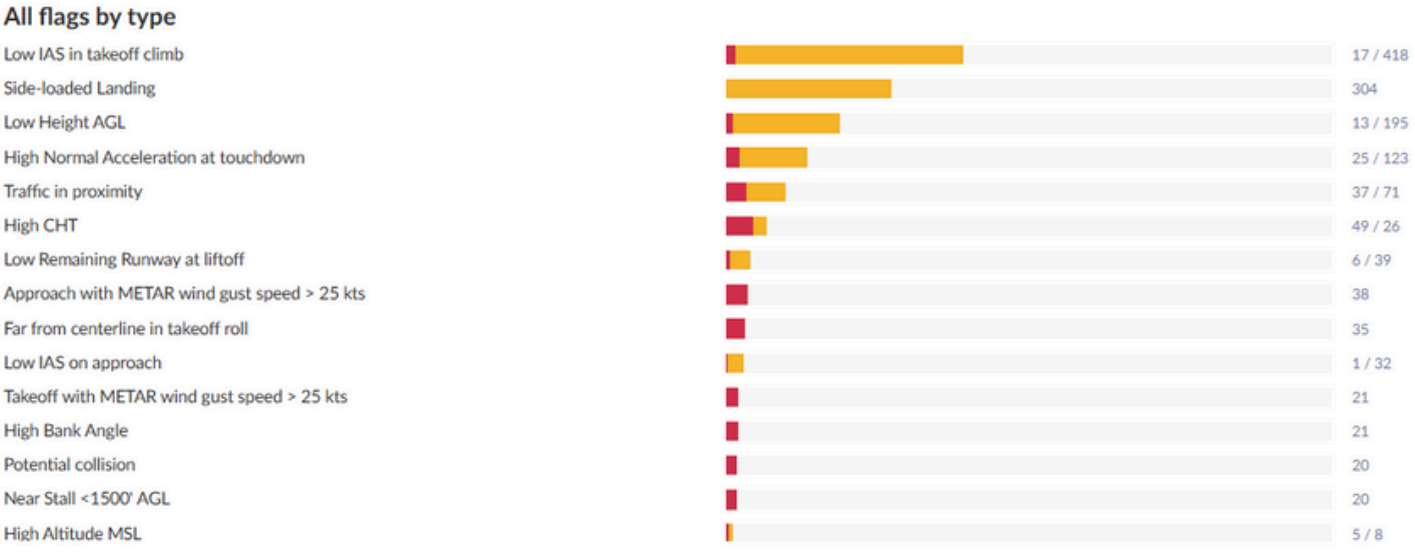
SAFETY PERFORMANCE DATA

A total of **103 reports** have been received since the beginning of the **2025 Summer Semester** compared to **68 reports** during the 2024 summer semester!

CATEGORIZED REPORTS MAY-JULY 2025



FLIGHT DATA EVENTS SUMMER 2025



GIVE BACK AND INVITE IN

JUST A REMINDER...

WHEN SHOULD I SUBMIT A SAFETY REPORT?

We depend on your feedback to continuously improve the safety of our operations!

Safety reports are designed to capture **hazards, concerns, and recommendations** from those participating in the Department's operations.

Safety Reports are **confidential** by default, meaning identifying information included in the report will only be visible to the Safety Department.

There is also an option to make a Safety Report **anonymous**, meaning all identifying information is completely removed from the report.

WHAT'S AN IROP?

Irregular Operation Reports (IROPs) are used to notify the Department's management team of significant events and to gather data as part of the investigation process.

IROPs must be submitted in response to the events listed below:

1. Any event reportable under 49 CFR 830 (involving MTSU or non-MTSU aircraft);
2. Damage events;
3. Propeller Strike;
4. Tail Strike;
5. Wildlife Strike;
6. Runway or taxiway excursions (at least one wheel leaving the pavement);
7. Potential regulatory violation;
8. Potential violation of Department policy;
9. Off airport landing;
10. Aborted takeoff at a towered airport;
11. Declared emergency or minimum fuel;
12. Partial or total engine failure at any point after initial departure;
13. Personal injury/illness; and
14. Other events, upon request.

SUBMIT A SAFETY REPORT

SUMMER 2025 REPORT SUMMARIES

The following report summaries have been redacted and reworded to preserve submitter confidentiality.

*The Department of Aerospace is committed to maintaining a **positive safety culture**, one in which error is seen as inevitable and admission of errors results in productive dialogue and learning opportunities for all. Some of the report summaries below include errors in checklist usage, policy compliance issues, and procedural deviations. Report submitters range in age and experience level from student pilots to senior management. The hazardous attitude of invulnerability may lead us to believe that we are incapable of making the same mistakes, but please fight complacency and diligently adhere to the policies and procedures designed with your safety in mind.*

- A DA-40 crew was holding short to takeoff and left the canopy in position 2, with plans to shut it prior to takeoff. Due to high traffic and a short window to takeoff, the reporting crew forgot to the close the canopy and didn't realize until after takeoff. The canopy was later shut and the door warning annunciation ceased.
- A reporting crew began their taxi from the ramp to the active runway and accidentally taxied onto a closed taxiway. The crew realized it was closed and turned around to exit the closed taxiway.

Keep up your situational awareness, even at familiar airports

- A PA-44 crew extended the flaps at ~114kts (about 3kts above Vfe)
- During a landings flight in a DA-40, the student was struggling with crosswind landings. On one of the landings the aircraft was landed ~30 feet from centerline.
- During a commercial mission, the reporting crew climbed above 14,000ft without appropriate oxygen source.

§91.211 Supplemental Oxygen

- During a PA-44 simulated one engine inoperative (OEI) after takeoff, the aircraft descended below 400 ft AGL (minimum altitude for OEI operations. Crew identified factor as decreased performance due to temperatures.
- Reporting crew experienced the oil door cover opening during a practice instrument approach. The crew landed and secured the door.
- A DA-40 struck a small coyote while landing. The crew was able to maintain aircraft control and exit the runway.
- PA-44 crew noticed a hole on right engine cowling during a postflight inspection. The flight was normal, and there were no indications of engine issues.

This is why post-flight inspections are so important!

REPORT SUMMARIES CONT'D...

- A DA-40 crew was holding short to takeoff they left the canopy in position 2, with plans to shut it prior to takeoff. Due to high traffic and a short window to takeoff, the reporting crew forgot the close the canopy and didn't realize until after takeoff. The canopy was later shut and the door warning annunciation ceased.

- A community member reported having been cut off in the traffic pattern multiple times by Blue Raider aircraft on practice instrument approaches.

Advisory Circular 90-66B & AIM 4-1-9 discuss VFR traffic priority over IAP traffic

- The reporter identified high traffic in the traffic pattern due to lower clouds. Reporting crew executed an alternate missed approach as a means to avoid traffic.

- Prior to a nighttime solo, an instructor briefed with the student about using position lights for start up instead of using the strobe. While watching the student start up, the instructor realized the student started with no lights. There were attempts to contact the student; however, no contact was made.

§91.209 Aircraft lights

- While setting up for a steep spiral, a DA-40 crew noticed another aircraft 3-5 miles from their location. While in the steep turn the crew encountered this aircraft within about 500' and 2nm. The crew kept this aircraft in sight. When the crew debriefed they discussed waiting until an aircraft passes to start the maneuver.

- A reporting crew began their taxi from the ramp to the active runway and accidentally taxied onto a closed taxiway. The crew realized it was closed and turned around to exit the closed taxiway.

Keep up your situational awareness, even at familiar airports

Ongoing participation in the safety reporting system continues to enhance our overall approach to risk management and operational awareness. Each report—whether big or small—contributes to a more informed, resilient, and robust Safety Management System (SMS). By sharing your experiences, you help ensure that we all learn, adapt, and continue to improve our operational safety.

Please continue to submit reports whenever you encounter something unusual, concerning, or worth learning from. Your voice matters, and your commitment helps keep our skies, and each other, safe!