CHIRP FEEDBACK

Issue No: 104 4/2012

COMMENTS

'More is Better' (FB102) - An ATCO View

Report Text: I am an air traffic controller and would like to add to the comments in response to the item 'More is Better' published in FEEDBACK Issue 102.

Please can you publicise the fact that the practice of 'splitting clearances' by controllers is not new; it is necessary if the transmission contains mandatory readback items. These cannot be passed to pilots with a frequency change as it is imperative that we receive confirmation of heading/level etc., before instructing the aircraft to change frequency. It is nothing to do with us doubting pilots' ability to 'cope with' two pieces of information, but as someone who has worked as a radar controller for over 10 years I would not even consider giving a heading/level instruction and a frequency change in the same transmission. The outcomes of this can all too often be: an incorrect readback followed by a frequency change (not good), or just, 'Roger' followed by a frequency change (not good), or perhaps something like, 'Seeya'...

In busy environments such as this it is absolutely imperative that we as controllers listen and ensure the readback is correct and we would be remiss if we allowed the pilot to leave the frequency without doing so. I am sure that the potential consequences of a pilot being between frequencies or perhaps even going to an incorrect frequency whilst climbing/ descending to an incorrect level don't require explanation.

Similarly, when vacating the runway, depending on the instruction issued it may also be necessary to split the transmission whilst receiving a safety critical readback from the first part of the message. Also, controllers operating at airports with high intensity runway operations may need to retain aircraft on the tower frequency to ensure that instructions are carried out as required or in case the need to 'expedite' arises. The transfer of frequency is not necessarily the highest priority at this point and it may be prudent for the tower controller to be fully in control and in communication with both an aircraft on the runway vacating and one on short final for example.

The reporter also commented that particularly at their home base they can cope with multiple instructions on the ground. It is not always possible for controllers to know who is operating at their home base as even home based airlines often have non-home based crew, who report that they are unfamiliar with an airfield.

In summary, this practice is not 'needless', it has been derived from safety 'best practice' and the only way we can ensure we receive the mandatory readback items correctly is to not pass a frequency change at the same time. I do agree, however, that a pause between the two transmissions would be a better practice as far as the pilots are concerned, and this is something I do try to carry out myself but sadly in the highly R/T intensive environments this is not always practicable.

Incidentally, regarding the CHIRP comment; I had always believed our policy to be that of issuing up to three instructions and CHIRP mentions is as just two? Clearly it would depend on the complexity of the instruction etc., but certainly issuing heading, level, speed in one transmission is not uncommon.

Maybe it would be useful to publish the list of MATS 1 mandatory readbacks in a future edition just for the pilots' information?

CHIRP Comment: **This comment is correct regarding the recommended maximum number of instructions that may be issued. MATS Part 1 states that a single message may contain a maximum of three not two phrases, as we quoted incorrectly in the last issue [Appendix 'E'; Para 3.1.1 j)].**

The importance of correct readbacks cannot be overemphasised; incorrect readbacks have been a significant causal factor in Level Bust/Airprox incidents.

MATS Part 1; Appendix 'E'; Para 5 - Mandatory Readbacks:

5.3 Pilot/Driver Read-Back of RTF Messages

5.3.1 Pilots/drivers are required to read-back in full messages containing any of the following items:

- **Taxi/towing instructions;**
- **Level instructions;**
- **Heading instructions;**
- **Speed instructions;**
- **Airways or route clearances;**
- **Approach clearances;**
- **Runway-in-use;**
- **Clearance to enter, land on, take-off, backtrack, cross or hold short of any active runway;**
- **SSR operating instructions;**
- **Altimeter settings;**
- **VDF information;**
- **Frequency changes;**
- **Type of ATS;**
- **Transition levels.**

'More is Better' (FB102) - A Flight Crew Comment

Report Text: In reference to the points made in "More Is Better" - Issue 102, I strongly disagree with the reporter's statement that "most licensed commercial pilots could cope with being told to descend to FL90 and call ###.### in a single transmission". Whether a pilot could cope with this or not, it has the potential for a

mis-set altitude/flight level. I concentrate hard on the ALT/FL spoken by ATC and often have to ask for the radio frequency to be repeated, especially now that we have six-digit frequencies; though this problem only occurs in foreign airspace, as UK controllers do not combine the two instructions.

This leads me on to the reporter's second paragraph, which is an excellent observation and quite correct that UK controllers issuing two instructions in quick succession disrupts our flight deck actions. A recent example: Descending into XXX to FL70 we were then asked by Approach/Radar to descend to 5,000 feet QNH 1005. Immediately after reading this back and before we could confirm with each other the change to QNH the controller then gave us a frequency change to call Director on ###.###. Changing from 1013/Standard to QNH is very important and flight safety requires that both pilots reset their altimeters and cross-check with each other the new altitude and also that the QNH is set and cross-checked. In our company this also triggers the APPROACH CHECKLIST which only contains one item! - ALTIMETERS. It is easy to be distracted during this part of flight, which is arguably the highest workload of the entire flight, with cabin crew calls, icing considerations, speed, distance and flap settings all coming at once. It can be seen that with ATC interrupting our safety cross-checks there is the potential for a miss-set altimeter or altitude window. This problem happens on a regular basis by most of the different controllers at XXX and it always frustrates me as I know this is a safety hazard waiting to cause an accident.

Lessons Learned: I appreciate that it is a good safety feature in the UK that a climb or descent clearance and frequency change are separate ATC transmissions, (unlike the previous reporter). To solve my second issue above the two transmissions need to be separated by a minimum of 10 seconds (preferably 15 seconds); this will allow all cross-checking of altimeters to be completed prior to the next piece of R/T. I appreciate that this will add slightly to the controller's workload; however it should not present ATC with a major problem, particularly at XXX as Approach and Director are physically sitting next to each other!

Think of the massive increase in flight safety for this relatively small inconvenience.

CHIRP Comment: **The mental ability to remember and recall a six-digit VHF frequency in conjunction with other information is another reason why the frequency change instruction should be given separately.**

It is also relevant to note that whilst a pause of 10-15 seconds between the two instructions assists flight crew, it can increase the opportunity for an ATCO to forget to issue the second instruction if distracted; thus to do so might not always be possible.

INSTRUMENT APPROACHES IN CLASS 'G' AIRSPACE - AN ATC PERSPECTIVE

Report Text: The report from a pilot on the problems of instrument approaches in Class G airspace (FEEDBACK Issue 103) describes the situation that can occur at an aerodrome without radar. Where the ATC Unit has radar, it is even more apparent that so many pilots, who transit or even manoeuvre within such airspace, do not appreciate the hazard and workload that they are creating for themselves and others.

I say this from the perspective of providing air traffic services including Lower Airspace Radar Service at a unit in Class G airspace. The aerodrome operates regular IFR flights, including instrument training, by such diverse types as helicopters of all sizes, twin and multi-propeller aircraft, twin jets, and on occasions, large jet aircraft.

Unknown aircraft flying near or through final approach between five and ten miles from touchdown, frequently around 1,500 or 2,000 feet, are a daily occurrence; some do not contact ATC at all, others do so only after having flown through the final approach path, and some are often not transponding on mode C even when they have the capability. Many pilots frequently manoeuvre and change level with no appreciation of the types of aircraft and instrument procedures applicable at such aerodromes. When vectoring inbound traffic under a Deconfliction Service, this puts a considerable workload on the radar controller and can result in a delay by having to apply either five miles or 3,000 feet separation minimum – while still effecting a satisfactory ILS interception. Any such delay means, of course, extending the time operating in the Class G airspace with the attendant risk of further confliction with other unknown traffic. Even with inbound traffic under "only" a Traffic Service, the controller has to call the traffic information as well as vector the aircraft in an acceptably safe fashion – equally undesirable in the intermediate and final approach phases.

As the CHIRP comment noted, to alert transit pilots to the situation, there are the chevron/cone symbols (extending to only 5 nm final) and a footnote on the charts (where nobody will read it). Both measures are entirely inadequate to address this safety issue but unfortunately it does not fall in the spotlight because any close encounters, unlike similar incidents within controlled airspace, are invariably dismissed as being "lack of adequate look-out by the pilots" or merely "a confliction in Class G airspace".

I would suggest that what is required at such aerodromes is either a Class E (at the very least) control zone or an enlarged Aerodrome Traffic Zone plus an "Aerodrome Traffic Area" to provide airspace delineation similar to, but slightly larger than, that of a MATZ.

CHIRP Comment: **This and the following report reflect the diverse views expressed on operations in Class G airspace.**

It is worth noting that in 2011 a total of 18 incidents reported to the Airprox Board involved an aircraft undertaking instrument flying training in Class 'G' airspace. Eight of these were assessed as 'Risk bearing' and six were assigned a Risk Category 'A' (high risk of collision), but none involved commercial air transport aircraft.

One common factor identified in a number of Airprox investigations is a lack of appreciation among commercial flight crew of the classification of the airspace in which they are operating and, consequently, their responsibilities. This information is not displayed

on many current electronic flight displays and, as in many cases flight crews are remote from the flight planning process, this information may not be readily available to flight crew. (As an example, does your company's instrument approach plate to an airfield outside Controlled Airspace contain a reminder that it is Class 'G'?).

Some operators have introduced a SOP whereby transitioning to Class 'G' airspace is briefed as a specific event; this includes highlighting the increased importance of maintaining an effective lookout scan.

As regards airspace classification changes, the National policy on airspace re-classification is the responsibility of CAA Directorate of Airspace Policy (DAP). The current policy requires an airport authority to submit a formal proposal for a change in airspace classification in the vicinity of the aerodrome, which is then subject to a consultation process.

Instrument Approaches in Class G Airspace (FB 103) - A GA Perspective

Report Text: Did I detect a hint of superior entitlement in the report titled 'Instrument Approaches in Class G Airspace'? Does anyone undertaking "ordinary" flying have no business crossing the instrument approach path? Well sorry, but what might be desired and what is required by regulation are two different things!

If it's Class G, everyone has a right to be there. The watchword is "watch out"! Surely anyone flying in good VMC in open FIR who has their head buried in their instrument panel on an instrument approach is the one displaying poor airmanship? Your reporter had a student with him, so hopefully someone was keeping watch outside the cockpit.

What perhaps needs to be understood is that a lot of GA takes place between 1,500ft - for terrain clearance - and 2,500ft - to remain below our customary cloud base.

Many VFR pilots put in a call to any significant airfield passed en route, so they become known traffic; or as a minimum maintain a listening watch for other traffic. But if already talking to another, larger ATC, would one go to the trouble of switching to the local airfield frequency to pass by, before switching back? Possibly not. In any case, it is not a requirement for pilots to have a radio in the open FIR, let alone use it.

No, heads in cockpits in Class G and VMC is a bad idea!

CHIRP Comment: This comment expresses the opposite viewpoint to that in the report published in FEEDBACK Issue 103 and contrasts with that in the previous comment.

Many close encounters in Class G airspace could have been avoided by both parties being more aware of the possibility of a close encounter and accepting responsibility for managing the situation.

Whilst everyone has a responsibility to comply with the Rules of the Air, restoring a degree of old fashioned courtesy among airmen would greatly assist in such situations. Whereas a pilot might have the right to cross a published instrument approach path, if it is not a significant inconvenience to make a small track correction to avoid, why not do it? Similarly, conducting instrument approach training in Class G requires an acknowledgement that a good lookout must be maintained and avoiding action might be necessary against other aircraft.

ENGINEER REPORTS

Quality Audits

Report Text: The standard of quality audits regarding Part 145, Part M, Part 147 and Part 21 has deteriorated at #### due to a lack of staff and resources. I know personally that the work is not being completed to the correct standard; it is token lip service to the regulation requirements. Just enough is being completed to meet the requirements and this is not completed to the required standard. Not enough time is allowed to do the job correctly. I am concerned that major issues will be overlooked that will become contributory elements of a major accident.

A new policy is also now in place to train EU-OPS auditors to audit in the Part 145, Part M, Part 21 and Part 147 areas. These individuals do not have the aircraft maintenance or engineer licence background and experience to support them in these areas; this takes many years of working in the areas to understand. I myself have been involved in this training of EU-OPS auditors in the engineering areas of base and line maintenance and spend a lot of time just keeping them safe. As a Licensed engineer, I have serious concerns that so much is going unnoticed because of how the Quality Department is being managed and the standards presently adopted in the department.

The Quality Department should be more focused on aircraft maintenance issues but they are clearly not. As much as I hate to say it, my own work has deteriorated because I do not have the time available to do a good job; I have to cut corners so that I can do the next task. I personally hope the CAA start to probe deeper within the #### Quality Department to enable them to see what is really going on and being hidden. The airline has insufficient Quality engineers and they are also conducting EU-OPS audits, security, health & safety, environmental management audits, with less and less focus on the engineering areas.

I have on numerous occasions tried to raise my concerns with the management, but all my concerns are ignored or ridiculed and fall on deaf ears. I have now reached a point where I feel I can no longer ignore the issues, so I am raising them here. As a Licensed engineer I feel it's my responsibility to make this known before it's too late and an accident has occurred.

Lessons Learned: Perhaps the #### Quality dept could be audited in depth by the CAA to establish what is occurring.

CHIRP Comment: Part 145 requires that QA auditors must have the relevant experience and background knowledge to undertake audits.

The reporter's concerns were referred to the Chief Surveyor CAA (SRG). The CAA subsequently advised that a shortfall of audit resources had been identified

following a reorganisation but this had been resolved by the company.

A recent CAA audit of the Part M quality system had not revealed any significant shortcomings. Oversight of the Part 147 quality system had identified some issues that had been addressed subsequently by the company but these had not been in areas raised by the reporter.

A further CAA audit of the Part 145 procedures is planned; the focus of this will be adjusted to look more closely at the concerns raised by the reporter.

Scope of Line Maintenance

Report Text: Whilst the company business has increased with new management making changes for the better, animosities between the hangar and line have created an "us and them" attitude. In our eyes this has led to certain hangar type maintenance to be carried out on the line of an active airport in some of the UK's worst weather conditions. The scope of line maintenance appears to be stretched beyond the norm and as such what we would class as hangar maintenance appears to be happening on the line for the scope of work to be carried out. As instructed per the AMM certain tasks are required to be carried out in a "controlled environment"; however, this is being ignored by management when challenged by employees.

It is becoming common practice at AAA (UK regional airport) for the company to carry out some defect rectification tasks, including fuel tank and engine maintenance that in our eyes should be carried out in a controlled environment as instructed by the AMM. The potential is there for a serious incident and must be addressed.

Lessons Learned: Management must ensure maintenance is carried out within the scope of their approvals.

CHIRP Comment: Whereas some specific tasks such as fuel tank inspections require a controlled hangar environment, the situation regarding the completion of other unscheduled maintenance tasks in a ramp environment depends on the nature of the task.

A risk assessment should be undertaken to determine whether it is viable to undertake a specific task on the ramp. If it is, then it is important to ensure that engineers on the ramp are trained and capable of undertaking the task. Although an engineer may be experienced to carry out line maintenance, they may not possess the necessary competence or recency to carry out tasks not normally associated with routine line maintenance activity.

The reporter's concerns were referred to the Chief Surveyor CAA (SRG). The CAA subsequently advised that an in-depth review of CAA audit findings/non-compliances over a ten-year period had been undertaken and had included the organisation in question; the results had been shared with industry in June 2012. The organisation had acknowledged the review findings and the compliance issues identified were resolved to the CAA's satisfaction. The CAA did not recognise the reporter's 'them and us' assertion and had not observed the line maintenance practices described. However, the relevant CAA personnel have been apprised of the reporter's allegations and will include these in their future oversight of the organisation.

ATC REPORTS

Sickness Absence Policy

Report Text: I have just read issue 103 of CHIRP. On page 3 "sickness absence policy" the contributor states that they must;

1. Call in everyday you are sick, whether you were due in or not.

I thought it might be helpful to bring their employer's attention to the Direct Gov website:

http://www.direct.gov.uk/en/MoneyTaxAndBenefits/BenefitsTaxCreditsAndOtherSupport/Illorinjured/DG_175850 which states:

Telling your employer you are sick

If your employer does not have their own rules, you should tell your employer within seven days of the first day that you are sick. However, your employer cannot insist that you tell them:

1. **In person**
2. **Earlier than the first qualifying day or by a set time**
3. **On a special form**
4. **On a doctor's statement of fitness for work (fit note), which was previously called a medical certificate or sick note**
5. **More than once a week during your sickness**

Staffing Pressures

Report Text: The management and running of this Unit has dropped to what can only be described as below an acceptable level in terms of safety. There are varied opinions on how this situation was reached; the important point is that the issues are known and safety concerns addressed by senior management without delay.

Staff levels have reduced over a period of a few years until we have reached the current situation where almost every shift operates with less than the recommended staff and support services are not provided by staff experienced in the role. Staff are working to their SRATCOH (The Scheme for Regulation of the Hours of Civil ATCOs in the UK) limits each and every shift. As a short-term measure this is manageable; however, controllers believe that continually working to this limit over a sustained period of time is taking its toll on their health, with high sickness rates adding to the staff shortages and the shift pattern worked believed by many to be causing problems. Many staff sense that there are underlying pressures to combine sectors and work more aircraft than they would have previously to ensure there are no SRATCOH busts. This is not direct pressure, but the fact that everyone is aware of the staff shortages. I believe such instances and SRATCOH busts of a few minutes are not reported as there is limited time for staff to

complete anything other than mandated reports and essential extraneous duties.

The ideal is to complete a practical check every quarter, where the Unit Competency Examiner (UCE) observes the controller operating; this is being carried out perhaps twice a year (once is the minimum) and is increasingly occurring during lighter traffic as there is absolutely no capacity to complete the task during busier times. Day-to-day observations, which are designed to look at the operating techniques in a bid to improve safety before an incident occurs, are not being completed.

No experienced support services (Procedures, Investigations, Safety) are available. Those who undertake these tasks do so without the specialist knowledge that is required for what is a unique environment. Procedures are published, only to be re-issued a few days later with an amendment, leading to a great deal of confusion for those that need to know, the operational staff. The Manual of Air Traffic Services for the Unit contains many inaccuracies and conflicting information; this has been highlighted, but, it appears, there is no pressing urgency (or perhaps resource) to correct it. With the subtleties found in the environment in which my colleagues and I operate, the full extent of the issues highlighted in reports to Investigations and Safety aren't always easily identified by those without specialist knowledge.

Another aspect negatively impacted by the staffing shortage is the loss of operational staff testing systems prior to the introduction of major projects. This leads to aspects that might have been highlighted in testing being highlighted in the live environment.

The individuals taking a lot of the pressure are the supervisors, who are filling the gaps left by the shortage; this means that their actual task list does not get completed or is rushed. Furthermore, previously the supervisors had an experienced assistant who had their own tasks; this position has been removed. Although these tasks have been reassigned to other assistants, some critical tasks required specialist training and knowledge which has not been trained to anyone else. The supervisors are struggling to use what knowledge they have in these support tasks to ensure that the operation remains safe.

This report highlights many different areas that can have a potential safety impact on the environment in which we operate; individually they may be manageable, or for a short period of time, but all together and for a sustained period there is a definite risk to the safety of the operation. The professionalism of the operational staff ensure that they will continue to provide an outstanding service, under increasing pressure although a fear exists as to how far this pressure will be allowed to go. A plan is in place to train more trainees in the Unit's operations, but that will bring more challenges with no dedicated training staff. Resource to provide this training will be required from the operational environment and controllers realise that they will have two more busy summers to survive with current staffing before any new staff can be introduced. The situation with the support services cannot be allowed to degrade further during this period.

CHIRP Comment: The two principal issues raised in this report were referred to the operational management.

The management response noted that the issues raised in the report were all known, had been notified to the CAA and were the subject of ongoing discussions with both staff and CAA (SRG).

In relation to staffing levels, the numbers matched those agreed with employee representatives; it was acknowledged that sickness had adversely impacted the number of operational staff available. As regards support staff, the Unit policy was to consolidate support functions; additional training for support staff was scheduled to be conducted towards the end of this year.

In subsequent discussions, it was apparent that some concerns related to staffing and support capabilities remained in spite of the ongoing discussions; these were represented to the Head Aerodrome and Air Traffic Standards CAA (SRG) directly. The following CAA response was subsequently received:

The CAA is aware from its ongoing safety regulatory oversight of the current constraints on staffing within this Unit and the broader impact that this could have on future service delivery and is content plans to train additional controllers are in place.

The CAA is also aware of some issues regarding the production of the Unit's Manual of Air Traffic Service and the management's plans for improvement. The CAA will continue to monitor the effectiveness of planned developments.

The CAA encourages controllers to report all SRATCOH 'busts' so that they can be assessed and appropriate action can be taken.

OPERATIONAL CONCERNS

Report Text: I have concerns regarding the fitness of my employer to act as an ANSP. As ATCOs we are put under a ridiculous amount of commercial pressure with no due regard to safety. I feel compelled to report through CHIRP as I am quite sure that if I was identified I would without doubt be sacked.

Several recent instances have caused me concern:-

1. The manager regularly elects to work beyond the maximum duty periods permitted by the Scheme for Regulation of the Hours of Civil ATCOs in the UK (SRATCOH), does not have the minimum required rest and takes very few days off. On one recent occasion, the manager opened the watch at 0630L, was present all day to give breaks/attend meetings and then undertook the final duty to close the watch at 2230L - a total duty period of 16 hours.

2. In preparation for an expanded operation the Approach Control function (APP) was relocated from Visual Control (VCR) to a separate room. This required there to be an assistant present in both rooms as the Flight Progress Strips are hand written and telephone co-ordination was very long winded and extensive. However, there are insufficient assistants employed to allow the APP assistant position to be manned most of the time. As traffic levels have increased, several ATCO colleagues deemed APP unsafe to operate without an

assistant and took the only course of action available which to operate from the VCR utilising the VCR assistant) and apply appropriate restrictions to training traffic to prevent an overload.

The management response was to issue a memo stating that we were to operate APP from the GMC position in the VCR. This position has no DF, no standby radio for the APP frequency (the memo stated we could use the handheld ICOM [handheld transceiver] in the event of RT failure, which I suspect is not an acceptable means of compliance) and the VCR assistant is too busy with VCR tasks to be of use to the APP ATCO (and is seated too far away to effectively communicate with). Furthermore some of the recently validated staff have not been trained or validated working APP from the VCR. Additionally no safety case or change process was carried out to ensure that the SMS was complied with. It later transpired that the senior airport management had threatened to sack all the ATC staff if we refused to operate from this position and accept normal traffic levels.

3. More worryingly a controller was recently threatened with disciplinary action by the airport manager for refusing training traffic when he felt that the traffic loading (he had to operate bandboxed [combined] RTF frequencies) was becoming too high. This is unacceptable. As a result none of us feel able to refuse any traffic. Personally, I have found myself overloaded on a number of occasions yet I feel I cannot file a report or take any action to prevent a re-occurrence for fear of disciplinary action.

4. We are expected to exceed the SRATCOH duty limits every late shift by 30 mins. The manager states that we have an exemption in place but this has never been seen by anyone on the unit nor is it reflected in any of the documents.

The unit is staffed by extremely competent and professional ATCOs who are doing their best in a very busy environment. The airport has expanded and is now having to integrate a large number of high performance jets and turbo-props with light singles and twins. There is no flow control and very few checks and balances to ensure that safety margins are not eroded. The only filter that is providing a safety net are the ATCOs but these are the very people who are constantly being pressured into being "less" safe in the interests of commerce.

We feel that unless regulatory action is taken to enforce a "safety first" culture (and I mean a genuine culture not just paying lip service to the words) within the airport management it is only a matter of time before there are one or more major incidents/accidents.

CHIRP Comment: **The reporter's concerns were referred to the Head Aerodrome and Air Traffic Standards Department CAA (SRG) and subsequently reviewed. The following summarises the CAA findings:**

1. The Unit management has been reminded of the need for compliance with SRATCOH, and that any instances of SRATCOH 'busts' must be reported to SRG.

2. The relocation of the Approach Control (APP) function does involve a significant increase in co-ordination between the Aerodrome controller (ADC) and the APP position. The Unit management acknowledges the need for an additional assistant to support the relocated Approach Control function and has been seeking approval for several months without success. Operating APP and ADC from the VCR removes the need for much of the telephone co-ordination, and the controllers have been able to assist each other, as they have done for many years without incident or concern. The management have been formally advised of the need for additional Air Traffic Assistant resource and that failure to provide this represents a significant risk to the successful completion of the project to expand the Unit's capability.

The use of ICOM handheld transceivers as emergency VHF communications is undesirable in respect of approach services; however, this is not non-compliant and the Unit is able to undertake a controlled closure of any service affected by system failure using the current level of equipment. The CAA will continue to work with the Unit to ensure that establishment of improved emergency VHF equipment takes place.

3. The threat of disciplinary action issued by the airport manager had been followed up by the Unit management; the controller's actions had been endorsed and any suggestion of disciplinary action had been refuted. The airport manager had accepted this. The Unit management has been formally reminded that the ultimate decision as to what is an acceptably safe level of service will rest with the ATCO(s) on duty at the time and will be supported by the CAA; the Unit management's attention has also been drawn to the provisions of MATS Part 1; Section 8; Chapter 1; Para 7 regarding visitor access to a control room.

4. The Unit management has been notified that no SRATCOH modifications have been agreed by the CAA, and that any request for a modification would be unlikely to be accepted in the light of the increase in activity at the airport.

In the opinion of ATSD, an appropriate safety culture does exist within the Unit.

FLIGHT CREW REPORTS

STOP-BARS, GREEN LIGHTS AND TAXI CLEARANCES

Report Text: I have been reading Feedback for many years now and have enjoyed the numerous reports from flight crew, cabin crew and engineering colleagues, so congratulations on keeping us all informed and updated on safety-related matters.

I thought it might be my turn to send in a report as I have noticed a discrepancy at my airport for which there thus far has not been a satisfactory explanation. Perhaps you would be able to find one? I am sure you will de-identify the correct bits and edit accordingly, so here goes:

When "following the greens and stopping at the reds" during night procedures at ZZZ, I have noticed that the red stop bars are invariably illuminated some distance beyond the relevant marker at the ATC clearance limit (CAT III holding point) with green taxi lights inviting continuation of the taxi beyond the cleared limit. On one occasion in the past, while taxiing to the holding

point of the active runway at night, the Captain was proceeding at a normal speed with the intention of stopping at the red stop bar ahead. I noticed, however, that we were only several metres from the #### (CAT III) marker and informed him of this, as this had been our taxi clearance from the ground controller. He had to brake hard to avoid overshooting the marker and a subsequent call from the Senior Cabin Crew Member informed us that he had been slammed into the forward bulkhead while preparing the galley for take-off and had suffered a minor injury.

We asked ATC why this discrepancy between the airfield lighting and the ATC R/T clearance existed and some answer about the lighting system authority of the ground and tower controllers was mentioned.

This seems unusual since each clearance limit has a set of red lights associated with it which could be switched on somehow by someone.

I do not recall what the situation is during Low Visibility Procedures (LVPs) as there haven't been many for a while but the potential for more serious accidents exists if this mismatch still occurs then. Would it be possible to obtain a more detailed answer from the ZZZ airport/air traffic authorities as to why this misalignment is in place?

CHIRP Comment: **The situation described was referred to the Air Traffic Services Unit (ATSU) management.**

In their response, it was explained that the runway holding area is the boundary between the Ground and Aerodrome controller's responsibility. The most probable reason that a red stop-bar had not been lit at the Cat III holding point was that a sequence of green lights had been selected by the Aerodrome controller for the previous aircraft in the departure sequence. This situation could occur as a result of the method of controlling the airfield ground lighting in the holding area.

The ATSU response acknowledged that the reporter had raised an important Human Factors issue, this being whether, when 'Following the Greens' to a clearance limit, a pilot expects that a red stop-bar will be displayed at the clearance limit or not. The Unit management emphasised that it is important to remember that the clearance limit issued by ATC is the clearance limit; the fact that green lights are illuminated beyond the clearance limit or that a stop-bar can be seen in the distance does not over-ride the clearance limit issued by ATC.

Following discussions with a number of pilots, it became apparent that the situation described in this report had been discussed previously with the ATSU management at a local level.

Interestingly, an air traffic report on the same topic was subsequently received. This suggested that a practice had become common among some controllers at this ATSU whereby a 'workaround' procedure was used to avoid the selection procedure on the ATCO's electronic flight progress strip display for clearing an aircraft to a CAT I hold. The effect of this was that regardless of whether Low Visibility Procedures were in operation, some controllers issued a verbal ATC clearance to the CAT III runway holding point, whereas the airfield ground lighting (green taxiway lighting) was illuminated beyond the CAT III holding point to the CAT I runway holding point and the CAT I red stop-bars (closer to the runway).

From a flight crew perspective, as acknowledged above, the situation described is counterintuitive as this flight crew report clearly shows. Moreover, it would appear to be a subtle but significant difference from ICAO procedures that is not promulgated to flight crew. As such it is a classic Human Factors 'gotcha', especially for those pilots unfamiliar with the airport in question, as the CAT I and CAT III designators are similar.

Preventing runway incursions is one of the 'Significant Seven' safety objectives set by the CAA; this matter has been referred to the CAA for review by the Runway Incursion Working Group.

AIRPORT INFORMATION - POOR ENGLISH

Report Text: An airport information chart issued by my company's chart provider contained the following statement for a Southern European airport

Section 1.3.2 GROUND MOVEMENT: "Pilots will proceed to verify in every moment the ACFT position, especially in intersections, making sure that the taxiing is being executed under total safety conditions. In case of being disoriented or in doubt, pilots will stop the ACFT, notify to ATC immediately and request the assistance of a Follow-me car. Pilots will be responsible for maintaining the appropriate separation between ACFT and Follow-me car."

The standard of English here is not perfect; it could be better. I can understand what is being stated but can anyone be sure that aircrew whose native language is not English would reach the same conclusion?

Someone employed by the chart provider typed the statement above for input into their airport information database. Did they not think to make a recommendation that the paragraph could be rewritten to a better standard? How can it be that a chart provider can issue information relating to the operation of aircraft that is not written correctly?

Why do chart providers not employ a procedure that seeks to correct information that could be deemed to be incorrect? In this example we, as native English speakers, can see through the quirkiness and understand what is meant without too much trouble. Would someone, whose standard of English is only basic, understand the same as we do? It should not be like this.

There are similar examples at other destinations, principally in Southern Europe. Why can they not employ someone (a pilot) whose native language is English and who can therefore ensure a proper translation?

One day they will incorrectly translate something that is important, nobody will suggest an improvement and a mistake may happen - perhaps with consequences.

CHIRP Comment: **The information used by chart providers is sourced from airport authorities and National Aviation Authorities. It is not reasonable to expect chart providers to interpret information so provided. The Aeronautical Information Package (AIP)**

published by some Southern European States contain English entries in addition to the national language; in such cases the chart provider will reproduce the relevant English entry. Any errors or difficulties should be reported by raising an ASR/MOR and represented to the appropriate airport or National authority

ADVERSE WEATHER OPERATIONS

This report was received towards the end of last winter:

Report Text: Weather (European airport): Snow falling with sub-zero temperature.

I was positioning as a passenger on a flight operated by a non-UK EU operator. After push back the pilots cycled the flaps full down, selected the take-off flap setting as per normal procedure and taxied in this configuration to the de-/anti-icing bay.

Before the de-/anti-icing procedure started roughly 10 minutes had gone by because we had to wait for our turn. The crew retracted the flaps to up just before the de-icing started. However, the flaps had already accumulated a considerable amount of snow on them; by retracting them the crew hid them under the wings. After the application of the de-icing fluid the take-off flap setting was selected again. Unfortunately the flaps were still considerably contaminated.

The crew taxied to the holding point in the take-off configuration; therefore, the contamination got worse. We subsequently took off with a beautiful layer of snow on the flaps.

Lessons Learned: Being a pilot rated on the same aircraft type, the procedure followed was not even close to what the aircraft manufacturer recommends. If this operator does not have a clean wing policy in place, it should adopt one. The manufacturer's advice is to taxi on contaminated taxiways with the flaps up and after the de-/anti-icing procedure to leave the flaps up until the holding point. This procedure will minimise the time the flaps will be exposed to contamination.

CHIRP Comment: **The aircraft manufacturer's recommended procedures for adverse weather operations include taxiing with wing flaps retracted when snow/slush is present and also require the crew to confirm that the wings are clear of any contamination prior to take off, except in those areas where hoar frost is permitted.**

Also, in similar conditions it might be worth reminding cabin crew to report any significant contamination they may observe to the aircraft commander.

CABIN CREW REPORTS

PILOT PRESENCE WHILST DISEMBARKING

Report Text: After pulling on stand the aircraft was being disembarked from the forward door. With approximately 40 passengers still waiting to leave the aircraft both pilots left the aircraft. This is against the company procedure for this aircraft type and seems to be happening with some frequency at my company; I feel that this needs to be reported. My understanding is if there were an incident on board pilots are needed to lower the flaps so passengers can evacuate from the overwing exits. Should an incident have occurred then no one would have been there to do this. An engineer was present but my understanding is that at least one pilot should remain on board at all times should passengers be on the plane.

CHIRP Comment: **The Commander is legally responsible for the safety of passengers at all times that he/she is on board [EU-OPS 1.085 (f)]. When he/she is not on board a company instruction/procedure should formally identify the responsible individual, such as an appropriately trained engineer. A minimum cabin crew complement is required to be present whenever there are passengers on board the aircraft.**

If, as reported, the flight crew left the aeroplane without good reason whilst passengers were still on board it would be difficult for the Commander to explain if anything untoward had occurred how he/she had carried out his/her responsibilities towards the safety of passengers and crew.

The occurrence was reported to the company. Following a review of the relevant company procedure, a clarification as to when a flight crew member is required to be present on the aircraft is to be issued.

MINIMUM CREW COMPLEMENT

The Captain wanted one of the crew to join him in the flight deck for landing. As the senior cabin crew member, I said that I wanted all the crew in their cabin positions as the cabin crew complement was the minimum crewing level for the aircraft. I also stated that although the company manual permitted one less crew member in specific circumstances that required a company report to be submitted by the captain, this wasn't an unforeseen circumstance and no report would be raised. I suggested that, as the Captain, he could overrule me but I would not agree otherwise.

I think had I not been so confident in my knowledge of the company procedures manual because of my experience, he would have gone on until I conceded my opinion. Please could you clarify if I was right to stand my ground in that minimum crew means minimum crew in the cabin, so that I can be confident if I am faced with the same dilemma again?

CHIRP Comment: **The minimum cabin crew complement specified in the Operations Manual is that required for the safety of the passengers and where only the minimum cabin crew are on board they must all be seated in their allocated seating positions. Alleviations to the minimum crew may only be permitted in specific circumstances.**

It is not clear why the Commander sought to have one of the cabin crew on the flight deck and therefore override Company procedures - this would be acceptable only in emergency or abnormal circumstances which could affect safety.

The reporter handled a difficult situation well in the interests of the safety of passengers.