CHIRP FEEDBACK

Issue No: 110 2/2014

FEEDBACK is going electronic.

It is our intention to cease producing the paper version of FEEDBACK in favour of electronic distribution, probably commencing with Issue No 112 in autumn 2014. The details have yet to be worked out but one option is to use the CAA's database of licence-holders' e-mail addresses in the same way that we currently use the list of postal addresses. Does the CAA have your current e-mail address? If not, please let them know – details of how to do this are on page 8. If you would like to receive FEEDBACK electronically before the general handover, please send your e-mail address to us at mail@chirp.co.uk

EDITORIAL

There have been several reports to CHIRP about the use of electronic media replacing traditional hard copy documents and processes. Issues include the transition process itself, inadequate training material, insufficient training opportunities and/or insufficient time allowed for training. Recent reports highlighted electronic flight bags that were introduced before they were sufficiently mature. Once electronic processes and media are in use, operators are faced with implementing procedures to ensure crews have ready access to up-to-date publications, that changes are clearly highlighted and acknowledged and old versions are deleted. It has become clear that experience is not being shared effectively across industry and each operator is innovating in isolation. CHIRP has, therefore, written to the regulator to encourage the publication of guidance on the transition to, and use of, electronic media and to seek the sharing of good practice.

Are you a conscientious reporter? Most people are when it comes to reporting incidents – but what about hazards and risks that fall short of actual incidents. Most safety management systems do not react to a single hazard report but they are better when there is a build-up of data that begins to identify trends. A single fatigue report could be the result of factors associated with the individual submitting the report on a particular occasion; multiple reports point to a broader issue. Almost no matter what the issue, changes are more likely if there is evidential data to highlight that there is a problem. You may not get a favourable response or reaction to every report, but you are adding to the data.

Cabin crew reports to CHIRP are often written by cabin crew members looking for advice and reassurance on a variety of issues. Minimum Equipment Lists (MELs) and flight crew in-flight rest policies are often raised.

- If the cabin is fitted with X fire extinguishers, why is it safe to depart when only Y are serviceable?
- Why do flight crew need to rest in-flight? Is it safe?

We answer these questions in Cabin Crew FEEDBACK whenever they come up but we are unable to send a copy to every cabin crew member in the same way that we manage for pilots, engineers and ATCOs (Cabin crew are not licenced and their contact details are not held by the CAA). I recognise that the opportunities for dialogue between flight crew and cabin crew are limited for some types of operation, and the younger cabin crew in particular can be nervous about asking questions, but if the opportunity arises do please help to reassure the cabin crew about issues such as MELs.

In the last edition of FEEDBACK I wrote about the membership of the Air Transport Advisory Board (ATAB), highlighting their role in providing advice to me in progressing reports and the providing the CHIRP comments that appear in FEEDBACK. I might also have added that the ATAB Members nominated by industry do not have access to the identity of reporters or aircraft operators. Although ATAB Members may suspect that a particular report is about their employer, CHIRP will only confirm it if the reporter agrees.

Finally, there were no reports submitted by ATCOs since the last FEEDBACK was published but I hope you will find plenty to interest you.

Ian Dugmore – Chief Executive

ENGINEERING EDITORIAL

Following on from my first introduction through CHIRP FEEDBACK, I thought it might be useful to provide some background to other initiatives that CHIRP is engaged in.

The CHIRP MEMS (Maintenance Error Management System) group meets 4 times a year to review MEDA (Maintenance Error Defect Analysis) data provided by a number of organisations. MEDA is the Human Factors (HF) based approach to investigating incidents that was developed by Boeing in the late 1980s. Use of the tools provides an opportunity for organisations to undertake a more comprehensive HF centred approach to incident investigations. The group of some 20 companies share de-identified incident data in a confidential environment to improve use of MEDA and collective learning from events.

In addition, through CHIRP, the group provide data for entry onto a common system. This allows analysis to take place with the results being shared by the CHIRP MEMS group. Given that most of the activity undertaken by the maintenance organisations is installation or component replacement related, it is no surprise that most HF errors relate to this topic. Recent trends however are showing an increase in damage related events. These are due, in part, to a lack of concentration on the part of individuals. Key activities to watch are, when opening C Ducts or cowlings, operating powered flying controls and moving equipment or aircraft.

Within the causal factors sections, a very large percentage relate to engineers not following task card or MM procedures. Similarly vigilance relating to panel close out inspections not being performed rates highly. In addition, when working as part of a team do not just assume others have completed a task, this is another risk area. If you are the certifying engineer make sure the task is done before you stamp!

The message to us all must be, irrespective of the operational pressures involved, ensure you are completing the task items as outlined in the MM or Task Cards! If in doubt go back and check again. When completing tasks or closing out panels ensure you have completed a good visual inspection prior to putting the panels back in place. Last but no means least did you check that the CB's were reset?

Bruce Hunter - Deputy Director (Engineering)

ENGINEERING REPORTS

BASE MAINTENANCE

Report Text: It came to light that there was a possibility of a lucrative overseas contract and the Accountable Manager was organising this in conjunction with the commercial team. The deployment was initially scheduled for approximately 7 days' time. The aircraft was currently on task but the time would still be sufficient to perform any required maintenance prior to deployment. Following intense pressure from the customer and the commercial team the deployment was moved forward. The decision was taken to perform the required maintenance during the deployment. I was unhappy about this but the inspection was not due immediately and I hoped the aircraft would be back by the time the inspection was due or that alternatively an extension could be applied.

During the deployment a work package was produced and I was advised it needed to be stamped prior to the aircraft's return to base. The deployment was very lucrative with potentially high losses and as the certifying engineer I was made aware of these issues. Following an argument with my colleague (also a certifying engineer) we begrudgingly stamped off the work package as completed. As the engineers on station it was difficult to contact anyone in authority at the company and we felt isolated and under a lot of pressure due to how high profile the contract was.

Notes: The check was signed as completed and backdated to the departure date from base. The aircraft returned within the check period (1 Hour remaining to the check) and was subsequently grounded by the CAA. An internal investigation has been completed by the organisation in question.

CHIRP Comment: **With proper pre deployment risk assessment, management control and planning this issue could and should have been avoided. The organisation has taken steps and improved controls to ensure this incident will not be repeated. For the individuals involved they feel strongly that others could learn from their experiences.**

When making certification statements individuals should always ensure the work has been completed, that the CRS statements reflect accurately the work that has been carried out and that dates/times used time are correct. This must apply irrespective of commercial or operational pressures.

RAMP CALLOUT PROBLEMS

Report Text: I was in the middle of a job on the aircraft in the hangar. The Controller took a call to say that there was an aircraft on the ramp with a defect that had been reported by the incoming crew but not passed on until 5 minutes prior to departure. The Controller told me to attend with the Technician. We had been in the middle of trying to prepare an Airbus to be dejacked with only 4 team members; I was acting as crane operator removing wing grip when asked to attend the aircraft on ramp so had to stop the task we were doing. There was no other certifying support on this shift.

Security was on high alert and we had to remove shoes/belt etc. adding to the potential for delay and pressure on us. In addition the passengers were already on the aircraft to reduce any delay time.

As I had gone over to the aircraft without any Maintenance Manual (MM) material, I had to resort to memory for the operating sequence on Thrust Reverse (TR) functions, I called the hangar for MM ref to lock out TRs as required by MEL to complete procedure, about 10 pages (no facilities for manual refs on ramp). Crew had advised me that the fault had cleared when I arrived at the aircraft but I did a function check anyway and the fault was still there, so I tried to do a system reset with no satisfactory result. Therefore we had to do a TR lock out to comply with MEL. Operations centre was advised of additional delay.

The technician had to return to hangar for tools/locking wire and MM refs.

Also there was no suitable licensed support as required by line maintenance bulletin for review of non-scheduled tasks. I lacked oversight of this requirement until it was brought to my attention the following day by another Licenced Aircraft Engineer. Despite speaking to 4 engineers from the operations centre, no one advised or hinted that I might need a second review and they could help. The Production Manager also admitted that he was unaware of the above requirement.

My experience level on the type was low, the equipment to perform the task was not available (lock out CB collars), there was limited availability of staff due lack of current airside passes and I was asked during the activity to look at another aircraft with a defect.

Following the aircraft's departure I reviewed the maintenance manual requirement in more detail and noticed that I had missed a stage. I recalled the aircraft from departure.

I spoke to the hangar bay production manager after the event regarding my concerns of the pressures that I had been through the previous day and over my concerns over how we were supporting the Ramp Operation.

CHIRP Comment: **The operator is reviewing the support of the line operation at this station in light of the events notified by this reporter.**

When performing tasks on aircraft where cover is held but recency is low, engineers should be extra vigilant to ensure they undertake the task in an appropriate manner using the relevant technical information.

This is a classic Human Factors event where numerous issues relating to the aircraft type, the environment, the support and equipment available can all lead to errors. These are exacerbated by the operational pressure that can build up, often unconsciously, resulting in errors that can have significant effects if undetected. The reporter is commended for reviewing the work done, recognising their error and recalling the aircraft from its departure.

FLIGHT CREW REPORTS

Downwash Awareness

Report Text: The incident occurred on a Floating Production, Storage and Offloading Platform. The helideck met the requirements of CAP 437 and was normally used by Puma helicopters until these were grounded following an accident. When a S92 landed during the course of a normal crew change, a metal cabinet located beneath the helideck had one of its doors detached due to influence of down wash from the S92 - the door fell over a hand rail to the deck below. Although the incident was reported through the company safety management system, I wonder how many people are aware of the significance of different aircraft types.

Lessons Learned: The fact that the Helideck had been inspected does not guarantee its fitness for purpose - especially if a different helicopter type is used.

CHIRP Comment: **The downwash from the S92 is considerably stronger than that from a Puma. Good practice when a permanent change of aircraft type occurs is for the crew to shut the aircraft down during its first visit to a platform in order to brief the helideck crew about the new type's specific characteristics and hazards. The Helideck Certification Agency considers the operating environment as a whole but is primarily concerned with the helideck itself. Recent changes to the training for helideck crews should improve awareness of hazards on the helideck and other areas affected by downwash. Although a safety report would routinely be shared across other operators, the report to CHIRP was forwarded to the British Helicopter Association (BHA) where it was added to the agenda for the next BHA Offshore Committee meeting to ensure that all three major operators are aware of the incident.**

ATIS

Report Text: Following the report regarding ATIS Broadcasts in the recent issue of CHIRP, I'd like to add my support for the sentiment of the author. These broadcasts are being abused and mis-used to the detriment of safety. As so often, I think the automation of such broadcasts is often to blame for some issues and 'self-protection' for others. Furthermore, because a station has the digital ATIS facility, they seem to rapidly forget that many users may still have to listen to the audio version.

The fundamental issue, so far as I am concerned, is that many ATIS broadcasts have become far too long, distracting crews from primary tasks at critical stages of flights. This is the result of:

A. Too much unnecessary supplementary information (e.g. info already NOTAM'd etc.).

B. Too much detail (e.g. as quoted before, wind variances when insignificant).

C. Too many updates (e.g. [a UK airport] now changes every 10 mins even if nothing significant alters).

I went into [US East Coast airport] the other day and the ATIS broadcast ran for 1 min 45 seconds and was full of masses of already NOTAM'd info.

Safety is being compromised in all sorts of ways to ensure [six o'clock]-covering. ATIS broadcasts are too long, NOTAMs are so trivial in most cases that the one or two important items are lost in a mass of 'junk mail'. I have no idea how but, somehow, some sense of reality has to be brought back into these types of communication.

CHIRP Comment: **We agree! Just one point, though: we have confirmed that [ ] does not change its ATIS every 10 minutes irrespective of significant changes. There are mandated criteria for what constitute significant changes to weather information. However, there is no definition of 'significant change' for other information and this compounds the problem of what is significant enough to be included in the ATIS to begin with. CE CHIRP will write to the CAA formally to express the Air Transport Advisory Board's concerns about ATIS broadcasts.**

Taxi Instructions at Night

Report Text: Although you have dis-identified the airport it is pretty obvious from the content of reports you have published previously that others have raised this potential safety issue through you already but still nothing has changed and at night time at [ ] the ground controllers continue to issue clearances along the lines of "follow the greens and hold at Echo".

Will it really take a runway incursion or worse before this intrinsically unsafe practice is stopped?

Firstly one has to ask WHY? In daylight hours, when generally the airport is busier anyway, the operation runs quite smoothly with conventional clearances. If, come darkness, two hundred little nocturnal extra aircraft came out to fly I could understand it but at the moment to me it looks like nothing more than sheer laziness!

If someone is misguided enough to think that this somehow improves safety (by reducing RT) then why not have the lights on 24 hrs and issue the same clearances in the day. I have yet to see a bright enough sun to obscure illuminated taxi lights!

The real issue is that the controllers mix and match - they say follow the greens (requires no SA) and then tell you to hold at Echo (needs good SA), but frequently there will be no stop bar at Echo, the green lights will extend several hundred yards past the clearance limit, possibly to another stop bar, just "suckering you in".

Preventing runway incursions or ground collisions is a joint responsibility. The current practice forces us to either abrogate that responsibility and leave it entirely to ATC or requires difficult head-in time at night establishing

just where we really are going. Admittedly not too bad for those of us based at [ ] but what about visitors.

I have heard both the following transmissions at [ ] at night:

1. Foreign aircraft, querying which taxi route they are supposed to be taking, obviously confused; ATC "Just follow the greens, sir, follow the green lights, they will take you where we want you to go."

2. When following the greens a sudden switch of direction as we were almost on top of the junction caused us to query whether this was intended for us or the aircraft behind us and elicited the irritated response "Yes, just follow the greens please."

It is not a good safety culture to work on a "just do as you're told" principle, especially if someone has clearly expressed some doubt. To "Just follow the greens" might seem like a no-brainer until the day the lighting controller gets it wrong (and let's face it, haven't we all been "lit" the wrong way at some point or another by the lights and on querying it get an "oops, sorry, just switching it now").

At the very least, we should be told "follow the greens on Bravo, Charlie, Delta and hold at Echo".

I really fail to see why there is resistance to tightening this up a bit - as I said at the start, they cope quite happily in daylight that way. The last thing I need at night is reduced SA.

CHIRP Comment: There are times when simply doing as one is told is essential - but risks are minimised when pilots maintain good SA.

As occurs at other airports, operating procedures at [ ] are agreed at regular meetings of the stakeholders who include the airport operator, the air traffic service provider and aircraft operators. The mechanism for changing procedures or highlighting problems is through this committee. Reports through company channels will, as mentioned in the editorial, provide the data to enable the committee to make informed assessments. In this case, the majority of pilot feedback around the current taxi instructions is positive.

Of interest, the SESAR European Airports Consortium is involved in work to improve taxi communications and procedures. The aims include reducing RT congestion, improving pilot SA, minimising taxi times and therefore minimising fuel burn. One element, called "Follow the Greens", is a project involving enhanced infrastructure and procedures; an overview can be seen at http://vimeo.com/88132688. **Early feedback from this project includes the increased SA noted by pilots taking part in the simulator trials.**

FTL Averaging

Report Text: After two days off I was on a four-day short haul tour, all early starts. On day 3 at arrival at our night-stopping destination I was called by Ops to tell me that they had taken me off the last two sectors of my planned three sector final day as - due to disruption earlier in the tour - to complete it would take me over the 9hr average duty per day for consecutive earlies. (This is a rule in our FTL scheme that requires the average duty length per day to be less than 9hrs when on a block of 4 or 5 days of early starts) So far so good!

When I volunteered to tell my F/O the news, Ops said that although he had been with me the entire trip he would NOT be removed, because he had worked the day before our trip started (whilst I was on a day off). Yes - that's right; when I was on a day off, he was working (another early), so he had done more earlies and worked longer than me, but it was me, not him that was being removed from the trip! Ops' reasoning was that they average his hours over the 5 days of earlies, which calculated out as less than 9 per day, and so he could stay on the trip.

Common sense would suggest that in this case, you should look at each four-day 'window' within the 5-day block, and if the 9-hour average is exceeded in either window then you can't continue. We both wondered if an incident were to occur on his last two sectors the following day, where would he stand. Using the same logic, if - having been on the point of being removed from the trip - I had at that instant volunteered to a further day of work and picked up another early the following day then suddenly my hours could have been averaged over 5 days not 4, and suddenly I would miraculously be legal to do the final two sectors, once more!

The union have been attempting to resolve this with the company for years, I am told, to no avail. The latest 'excuse' is that we will shortly be having to change to new EASA FTLs so there's "no point" in looking at this further.

But - either the duty is too tiring or it isn't. It can't be too tiring for the person who has done less work, but not too tiring for the person who has worked more days and done more earlies!

CHIRP Comment: The combination of 'average' and '4 or 5 days' permits the situation described by the reporter, which is counter intuitive and illogical. However, the FTL scheme is approved and there is no appetite to address this aspect of it before the introduction of new European regulations. Applications to operate in accordance with the new regulations can be made from November 2014 with the earliest implementation date being February 2015. All operators required to transition to the new regulations must be operating under Subpart FTL by 18 February 2016.

Fatigue is something that affects different people in different ways. One person may find a combination of duties to be particularly fatiguing while another person will manage the same combination without difficulty - and vice versa. In addition to individuals' natural resistance or susceptibility to fatigue, factors such as illness, taking medication and stress can have huge effects.

Standby Call-outs

Report Text: I work a fixed pattern schedule of 5 early and 5 late duties. AAA [Airline] rostering has been using early standby duties to crew late departures with report times several hours after the original standby duty should have finished resulting in long duty periods and significant disruption. These duties are of course "legal" but more importantly are extremely fatiguing.

When working 5 early duties rest is based around expecting an early duty, not one starting many hours later resulting in duty periods well in excess of 12 hours. This

is common practice at AAA. Today's 0600-1000 home standby has resulted in a 13 hour duty with a report time 3 hours and 30 minutes after the standby should have finished and a scheduled finish time of 1900. I will arrive home at around 1950 and have minimum rest for another home standby commencing at 0800, but the finish time is meaningless as I can be called out for any duty starting many hours after any notional off duty time. AAA has a Fatigue Risk Management System (FRMS) which only looks at a fraction of published rosters and takes many days to reply to fatigue reports. Last block of late duties I flew 20 sectors in 5 days with one day over 11 hours and another over 10 hours. The fatigue report came back as no fatigue risk. On the last day I was feeling rundown having already flown 16 sectors in the previous 4 days but generally ok to fly. On the last sector of the day I fell asleep in the descent for about a minute. It was dark and the First Officer didn't even notice. AAA's rostering staff are deliberately rostering long duty days and the company FRMS is unfit for purpose. Fatigue at AAA is a huge concern of mine and needs addressing urgently.

CHIRP Comment: The CAA FTL specialist has confirmed that the duties described are consistent with the provisions of CAP 371 and compliant with this operator's approved scheme.

Although some operators are beginning to build the foundations of FRMS within their organisations, there are currently only 2 that have a FRMS approval from the CAA. Initial approval requires the operator to demonstrate that the system is consistent with FRM principles; continued approval requires the operator to maintain a dialogue with the regulator about the data collected, analysis of trends, studies and other work done to mitigate fatigue. The regulator's audit process for all operators includes visibility of fatigue reports; the absence of any reports would prompt the regulator to question an operator's ability to recognise and manage fatigue. Notwithstanding the response to any individual fatigue report, it is important that flight crews and cabin crews submit fatigue reports to build up the data set held by operators. If reporters are dissatisfied with the company's response they may report to the CAA directly or through CHIRP.

With the agreement of the reporter, this report has been passed to the operator and the CAA.

DESCENT CHECKS

Report Text: The company has an active FRMS. Some time ago a pilot awareness form was introduced; this was a paper form to be completed with a tiredness/alertness value at top of descent. Later an ACARS message was devised to be sent at either top of descent or after landing. It is acceptable to use the paper or ACARS form of message.

In the latest change to the checklist an item has been introduced to the DESCENT Checks; this is 'Pilot Alertness Report Form'. This item on the checklist is neither operational, nor is it safety related. Furthermore, it is not applicable on every sector (only the last sector of a duty) and not required before descent (it can be completed and sent after shutdown). Crews have been known to fly beyond the descent point whilst completing the ACARS report, having been reminded by the checklist. It is interesting to note that this item does not appear on the version (correctly dated) of the checklist that is in the operations manual. It is only on the aircraft checklist. Does the CAA know and has it been accepted?

Lessons Learned: This checklist item is distracting and inappropriate. It should be removed or, at the very least the response changed depending on how applicable the item is.

CHIRP Comment: The operator introduced the item into the checklist because it was receiving too few reports when it relied on pilots remembering to make their assessment without a prompt. It is important for the accuracy of the study for flight crew to make their assessment at the top of descent rather than recall it later. Pilots are required to assess their sleepiness on a scale of 1 – 9 (the Karolinska Sleeping Scale) where 1 is 'not sleepy' and 9 is 'fighting sleep'. Provided the assessment is made at the top of descent, the report form (duty start time, sector, total no of sectors for the duty period, and fatigue value) can be submitted later.

The introduction of non-operational items into the aircraft checklist is a cause for concern. Furthermore, the checklist on the aircraft should not differ from the one in the Operations Manual. However, the CAA Flt Ops Inspector was aware of the study and the amendment to the aircraft checklist. The discrepancy between the laminated aircraft checklist and the one in the Operations Manual was an oversight that was corrected as soon as it was detected.

The company comments that the whole exercise will take about a minute to complete for both crew members. It is a good way to discover how tired your crew mate is at top of descent and adjust your mental model accordingly. Crew members are encouraged (and trained) to brief and complete the cruise duties in plenty of time prior to TOD. However, in some areas (Germany being one), ATC can ask for an extremely early descent. The crew members should not allow themselves to be distracted from their primary roles to complete the fatigue survey. The number of reports has increased fourfold since the introduction of the checklist reminder and the company's FRMS is the better for it. Given the nature of the company's operations, the data gained is considered to be safety-critical information.

FURTHER TO LVOS IN ISSUE 109

Report Text: I fully understand the frustrations of the author.

Last year I flew to [ ] with a forecast of CAVOK and then 500m from midnight. It was 1900 and as we commenced the approach from 25 miles the Vis was reported as 2000m. On base leg we were given an RVR of 650m. We elected to fly a Cat 1 Autoland. At DH we went around due no visual reference. We asked ATC to confirm that they would be putting LVPs into place. The response was, "RVR is not less than 600m so, no. We will have safeguarding in place in around 10 minutes".

'Safeguarding'!?!? Neither of us had ever heard the word before or knew what it meant.

We again asked for LVPs but were given the same response. We only had 5 minutes contingency fuel before the missed approach and as we could not legally plan anything below Cat 1 we had to very quickly divert to [ ] (still CAVOK).

Stress when it is least required.

Our thoughts were:

1. The forecast was for deteriorating conditions and they had clearly arrived, so why not get LVPs in place.

2. What is and what use is 'Safeguarding'?

CHIRP Comment: The criteria and factors surrounding the implementation of LVPs in deteriorating conditions were discussed in the previous FEEDBACK but the explanation of the term safeguarding was not. From CAP 168 - Licencing of Aerodromes:

Low Visibility Operations (LVOs) is a general term used for airside operations in conditions of reduced visibility or low cloud conditions and consists of low visibility safeguarding and low visibility procedures (LVPs).

Low visibility safeguarding is the process carried out which prepares the aerodrome for low visibility procedures. The safeguarding measures must ensure that at the point when LVPs are declared to be in force, all actions to protect aircraft operations have been put in place.

Low visibility procedures are the actions carried out by ATC and the aerodrome operator in respect of aircraft operations and vehicle movements. This may include restricted access to the manoeuvring area, the protection of the ILS critical and sensitive areas and a reduced aircraft movement rate.

What does this mean to pilots? In the safeguarded state the ILS cannot be assumed to be protected. The transition from the safeguarded state to full LVPs can be relatively quick but being safeguarded does not imply an automatic move to LVPs. Therefore in circumstances similar to those in the report, the message to be passed to ATC is, 'We require LVPs. What is your estimate for us to be able to make an approach using LVPs?'

ATCOs: Reference to safeguarding being undertaken may be helpful but it should be borne in mind that not all pilots will necessarily be familiar with the term.

Of note, pilots may come across the term safeguarding in their company Ops Manuals in the context of whether Cat 2/3 approaches may be flown for crew training purposes at Cat 1 or better minima.

ATC Coordination

Report Text: A flight from Europe to a UK airport. High winds forecast from 12:00z throughout the day and evening, affecting most of the UK. We had anticipated delays with potential for wind shear and a go-around. Additional fuel was taken to permit holding and to allow subsequent approach attempts. Inbound, radar reported instantaneous wind outside of the aircraft's crosswind capability, wind speeds varying significantly. We had discussed to continue the approach until the final gate, receive a wind update, if not within limits then abandon the approach. At the gate, wind was out of limits, Go-around initiated. Tower almost immediately prompted "Straight ahead, 3000ft". (Main point A) The aircraft was still being configured for the missed approach. This was an unnecessary distraction with an already high workload within the flight deck. Our company policy is that we contact ATC after the aircraft has been accelerated with flaps up. We were transferred to Radar who climbed us to 4000ft and we entered the hold over the NDB.

Immediately prior to entering the hold we advised ATC that should we decide to divert, then [ ] was our anticipated diversion airport. The airport was not listed on our flight plan as an alternate, but we had discussed our options in the cruise and, based on weather reports, it posed the least number of threats for our operation. At our first flight plan alternate, the wind was nearing limits and expected to rise above. In the hold, we decided to use the available additional fuel to hold and make another approach if the winds subsided; failing that approach, divert to [ ]. In the hold for approximately 15-20 minutes we setup and briefed for an approach at [ ]. When we called ready for diversion ATC vectored us towards [ ] and handed us over to [ ] Radar who immediately informed us that [ ] airport was not accepting inbound traffic due lack of staff. (Main point B), ATC should have negotiated this within the time they were warned that [ ] was the intended alternate.

We received weather updates for 2 backup diversion airports. At this point we were planned to land at [ ] arriving with 2.1T of fuel and either of the backups with 1.5T. Although one of these backups had a cloudbase OVC003 (100ft above our minimums) we selected it because there were no delays anticipated. We requested direct to the approach, became visual to land at minimums +100ft and landed with 1570kg fuel remaining. Any subsequent go-around could have resulting in entering reserve fuel, with no option to continue to another alternate.

Lessons Learned:

1) ATC should not interject so early after a go-around, unless traffic separation is a factor.

2) ATC should consider the acceptability of aircraft to land at an alternate. With hindsight, as a crew we would confirm the Airport was accepting arrivals before diverting, in future.

CHIRP Comment: There are several different types of missed approach procedures that vary according to the topography, airspace and traffic requirements at the aerodrome concerned. Some aerodromes will promulgate a missed approach procedure specific to the instrument procedure which is operationally desirable together with another in the event of Loss of Communications. In other cases an aerodrome may publish a single missed approach procedure for an instrument approach which provides for Loss of Communications but which in practical terms is not always operationally desirable and usually includes the term 'or as directed' on the published chart (as at the original destination and [ ]). This allows ATC to provide a flexible alternative instruction, such as 'climb straight ahead' followed by radar vectors. Although this means issuing an instruction while the flight crew are conducting the go-around, a climb straight ahead could be seen as an easier option than following a published procedure.

That said, there is evidence that the most frequent causes of undesired aircraft states are late changes to published procedures. It would seem desirable therefore to publish procedures that can be followed in the majority of cases with published alternatives to cater for less frequent occurrences, such as RT failure.

Turning to the coordination of the diversion, the message that the crew were planning to divert to [ ] was passed without delay along the ATC chain and all of the elements were in place from an ATC perspective. However, [ ] publishes that visiting aircraft are subject to PPR. By the time it was established that not all of the required ground services or facilities were available, the aircraft was en route. The reporter correctly identifies the importance of confirming that an airport is accepting arrivals before diverting. The most expeditious method for doing this will almost invariably be through company operations rather than ATC.

NOT CLEARED TO DESCEND

Report Text: I write this as a former Air Traffic Controller and current pilot. We [twin turbo-prop] were No 1 for the ILS at [UK airport]. A [twin jet] was No 2. We were at 3000ft and being given a final vector to intercept the LLZ. Vectors given to us were necessarily tight (this was not a problem for us), and we were told that if we go through the LLZ then ATC would give another vector for us to regain the LLZ. This indeed happened, and we were descended to 2000ft. We intercepted the LLZ at 2000ft at approximately 6 miles. At the same time as intercepting the LLZ, we reached the point at which we should have initiated a descent with the GS. However, as the [twin jet] aircraft behind was being given his final vector, we were not able to call "established" and therefore were not able to (legally) descend with the GS. We were finally cleared to descend with the GS at approximately 1/2 dot fly down - which can potentially destabilise the approach. [ ] ATC consistently vector a/c to intercept LLZ and GS at the same time, and this situation is exacerbated when stepped descents are given.

Lessons Learned: The situation that we experienced today could have been avoided if UK ATC were to use a phrase that is common in all parts of the world, and that phrase is "cleared ILS". I appreciate that occasionally, ATC do not wish aircraft to descend with the GS and instead wish aircraft to hold their last assigned altitude. Also, when the GS is only checked to 10nm (with the LLZ being checked to 25nm), it is not possible to use the GS outside of this range - in which case, this is a very valid reason for not using the phrase "cleared ILS". However, when a controller intends an aircraft to intercept a LLZ and descend with the GS, the controller should be permitted to use the phrase "cleared ILS", instead of "when established on the LLZ, descend with the glide" (which, let's face it, is a bit of a mouthful).

CHIRP Comment. In the UK, ATCOs are permitted to use the expression "cleared ILS approach" provided that the controller has issued a descent instruction to the level that coincides with the published level that intercepts the ILS glidepath at the Final Approach Fix, or to a lower level when allocated in accordance with the Surveillance Minimum Altitude Chart. However, it is one of the phrases that may be used by a controller according to operational needs and priorities and may not be appropriate in certain circumstances e.g. areas of high terrain or known false localiser signals.

Guidance for the phraseology associated with ILS approaches and the circumstances for when different phrases may be used are published in CAP 413 Radiotelephony Manual, Chapter 6, Pages 10-12. (www.caa.co.uk). There is also an Aeronautical Information Circular on the subject which is still available on the AIS website (www.nats-uk.ead-it.com/public/index.php.html) reference Yellow 063/2012.

Of note: Work was already in progress at [ ] with a view to simplify the procedures for level/altitude allocation for traffic being vectored to final approach. Hopefully the revisions will result in procedures that are harmonised to the fullest extent possible with those of ICAO.

LOCKED FLIGHT DECK DOOR

Report Text: I work for a UK operator of Boeing 737 aircraft. The company route structure includes some sectors that, depending on upper winds, can frequently run into five hours plus flying time. The aircraft is clearly capable of such sectors but as pilots of this type know, the space available in the flight deck is seriously lacking. Combined with the company locked door policy, it is virtually impossible to achieve any sort of useful physical movement that is beneficial to one's health. All we can do is make a visit to the forward toilet which not only involves inconvenience to the cabin crew and passengers, but as probably only three or four steps in total is required to get there hardly constitutes beneficial physical movement!

Passengers are positively encouraged to move around during flight primarily to negate the possibility of suffering a DVT of which lack of movement is a significant contributory factor. We on the other hand are offered no advice whatsoever by the company and no reference is made to this issue in any of the Ops manuals, bar physiological requirements. Can this be a good thing? Health advice for sedentary type occupations such as those of office bound workers is to get up and move around once each hour at the very least. Clearly, this is not practical for our occupation. However, taking two toilet visits in ten hours from an "office" at eight thousand feet is certainly not good practice either.

I would be most interested in the views of other readers of this publication and also that of the CAA medical team.

CHIRP Comment: There have been many studies undertaken on the risk of Deep Vein Thrombosis (DVT) and these have confirmed that most DVTs occur in individuals with risk factors such as illness, after surgery or prolonged immobilisation. There is a small increased risk with any type of long duration (over 4 hours) travel (car, coach, train, aircraft).

General advice given to passengers includes avoiding constricting clothing around the legs and waist, maintaining adequate water intake and frequent calf muscle contraction and these measures can also be used by pilots.

Studies of pilots have not demonstrated any increase in risk; a study undertaken by the UK CAA in 2001 showed that the incidence of venous thromboembolism (VTE) in the pilot community was 0.2 per thousand per year which is considerably less than in the general population. Although the study predates the post-9/11 restrictions on pilots' freedom to leave the flight deck, the CAA has no evidence of an increase in the incidence of VTE among pilots since the study was concluded.

CABIN CREW REPORTS

POOR CABIN AIRFLOW

Report Text: At top of descent cabin crew were alerted by call bell to a passenger who had fainted in the aisle. The temperature in the cabin was extremely hot and stuffy. The passenger was around 35 years old. Oxygen was administered on high and they regained consciousness quickly. Whilst the passenger was on the floor in the aisle, we asked for their medical history and were told this hadn't happened before except whilst giving blood, that they had eaten and were not a diabetic. They had a clammy and sweaty appearance but quickly started to respond normally to questions and stated they were feeling much better. The passenger was moved to a seat with more air and space to recover fully. The passenger seemed very fit and healthy apart from this faint.

Air flow was set to LOW by the flight deck, the aircraft was almost full although the official trigger point of 115 'passengers' was not reached. Air quality is always low when the aircraft is almost full and airflow set to low and the temperature is difficult to regulate. Surely the trigger points for low/normal/high airflow should be reconsidered. An almost full aircraft and low airflow must put a strain on everyone especially the cabin crew.

Lessons Learned: Once again the airflow was set to low when the aircraft was almost full, this is happening again and again.

CHIRP Comment: CHIRP frequently receives reports on this subject, with a very similar report printed in Issue 48 of Cabin Crew FEEDBACK.

On the A319 and A320 aircraft with passenger loads of less than 115, LOW flow can be selected on the air conditioning packs to save fuel. The LOW flow setting at all times provides adequate air supply for breathing to the cabin. However in certain cases of passenger distribution, with loads less than 115, combined with the interaction of the elements of the air conditioning supply and temperature control system, there can be large fluctuations in the temperatures achieved in the cabin zones, which passengers and cabin crew may become aware of. Flight crew might also notice frequent fluctuations on pack flow rates between LOW and NORMAL, as the system tries to control the temperatures. Often this can be resolved by selecting NORMAL flow for a time to let everything stabilise, then revert to LOW flow, but sometimes one has to remain in NORMAL flow. This issue is not that common, but the solution relies on information being available and shared appropriately. By letting the flight crew know of the issue early the cabin crew may be able to prevent the problems, such as that described here, developing.

Address Changes

If you receive FEEDBACK as a licensed pilot/ATCO/maintenance engineer please notify **Personnel Licensing at the CAA using** a change of address form which is available to download from the CAA website at http://www.caa.co.uk/docs/33/SRG2156Issue01.pdf and send it by mail or fax to:

Civil Aviation Authority
Personnel Licensing Department
Licensing Operations
Aviation House
Gatwick Airport South
West Sussex RH6 0YR

Fax: 01293 573996

Alternatively, you can e-mail your change of address to the following relevant department (**please remember to include your licence number**):

Flight Crew .....fclweb@caa.co.uk
ATCO/FISO .....ats.licensing@caa.co.uk
Maintenance Engineer .....eldweb@caa.co.uk

Contact Us

Ian Dugmore **Director**
Flight Crew/ATC Reports

Bruce Hunter **Deputy Director (Engineering)**
Maintenance/Engineer Reports

Stephanie Colbourne **Administration Manager**
Circulation/Administration
Cabin Crew Reports

FREEPOST RSKS-KSCA-SSAT
CHIRP
26 Hercules Way
Farnborough GU14 6UU

Free*fone (UK only)*:	0800 772 3243 or
Telephone:	+44 (0) 1252 378947
Fax:	+44 (0) 1252 378940 (secure)
E-mail:	mail@chirp.co.uk

FEEDBACK via email...

If you would like to receive a copy of Cabin Crew FEEDBACK via email, please contact us at mail@chirp.co.uk advising us of your name, occupation and preferred email address.

Registered in England No: 3253764 Registered Charity: 1058262

If you wish to contact the CAA Flight Operations Inspectorate or to report any safety matter which is outside the scope of the MOR Scheme, please email the CAA at flightoperationssafety@caa.co.uk