Confidential Human Factors Incident Reporting Programme



FEEDBACK

DECEMBER 1993

NUMBER 31

CHIRP has lots of feedback to bring you on our activities and your reports — our Commandant kicks off!

"Since January 1993 when I was appointed Commandant of the Royal Air Force Institute of Aviation Medicine I have also been the Chairman of the CHIRP Liaison Group, and in this way have had both management responsibilities for CHIRP and the privilege to interact with many organisations concerned with flight safety. Over this period of time there have been various discussions on the place of CHIRP in the future of commercial flight safety initiatives and these have involved both the CAA and the Flight Operations Directors' Liaison Group.

How CHIRP should develop is essentially a decisign to be made by the Civil Aviation Authority, air ine management (hopefully through the Flight Operation Directors), and the pilots, controllers, and possibly in the future the engineers. I am concerned that such a system should be seen to contribute in a helpful way to both the Civil Aviation Authority and airline management, highlight ing real problems which need their attention. In this context I have been in discussion with the Safety Regulation Group of the Civil Aviation Authority and the Flight Operations Directors' Liaison Group. I have found these discussions useful and have every confidence that both the regulatory authority and airline management wish to ensure the highest levels of flight safety in UK operations.

"From these discussions two procedures have emerged which I feel are significant. In future, issues raised by the readership of FEEDBACK and deemed to be sufficiently serious will be brought to the attention of Peter Hunt of the Civil Aviation Authority if they are of a regulatory nature, and to the Chairman of the Flight Operations Directors' Liaison Group if they are of a managerial nature. This approach will be made by myself with the advice of Paul Wilson the Manager of CHIRP and Liz Wheatley, the Head of Psychology at the Institute. Further, a section in FEEDBACK will be devoted in each edition to outline the progress which is made. Obviously, reference to some actions concerning confidential reports to CHIRP, even if disidentified, would be inappropriate, and such issues will continue to require a "behind the scenes" approach. This has been very successful in the past in delicate situations.

"I have every hope that this development will be helpful and that the initiative will be considered by the readership as a step forward in handling the reports, and provide you with information on the actions taken. The present dialogue with the Civil Aviation Authority is given in this edition. The dialogue developing with the Flight Operations Directors was only initiated during the later part of November, and has yet to bear fruit."

Air Commodore Tony Nicholson OBE FRAeS RAF

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FEEDBACK 31 December 1993

Now read on: — yes, you have seen this one before — the CAA have asked CHIRP to publish this report again with their comments added.

NO SLEEP 'TIL MORN; REBORN

The day started on Standby Duty 1100-1800. The previous day I operated the afternoon Flight 1435-2135L, finishing duty at 2230L.

I woke at 0900L on the day of the standby feeling slightly jaded from the previous duty (it's been a long summer season) and spent the day at home completing odd jobs. At 1700L I received a call from Ops stating they wanted me to operate the 2200 flight finishing at 0520, total allowed duty 10.15. Cabin staff on delayed report.

On reaching destination, lurking in tricky mountainous terrain, weather deteriorated to below minima. We held for 40 mins waiting for improvement which did not happen, and then diverted to planned alternate. On the apron at planned alternate waiting for an improvement, talking to Ops on HF, they advise us a replacement crew is being sent to destination by another carrier when weather improves, our crew to slip at destination. By 0600 weather at destination now 100m, 6/1000. All crew feeling tired. At 0800 a senior company person put undue pressure on us to get airborne from planned alternate on route destination for another attempt as his weather report gave fog lifting to become CAVOK 0800-0900, our own reports giving 1000m. We arrived overhead destination 0900 and landed at 0915, both pilots VERY tired. By the time aircraft shut down and crew departed for hotel it was 1100, hotel at 1200 - Sleep at last. It was now 27 hours since I woke for the start of my standby duty. This cannot be safe!

The CAA, not knowing which company was in-

volved, commented as follows:-

The Authority was concerned to read the report in Feedback 29 'No sleep till Morn ...', concerned on two counts, first that the Commander somehow allowed himself to be convinced that what Operations/Management were asking him to do was within the Company's FTL scheme and secondly that Operations/Management did not appear to understand the rules.

This individual came on standby at 1100L after 12¹/2 hours rest. At 1700L he received a telephone call requiring him to operate a 2200L flight finishing at 0520. Since his FDP clock effectively started ticking after 6 hours on standby (i.e. at 1700L) and he remained on standby from original start time of 1100L until actual report time (i.e. arrival at airport which is assumed to be 2100L to 2115L), the most FDP permitted is the more limiting of the original 'on standby' time of 1100L (2 sector would be 13¹/4) or actual report time 2100L say (2 sector would be 11¹/4 hours).

Thus 11¹/4 hours is maximum FDP commencing at 1700L. Off duty time therefore should have been 0415L the following morning. Hence a planned 0520L completion was not feasible. This individual was still flying at 0915L and was exercising unauthorised discretion of 5 hours or more. No wonder he was very tired.

Regarding accountable duty hours, the pilot should have logged as follows:

1100L - 2100L Standby = 10 hours $\div 2$ (more than 3 times normal report time notice was given)

Accountable hours = 5 hours

2100L - 1100L on duty = 14 hours

Total accountable duty 19 hours

Note: Since more than 18 hours on duty the subsequent rest period should have included a local night. A Discretion Report together with Management comments should have been sent to the Authority.

If any operator or crew member needs to seek further clarification on this, or any other FTL matter, in confidence if required, give the Authority a call on 0293 573419 or 573420 or 573514.

..AND THEN SOME.....

FEEDBACK also prompted the following response from the CAA to an ATC report ref MODE C in FEEDBACK 30: "UNRESOLVED ATC"

...The difficulties referred to in the article had also been brought to the attention of Air Traffic Services Standards Department by a series of Mandatory Occurrence Reports. The reports indicated that a flight safety problem did exist with a number of radar displays and that rectification measures were required. Accordingly action has been taken and the height filters that were the cause of the problem have been removed. This would seem to have eradicated the difficulties, however, the equipment's performance is under close scrutiny to ensure that there is no recurrence of identical or similar problems or that the rectification has led to any unforeseen anomalies.

SINGLE RUNWAY=TROUBLE! PARALLEL RUNWAYS= DOUBLE TROUBLE?

* * * * *

I was handflying the aircraft "downwind" backtracking a VOR radial on NAV 2 with the airfield DME on NAV 1.

We were turned right onto a radar heading base leg for 24L. On the base leg the captain

asked if I wanted to look at the ILS now as I had finished backtracking the VOR radial, I said yes. He dialled it up and I identified it (well I thought I had) as it got busy with a right turn on radar, flap selection, gear selection, cabin secure from cabin crew and landing check-list - to establish ILS 24L. I did establish and looked up to see R/W 24R!

I visually flew across to R/W 24L the landing R/W and the captain dialled up ILS 24L. This gave two dots fly down 'cos 24L threshold was quite inset in comparison with 24R. I flew down @ 1500 ft/min to gain G.S. Stabilising the approach at 800 ft AGL in landing configuration. If it had not been visual we would have had to go-around OR could have landed on the wrong R/W!

The 24L approach plate looks exactly the same as the 24R plate - UNLESS YOU LOOK CAREFULLY!

In days of yore, one of the ways to ensure that you were looking at the correct plate was to look closely at the missed approach pattern. When this is different for each runway, and you are familiar with the airfield, it does confirm that the information before you is for the runway intended. You may have a better way — if so please let CHIRP know. The long term solution is probably to nominate each runway 10 degrees either side of the parallel heading (and so for 270 degrees there would be runways 26 and 28).

WITH FRIENDS LIKE THESE...

Working in a complex TMA monitoring an experienced controller who is training on that Sector. Moderate traffic when a shuttle and a rival company B737 appear.

80 miles to touchdown and we have to make a decision on the order to hand the traffic to

the major airfield. No holding required so the B737 will be number 1 as he is already 12 or so miles ahead. The trainee makes some reasonable attempts at speed control and the B737 co-operates. The Shuttle on the other hand does not and we almost have a discussion of relative relationships between Mach numbers and Indicated Airspeeds and the differing effects at altitudes. The Shuttle is being less than co-operative and the trainee is becoming agitated with several other aircraft under his control. The Shuttle finally asks "can't you just move that aircraft out of the way?". That was just the statement to seal it. The trainee puts both aircraft on headings and ensures that the B737 is No. 1.

What is it with some people? We allocate in the priority of emergencies first and all others as they come for the overall benefit of ALL aircraft. God help us when ATC is privatised fully because I see the effects of commercial pressure every day. Tired pilots who need the assistance of another pair of ears and eyes. The day WE have to prioritise according to individual airline economics is the day Ileave.

SOFT TOUCH AT THE CUTTING EDGE!

This report is being submitted to further emphasise the serious shortcomings of the "CRATCOH" system.

With all the recent trimming of resources, it needs just 2 or 3 people to report sick, to make the rosters go awry, and "on-duty" times inevitably stretch to the maximum 2 hours with minimum breaks. On this particular day there were at least 5 ATCOs sick. Had it not been for the dedication of watch staff, the number sick would have been even more.

My own shift should have ended at 17:00 after an 8 hour duty. CRATCOH regulates one individual duty to 10 hours. I was asked to continue working to 19:00, the latest time I could legally work until. This report is not a clandestine attempt to suggest that we should be entitled to overtime. My point is that I consequently had to work the morning peak period and the late afternoon peak period.

Had an incident occurred, I feel SRG would have criticised ME for not recognising how tired I was. Similarly the ATCOs who came on duty to avoid a staffing crisis - whose licence would have been in jeopardy had they had an incident when not in full health?

The problem is that ATCOs on this watch are a resilient bunch. Some might say we are too laid back - a "soft touch". But the fact is, that under even the most trying circumstances, WE MAKE THE CRATCOH SYSTEM WORK.

We ARE professional, and we DO pride ourselves in our skills, but being on the "cutting edge" of the service, there is a growing suspicion that CRATCOH was implemented to reduce staffing levels at quiet times and not to improve the system of rest periods.

As a result of this particular day, I returned home 12 hours after I had left for work and I was unable to sleep. I HAD to go sick the next day; otherwise I think I would have been able to have an incident without even realising it.

If we were machines, then CRATCOH would work. As it is, it is unable to cope with variables. The slightest alteration and the system creaks to a halt, increasing workload, and pressure, and reducing the standard of service. The situation is so ridiculous that it can take up to an hour to work out the CRATCOH for a shift. Whilst a person is

wasting all his time doing it, he is not doing what the CAA are paying us all for - providing a SAFE and EXPEDITIOUS service to our customers.

HEADS THEY WIN, TAILS YOU LOSE

Some years ago this Freight Company accepted a contract for a weight greater than the structural maximum allowed for the type of aircraft. For most of the year there is no problem as either the maximum contracted load is not used or the weather is such that the absolute minimum fuel can be uplifted together with the maximum legal load for the aircraft in use on the day. The aircraft are all quite old, have very varied histories so consequently have differing APS weights and MLWs. The heavier ones are unable to lift the maximum structural load let alone the contracted load. With a combination of poor weather, maximum load, minimum sensible fuel uplift and in the interests of safety some freight has to be left behind.

The client has complained to the Company and in turn the Flight Ops. staff have all received a letter from the management of the Company stating that they are expected to ensure that freight is not offloaded. The thinly veiled threat of redundancy and job losses if the contract is lost is very obvious. The majority of Captains are very experienced and operate all contracts for the benefit of the Company but I am convinced that if a Captain is involved in an incident through "bending the rules" he would receive no support from the Company at any enquiry. In fact he would be "thrown to the wolves". Previous incidents have proved that the Company would disassociate themselves from any blame.

This management attitude puts younger colleagues with large mortgages, children at school and repayment of licence courses and exams in a catch "22" situation. I know some who will do anything to ensure that their livelihood is not put into jeopardy. Unacceptable pressure is put on Captains to reduce safety standards in the interest of the great god profit.

We are told the Flight Ops Inspectorate are look—ing at these types of operation more closely.

YOU HAVE CONTROL ...!

During the pre-flight checks a flying control defect was found. The "Despatch Deviation Manual" allowed this in good w/x conditions, BUT did not recommend it, in the event of turbulence. In the destination country there was ONLY one flyable airfield. Destination and alternate were closed due strong winds and associated turbulence.

On failing to rectify the fault, even after being informed with adequate notice, I was then informed by "Engineering" that any delay (after S.T.D.) would be allocated to me, (i.e. blame the pilots).

This is to bring attention to the situation that now prevails where "managers" in engineering are only interested in "performance pay" without due regard to safety. In this case they quoted only the first line in the D.D.M. (see above) but chose to remove the following paragraphs which are quite clear about this defect and turbulence. Clearly pressure was put on me and pass the buck.

On querying this later I was requested NOT to file an air safety report!! We are now in a different safety climate - mainly all talk - performance and punctuality awareness

comes before common sense.

You all know what the bottom line is!

A FLASH OF WISDOM...

I was intrigued by this item in Issue 29 of Feedback. I agree entirely with your expert comment, however I would perhaps add a couple of points for your further consideration. When there is a large number of vehicles in an area, the resulting mass of flashing lights can be irritating or even confusing. It is for this reason that the emergency vehicles attending an accident are required to switch off their beacons except for the control vehicles, thus enabling these important posts to be readily identified. The number of vehicles in close proximity to moving aircraft should not usually cause a problem, but for the fact that there is an increasing tendency for some vehicles (often those belonging to airport management) to be fitted with the full roof width American police style units containing 2 or even 4 flashing units. The flash rate produced by these units is well above the flash rate specified in CAP168. There is no good excuse for this problem. The CAP168 requirement is quite clear. The units which create the problem are relatively expensive, so it is an additional cost to the operator. The CAP168 rules are simple to meet and have not changed for many years. They should simply be enforced or reviewed if they are inadequate.

Equally, I would urge that the lighting requirements on vehicles and trailers where the luminance output is below specification or is shielded by poor positioning is also important, and the rules should be enforced in this area.

Perhaps the authorities should give flashers a second glance!

Most informed analysts of confidential reporting systems operating throughout the world believe that anonymity cannot be provided if only a small population is sampled. One cannot run such a system on an oil rig or at a single nuclear plant or even one RAF Station. An airline can learn much from running an in—house reporting system but the confidential system that samples the whole industry is the one that gets to parts that other systems cannot reach.

Having said that the old adage still applies, "If you don't use it, it will wither away!"

With more and more forms to fill in at the end of an eventful flight, it is not surprising that the CHIRP report is relegated to another day, then a week, then forgotten. But, if you want change and improved safety then the only way forward is to provide the evidence of an event and you don't even have to diagnose the causes. If you just want to get some problem aired then telephone us and let off steam. We'll do our best to give constructive help.

Season's Dreetings from all at CHIRP – your very own Confidential Reporting System Here's to a safe 1994!

NAME:	DATE OF RECEIPT AT THE RAF
ADDRESS:	INSTITUTE OF AVIATION MEDICINE
-	
PHONE NO:	

We ask that you give us your identity only to enable us to contact you if we are not clear about any part of your account. In any event this part of the form will be returned to you, as soon as possible, to confirm that we have received your report.

Yourself		
1. HOW LONG AN ATCO		
2. HOW LONG AT PRESENT UNIT		
3. NATS/NON-NATS UNIT		
4. ON DUTY AS		
5. HOW LONG VALIDATED ON THIS POSITION		

THE INCIDENT		
6. DATE	11. ATC SERVICE(S) BEING PROVIDED	
7. TIME		
8. LOCATION AND NEAREST REPORTING POINT	12. IN WHAT TYPE(S) OF AIRSPACE	
	13. USING WHAT TYPE(S) OF RADAR	
9. TYPE(S) OF AIRCRAFT INVOLVED		
	14. WEATHER	
10. AIRCRAFT IFR OR VFR		

Please use this space to write your account, using extra paper if you need to.

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NAME:ADDRESS:		DATE OF RECEIPT AT THE RAF INSTITUTE OF AVIATION MEDICINE
PHONE NO:		
We ask that you give us you In any event this part of the	ur identity only to enable us to contact you if we are form will be returned to you, as soon as possible, to	not clear about any part of your account. confirm that we have received your report.
YOURSELF	THE FLIGHT	THE INCIDENT
CREW POSITION	DATE	TIME (PLEASE STATE LOCAL/GMT)
TOTAL FLYING HOURS	FROM:-	DAY/NIGHT
HOURS ON TYPE	то:-	LOCATION
THE AIRCRAFT	IFR/VFR	
TYPE	TYPE OF OPERATION	PHASE OF FLIGHT
No. OF CREW		WEATHER (IMC/VMC)

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