AIR TRANSPORT

CHIRP FEEDBACK

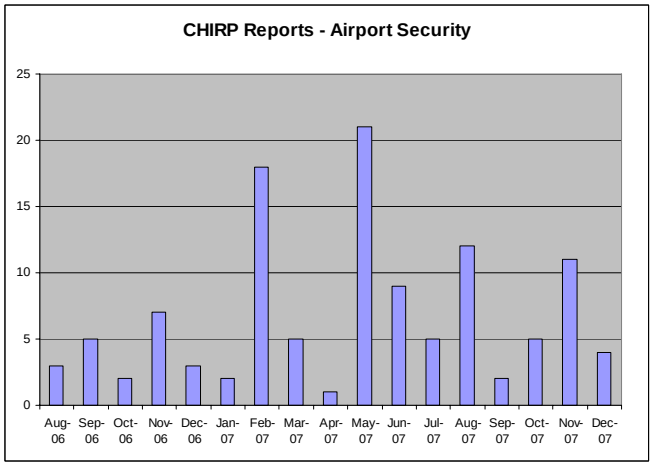
Issue No: 85 Winter 2007

SECURITY REPORTS

CHIRP Narrative: Sixteen months have elapsed since the Department for Transport introduced revised security procedures at UK airports for passengers and professionals employed in the air transport industry. In the last issue, I summarised the actions that we had taken in response to the complaints about inconsistencies in the application of the new procedures that had been reported through this Programme since shortly after the new procedures were introduced. Also, I posed the question as to why similar safety concerns were not being reported through other reporting channels.

Recent comments on this topic suggest that some individuals are now seeking to report such incidents through company/CAA schemes. However, it is also clear that other reporters do not wish to 'put their heads above the parapet' for fear of action being taken that could affect their employment, such as the withdrawal of their security passes.

If the new security procedures were working properly, the number of adverse reports from individuals who encounter them on a daily basis would have been expected to decrease as the system 'bedded in'. This is not apparent from the reporting trend which shows that a greater number of reports of problems has been received in the last two six-month periods than in the same period immediately following their introduction.



Partly as a result of this reporting trend, BALPA has elected to commission an independent survey of its members on this subject.

If the formal reporting of safety concerns is being inhibited by the threat of retribution by agencies with no accountability for safety, it reverses the open reporting culture that the UK air transport industry and the CAA have espoused over many years, and which has contributed significantly to the safety record of commercial aviation in the UK.

To date, there is no evidence to suggest that the situation is likely to change in the foreseeable future; thus, the question might be asked, "How many more reports and what additional evidence is necessary to prompt a formal review of the impact of the deficiencies in the application of the new security arrangements on aviation safety and the industry's safety culture?"

Peter Tait

WHY ONLY CHIRP REPORTS?

Report Text: Having just read the security report section in CHIRP FEEDBACK Issue 84, I find myself getting angry and frustrated reading the various reports - and I'm sitting at home!

However, I also find your leader barely believable that hardly any of these reports are submitted via the ASR/MOR system, so as to provide a statistical database. Has the existence of CHIRP unwittingly undermined the normal reporting channels because we are able to report confidentially?

Is it not possible, with the consent of the CHIRP reporters, to create a dossier of security related reports for onward transmission to the CAA and DfT, so that they are aware that the reports exist but have simply been submitted through an alternative route?

On a related note, I am afraid that non reporting/ recording of events is symptomatic of attitudes in aviation for various reasons, and is applicable also to technical problems, passenger disruption and medical situations. If events tend to resolve themselves with no serious outcome, they are often not committed to paper. This maybe because "it all sorted itself out in the end" or "nothing will get done about it anyway" or "I didn't think it was important" or simply "I was too tired".

As tedious as it may be, we must provide a base for statistics and a paper trail for intermittent technical problems.

If we don't write it down and report it to the right people, nothing will ever get done.

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CHIRP Comment: **Disidentified copies of all CHIRP reports received on this topic have been passed to the CAA with the reporters' consent.**

As the reporter correctly points out, it's no good complaining that nothing is done about a particular situation, if you elect not to report the matter. In the case where safety is or could be compromised the most appropriate method is a MOR or an ASR.

FLIGHT DECK SECURITY OF A DIFFERENT KIND!

Report Text: I was running the No. 2 engine on one of our company aircraft which had arrived with an ECAM Advisory "Nacelle Temp" message. The aircraft was on stand with an air bridge on the L1 door. One safety man was positioned in front and a second safety man to the rear of aircraft.

Due to the nature of the defect the engine was run for longer than normal in an attempt to reproduce the ECAM warning.

Approximately five minutes after the engine was started a member of AAA (Major UK regional airport) airport security came on to the flight deck and demanded to see my pass. I advised him to wait until I had finished and completed the engine run. I then gave him my pass and asked him what he thought he was doing; I also told him that I considered his actions dangerous. The matter has been reported to my company. I have also raised an MOR which has been passed to our Quality Department for submission to the CAA.

The latest issue of CHIRP FEEDBACK #84 highlights serious security matters; from my own experience this is the tip of the iceberg.

As engineers, security is always uppermost in our thoughts, yet what has developed over recent years appears to have little to do with effective security.

I have witnessed the most able of engineers spending a whole shift furious at the way he had been treated coming through security first thing in the morning. I myself have felt degraded and violated at the way I had been touched and spoken to by AAA security staff.

I have worked in many different countries on behalf of the company, witnessed many different approaches to security but none as poor as we now have in the UK.

I hope some one is listening?

OH, YES YOU CAN - OH, NO YOU CAN'T!

Report Text: I am based at XXX (UK regional airport) and have a company issued airside pass for XXX which also serves any other airport we operate at.

I was operating from YYY (Southern UK regional airport) and went airside at YYY with my XXX issued pass for my early morning departure. I flew two sectors and was then told by Ops to do another two sectors. I went to the front of the terminal to have a short break and to ring Ops to find out exactly what they wanted.

On attempting to return airside, Security then would not let me through because I did not have a YYY pass; my licence, which they did not ask for early am, was on the aircraft, which was now boarding.

The security man said my pass would not let me airside at any airport operated by ###. "Strange" I said, "I have only been using it for nine years!" I said, "Come with me to the aircraft so I can show you my licence" (yes, the one that has no photo on it). Security then rang my Ops who would not answer the phone.

When Security eventually let me through, I was late and fuming; not the way to go flying.

AFTER YOU, CLAUDE?

Report Text: Airport Security Processing at CCC (Major UK airport); usual queue of airside workers waiting to be processed to get through the single screening facility. There is a second screening facility but the Airport Authority never mans this even for the early morning rush.

On finally reaching the x-ray machine my colleague in front of me starts to go through the usual motions of placing items on the conveyor belt and in the trays etc. As he places his last item on the belt, I start to go through the same motions, as I was next in the queue.

We were both then astonished when of out of nowhere

WHAT'S IN THIS ISSUE?

Number of Reports Received Since the Last Issue and Report Topics:

ATC - 7

RTF Phraseology - Comments
ATCO Staffing/Workload

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Flight Crew - 43

Airport Security Procedures
Rostering - 18/30 hour Rest Periods
Post-merger Training/Route Familiarisation
Adequacy of Computer Flight Planning Information
Emergency Descents - MEL Considerations
Loss of Communications Procedure
Inaccurate Computer Sector Fuel Plan
Aircraft Not De-Iced
More on Oxygen Escape Routes

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Engineer - 9

Airport Security Procedures
Lack of Certifying Staff
Post-merger Quality Standards
Withdrawal of Company Approval

(cont'd from Page 2) an Airport Authority uniformed security man suddenly lobs all of his kit on the conveyor belt in front of me, between my colleague and me and darts through the metal detector machine in front of us while his fellow security colleagues swipe him through and say absolutely nothing about it. I remark to him that that move was a bit unfair and he returns "...thought you were busy" referring to the fact that my colleague and I were chatting as we got ready to put all of our stuff on the conveyor belt.

Not a good example for the Airport Authority to set to other airport staff and the incident felt like a very rude & distracting kick in the teeth to me for the next few hours.

I don't see any point in submitting anything through my company or through the CAA as security problems at CCC are just one part of the unnecessary daily grind of problems for staff operating daily out of CCC to which the CAA, my company and the Airport Authority have shown frequently to have no concerns about and do nothing to improve.

ENGINEERING EDITORIAL

MAINTENANCE ERROR - TAKE A SECOND LOOK

CHIRP Narrative: **As we enter 2008, orders for new fleets of aircraft are emerging and engineers eye with interest a new generation of technology coming over the horizon. However, whilst looking forward we also need to reflect on what can be learned from previous events to prepare us for the new challenges.**

At the end of December the CAA published Paper 2007/04 Aircraft Maintenance Incident Analysis (http://www.caa.co.uk/docs/33/Paper2007_04.pdf)

The report concludes that the most frequent type of maintenance error was as a result of incorrect fitment and set-up; from a review of all MORs assessed as high risk, maintenance error was the primary cause in 6% of occurrences.

A recent review of CHIRP-MEMS data supports the Authority's findings and from an analysis of investigations carried out by maintenance organisations, who are members of the MEMS group, it was identified that installation errors were largely attributable to engineers not following approved information that was available. Other causes were distraction and time constraints in the operating environment and in some cases, a lack of supervision by more experienced engineers.

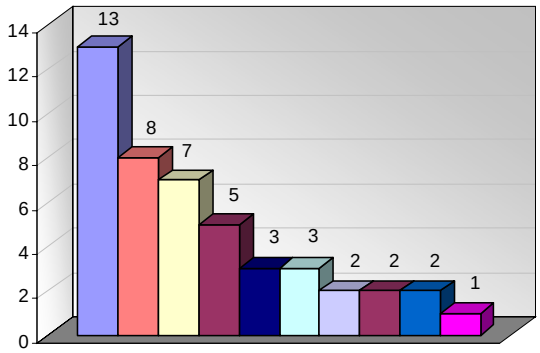
As corrective actions, organisations elected to simplify maintenance instructions and ensure that they were aligned with amended approved data and available. Communication has also been identified as important through feedback during Continuation Training, reminding engineers to follow task instructions and to ensure that Hand-overs are raised between engineers when necessary.

The analysis of CAA MOR and CHIRP-MEMS data confirms that both organisations and individual engineers need to continue their efforts to reduce further installation errors. The key messages are that organisations must ensure that the accessibility and utility of written procedures are such as to discourage any temptation to carry out a task without them. Also, engineers must be mindful that their prime responsibility when undertaking maintenance/certifying tasks is to ensure that aircraft safety standards are assured and never compromised – *if you are unsure, have a second look.*

Mick Skinner

ENGINEER REPORTS

Most Frequent Engineering Issues Received:
12 Months to December 2007



- **Security** (Ground)
- **Maintenance** (Line, Base, Repairs)
- **Regulation/Law** (Compliance with)
- **Procedures** (Use by Others, Adequacy, Existence)
- **Resources** (Manpower/Personnel, Tools/Equipment)
- **Company Policies** (Operational, Safety Reporting, Disciplinary/Grievance)
- **Documentation** (Suitability/Adequacy)
- **Pressures** (Commercial, From Management/Supervision, Time)
- **Training** (Technique, Relevance, Design)
- **Licensing** (Engineering)

A JUST CULTURE?

Report Text: A recent incident in our company has caused serious concern among engineers.

While an aircraft was on a maintenance check, an engineer was tasked to complete a modification, which involved replacing some avionics computers in the avionics bay, in which other work was being undertaken. The computers were replaced, tested and signed off. The next day, returning on shift, the engineer realised that he had forgotten to remove the old computers from where he had stowed them. He immediately informed the foreman, who in turn contacted Maintenance Control.

Unfortunately, the aircraft had completed the maintenance check and had just taken off; it is understood that the company notified the flight crew, who recovered the computers. An ASR was subsequently raised.

The following day, the engineer was interviewed by the Quality Department, and with no further investigation, his company approval was withdrawn.

This action taken by the Company raises serious concerns over the possible consequences of what appears to be a blame culture. If a similar incident happened again within the company, with the knowledge that this engineer's approval had been withdrawn for honestly reporting his error to management in an attempt to limit the possible consequences, would the engineer concerned take the same actions? Or would it be left until the aircraft returned and then quietly try to recover the situation, hoping that an event with serious consequences would not take place? Either way the approval would be withdrawn, so why not take a chance that nothing would happen and inform nobody of the incident?

We thought the aviation industry steered away from punishment under these circumstances, especially when a very experienced engineer has held his hand up and tried to honestly recover a potentially harmful situation as quickly as possible.

CHIRP Comment: **A 'just' culture is not a 'no blame' culture and where an individual has acted in a grossly negligent or wilful manner, disciplinary action may be justified; however, in such a case, a full open investigation should be conducted and the justification for any subsequent administrative action should be communicated to the workforce.**

In the case reported above, although not all of the circumstances are known, it is understood that a maintenance error investigation was conducted. Notwithstanding this, in the absence of a full explanation as to the rationale for the disciplinary action, the reaction of the reporter and his colleagues to the reporting of future similar incidents is understandable.

One of the foundations of aviation safety is trust. Trust is difficult to build and maintain, but can be destroyed very easily. This case would appear to be one in which actions by the company have spoken much louder than words about the corporate culture.

CONFUSION ON QUALITY STANDARDS

Report Text: My colleagues and I are in the middle of a merger of two companies, as a result of which our company assumed the responsibility for maintaining the ### fleet several months ago.

There have been numerous integration problems arising from the different working practices of the two companies which have been reported to our management.

Recently, the two engineering departments were merged into one organisation. However, part of the merger process is to run two AOCs until full integration is achieved in several months time. Up to this time we have to work to two sets of procedures. This is very confusing.

On speaking to the quality managers from both 145's no one is really in the know as to what procedures we should work to. As an example, we have no idea who to report a ground occurrence to, as we have two sets of forms and although we work for the new combined engineering organisation our majority of work is still on our previous company fleet. We have only just been given our stamps by the new organisation.

The feedback from our managers is that the CAA is happy with us just muddling on until the merger is completed and is aware that, as this is the first merger of this type, there will be problems. This isn't a very satisfactory answer or situation. We have the situation of two identical aircraft types sitting next to each other and being worked to different procedures. We don't really know what our direct report line is to Quality, which Director to speak to and what procedures to work to, from duplicate inspections to aircraft security sealing. It has been mentioned that we should work to the most restrictive procedure but some are so different that there is a conflict.

Our procedures training for maintaining the BBB fleet was an hour on the electronic tech log and five minutes looking at a paper one. Surely we should have the same procedures training as a new starter would, to highlight the new procedures and differences to those we are used to. Unfortunately this request has fallen on deaf ears, as our management are looking to the final integration without seeing what is happening now and are expecting us to get on with it.

Obviously we can understand the pressures they are under to fully integrate on the agreed timescale but we also need support and guidance during the months leading up to completing the merger.

CHIRP Comment: **In a merger such as that described the CAA requires the lead company to develop an integration plan of the two operations; this includes undertaking a risk assessment of all Approvals, including the AOCs, Part M and Part 145.**

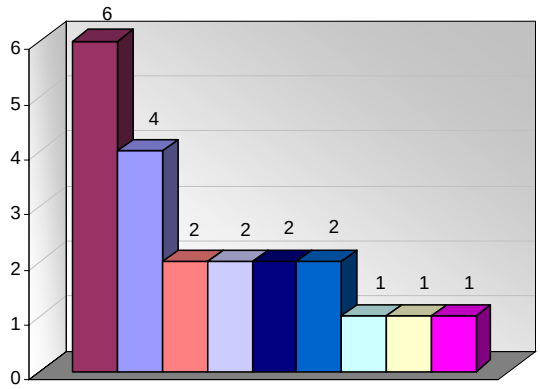
The decision to merge the engineering organisations, whilst continuing to operate under two separate AOCs should be supported by a clear plan describing how both AOC holders control their maintenance provider to ensure that the aircraft's continued airworthiness is assured.

Quality audits should ensure that transition plans are promulgated and clearly understood at all levels within the organisations concerned, with oversight by the CAA confirming that all necessary arrangements are in place.

The reporter's concerns have been passed to the CAA.

ATC REPORTS

Most Frequent ATC Issues Received
12 Months to December 2007



Air Traffic Management
(Separation)
Communications - External
(Pilots)
Duty
(Length, Rest)
Regulation/Law
(Compliance with)
Pressures
(Commercial, Domestic, Management)
Security
(Ground, In-Flight)
Procedures
(Use by Others, Adequacy, Use By Reporter, Lack of)
Handling/Operation
(Operation of Equipment, Airmanship)
Documentation
(Availability, Currency, Adequecy)

MORE STAFFING CONCERNS

Report Text: I would like to heartily endorse the comments made in CHIRP FEEDBACK 84 "The Straw That...".

I work as a controller at a small but busy Air Traffic Services Unit. Some time ago, due to a variety of reasons, our normal complement of available controllers was effectively halved for a period of several weeks. The situation eased slightly when another controller was validated but shortly thereafter our numbers were again reduced by a period of sickness.

Management was advised that the workload was such as to be causing individuals to become fatigued. The response was for us to change our shift pattern.

Somehow we managed to keep the operation running but had there been an incident or, God forbid, an accident ..... Need I say more?

CHIRP Comment: **There is a natural tendency, particularly at relatively small units, for staff to be asked to cover short-term absences in the manner described by this reporter.**

Whilst the Scheme for the Regulation of the Hours of Civil ATCOs in the UK (SRATCOH) provides guidelines for the avoidance of undue fatigue, it assumes that the Unit workload/manning levels have been assessed and are maintained in balance. Individuals and, in particular, managers need to be aware of the possible adverse effects of any additional workload associated with operating significantly below the appropriate manning level on a continuing basis, and mitigate any increase in the risk of fatigue by monitoring and, if necessary, managing capacity.

DIFFERENCES IN APPROACH PROCEDURES (FB84)

Report Text: Regarding the report "Differences in Approach Procedures" (FEEDBACK 84 Page 11), the procedure to which your reporter refers is not the ICAO procedure, as you state in your comment, but the "Modified Landing Clearance" procedure approved by ECAC states safety regulators for use at HIRO airports such as Heathrow, Gatwick, Stansted, Orly, Charles-de-Gaulle, Frankfurt, Amsterdam, etc. This procedure permits ATC to clear an aircraft to land on the same runway after a landing aircraft ahead or after a departing aircraft ahead, provided that certain separation distances can be achieved when the aircraft to whom the clearance is issued crosses the runway threshold. Responsibility for this separation remains with ATC ~ not the pilot.

CHIRP Comment: **The reporter's comment is correct. Use of Special Landing Procedures at Heathrow, Gatwick and Stansted in the UK by the ATC instruction, "ABC123, after the landing /departing (aircraft type), cleared to land Runway ##" is described in the UK AIP GEN 3.3 - AIR TRAFFIC SERVICES Para 6.4 and also in the relevant Manual of Air Traffic Services Part 2 for the above airfields, which contains airport-specific material.**

The precise separation standards and conditions of use depend on the airfield, runway and weather and are detailed at the AIP reference. However, in all cases the key difference from the Land After Procedure (AIP GEN

3.3 - AIR TRAFFIC SERVICES Para 6.3), in which the ATC instruction "ABC123, land after (aircraft type)" is issued, is that in the special landing procedure the ATCO retains responsibility for maintaining adequate separation.

The subtlety of the difference in phraseology between the two instructions will probably be lost on many pilots, whose first language is other than English. Also a significant number of UK pilots may be unaware, particularly as the special landing procedure is not described in CAP 413 Radiotelephony Manual - Edition 16. While this is unsatisfactory, in reality, in both cases the aircraft commander retains the ultimate responsibility for the safety of the aircraft and, in the case of the special landing procedure, the ATCO's continuing responsibility for maintaining the required separation provides an additional safeguard during closely sequenced landing operations.

Also, see the Flight Crew Report - 'Land After - A Comment' on Page 11.

CAA (SRG) ATSINS

The following CAA (SRG) ATS Standards Department ATSINS have been issued since October 2007:

Number 114 - Issues 12 October 2007

Change to UK ILS Phraseology

Number 115 - Issued 8 November 2007

Eurocontrol Guidelines for Contingency Planning of Air Navigation Services

Number 116 - Issued 13 November 2007

Winter Break 2007/08 (Christmas and New Year)

Number 117 - Issued 6 December 2007

Winter Operations at Aerodromes

Number 118 - Issued 10 December 2007

ATS Communication Facilities at Licensed Aerodromes: Publication of Designated Operational Coverage (DOC)

Number 119 - Issued 10 December 2007

Climb Above Notified Standard Instrument Departure Altitudes

Number 120 - Issued 13 December 2007

European Aviation Safety Agency (EASA) Consultation on Air Traffic Management and Air Navigation Services (ATM/ANS)

Number 121 - Issued 17 December 2007

Instrument Systems for the Assessment of Runway Visual Range

Number 122 - Issued 17 December 2007

ANSP Oversight of Air Traffic Control Service Provision

Number 123 - Issued 17 December 2007

Notification of Suspected Communicable Disease - Guidelines for Air Traffic Service Units

Number 124 - Issued 24 January 2008

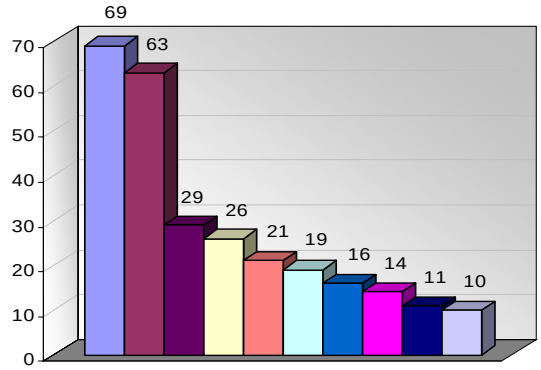
The European Aviation Safety Agency (EASA) Consultation on Air Traffic Management and Air Navigation Services (ATM/ANS) - Civil Aviation Authority (CAA) and Ministry of Defence (MoD) Response

CAA (SRG) ATS Information Notices are published on the CAA (SRG) website -

www.caa.co.uk/default.aspx?categoryid=33 and click on the link 'Search for a CAA Publication'

FLIGHT CREW REPORTS

Most Frequent Flight Crew Issues Received:
12 Months to December 2007



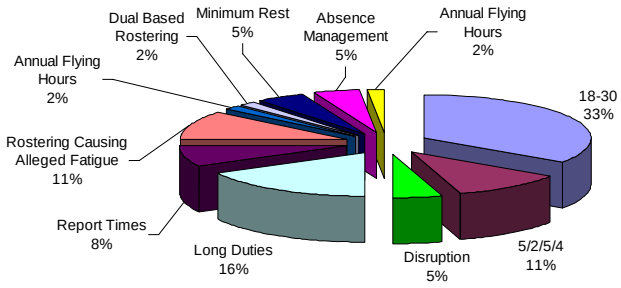
Duty
(Rosters/Rostering, Rest, Length, Crewing, Disruption)
Security
(Ground)
Company Policies
(Absence, Operational, Safety Reporting)
Communications - External
(ATC, Regulators/Government)
Air Traffic Management
(Separation)
Procedures
(Use by Others, Adequacy,Use by Reporter)
Handling/Operation
(Aircraft Handling by Crew, Airmanship)
Physiological
(Illness, Health, Injury)
Aircraft Technical
(Systems, Propulsion)
Training
(Technique, Relevance, Design)

DUTY/REST/FTL REPORTS - 2006/2007

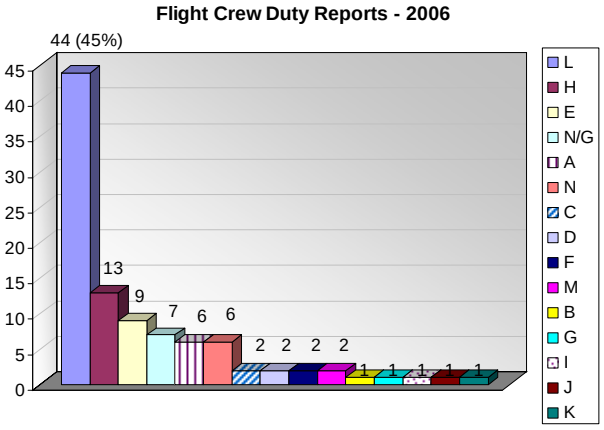
Introduction: Duty related issues are one of the most frequently reported topics by flight crew, as can be seen from the above chart summarising the issues raised in flight crew reports. In addition to individual issues being actioned on behalf of the reporter when relevant, an assessment of the trends in duty related reports received from flight crew members during 2006 was conducted in January 2007; the results of this assessment were submitted to the CAA.

A similar exercise has been carried for flight crew duty related reports received during 2007 and the results compared with those from 2006.

2006:



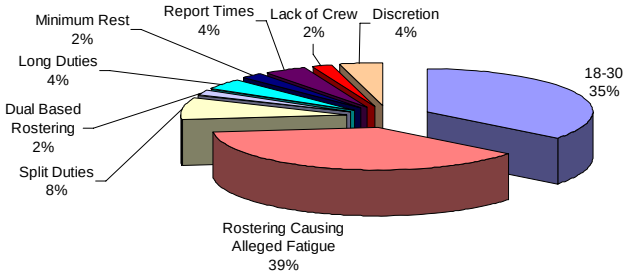
During 2006 a total of 98 duty-related reports were received in which 179 roster/FTL issues were identified. The three principal FTL issues raised in reports during 2006 were: Scheduling rest periods between 18 and 30 hours - 33% (32 reports); long duties 16% (16 reports) and allegedly fatiguing roster patterns 11% (11 reports). A fourth issue raised in a further 11% (11 reports) was the 5-2-5-4 roster sequence that had been introduced on a trial basis by one UK operator; in 9 reports in this group the roster pattern was the principal issue.



Of the 98 duty-related reports received during 2006, 45% (44 reports) were sourced from one UK operator (Operator L), two other UK operators (Operator H, Operator E) represented 13% (13 reports) and 9% (9 reports) respectively.

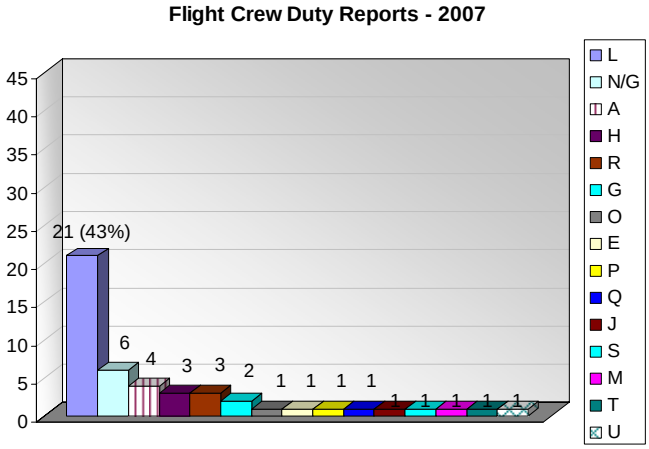
In the case of Operators L and H, the principal area of concern was the frequency of the rostering of rest periods of between 18 and 30 hours; roster disruption was also reported in the case of Operator L. All of the reports received from operator E referenced the 5-2-5-4 roster pattern

2007:



In 2007 a total of 48 duty-related reports were received, in which 69 roster/FTL related issues were identified; this represented a reduction in the number of reports of approximately 50% over that submitted in 2006.

The two predominant issues raised in reports during 2007 were allegedly fatiguing roster patterns - 39% (19 reports); scheduling of 18-30 hour rest periods was the principal issue in 35% (17 reports).



Of the total of duty-related reports submitted in 2007, 44% (21 reports) involved Operator L, less than half the number received in 2006 but a similar percentage of the total as in the previous year. Only three reports (6%) were sourced from operator H during 2007, compared with 13 reports (13%) in 2006. In the case of operator E, only one FTL related report was submitted in 2007 and this was not related directly to the operator's 5-2-5-4 roster pattern, which had been modified prior to the 2007 summer season.

EARLY MORNING WAKE UP CALL

Report Text: Reported for duty at 0530hrs; held in the early morning queue prior to takeoff for 40 minutes and then required to hold for over one hour at our European destination.

I was handling pilot for the second sector. The weather for take-off was RVR 6-800M, main cloud base at 100ft with low visibility procedures in progress. The take off roll and rotation were quite normal for low visibility, with the expectation of losing ground reference upon rotation. After rotation the First Officer (F/O) called, "Positive climb" to which I responded, "Gear up". In response to the "Gear up" command the F/O promptly selected Flaps 0.

Fortunately the aircraft has a relatively low Flap Retract Speed (Vfr) and we were light. Sink was controlled and level flight or a slight positive climb was maintained. The F/O realised his error just before the flaps became clean and reselected.

The subsequent climb was normal.

CHIRP Comment: **Many well-practised actions undertaken by qualified pilots are completed by 'motor action' where the action is automatic and requires little or no conscious thought. However, this report serves as a useful reminder that 'motor actions' are susceptible to mis-identification / mis-selection errors; such errors can occur very easily as a result of a momentary lapse in concentration.**

One way of avoiding an error of this type is to adopt the following sequence: consciously check the relevant limitation/ indication (LIMITATION) - make the relevant selection (SELECTION) - and confirm correct operation (OPERATION).

SEE AND NOT BE SEEN

Report Text: We were carrying out the Standard Arrival Routing (STAR) in VMC, being descended by Paris Control to FL50 when we received a TCAS Traffic Advisory; we stopped our decent at FL65 and became visual with an intruding A/C (PA-32), which passed 600' below us, right to left.

We advised Paris to be told that there was no traffic in our vicinity. The controller stated that he was not aware of the aircraft because it was on another RT frequency and was VFR, which is filtered out of the radar display!

The position of this event was in the far Eastern corner of Paris TMA 16. This area is Class E normally open to VFR traffic. However, NOTAM A2474/07 stated conditions for entry as a Temporary Restricted Zone: IFR- No restriction, VFR-compulsory by-passing of area.

The other aircraft was cutting the corner both horizontally and vertically. The vertical limits of the area are FL55 - FL85.

Without TCAS this could have been a much more serious incident.

Observations:

- Be aware that there is a large amount of Class E airspace in France to allow VFR traffic freedom to operate.
- This traffic may clash with scheduled commercial traffic under radar control flying a STAR.
- The temporary restricted zone identical with TMA16 exists to prevent situations such as the above occurring.

It should also be borne in mind that if we had not been within the vertical or horizontal limits of TMA16 we would have been in Class E airspace and obliged to give way to VFR traffic even though we might not have been made aware of VFR traffic by Paris control.

CHIRP Comment: **Many ATC radars have the capability to permit the controller to suppress selectively transponder information from aircraft that are not under his/her control in order to de-clutter the radar display.**

Filtering out those aircraft transmitting a VFR squawk (Code 7000) can lead to a situation similar to that described in this report, where the controller was not aware of the infringement by a pilot operating under VFR.

The reporter correctly highlights the wide use of Class E airspace in France; however, it is worth remembering that similar filtering techniques are used by ATCOs in the UK.

Although the Short Term Conflict Alerting system (STCA) that is available at major UK ATSUs will alert a controller of a loss of separation, it is important to maintain a good visual lookout at all times, particularly when operating close to the boundaries of Controlled Airspace.

THE COMPUTER SAYS "NO"

Report Text: Standard route UK - West Africa. Computerised briefing sent through to briefing room five minutes before crew depart for the aircraft. No NOTAMs available for our destination or either of two alternate airports. Computer printout stated "Other bulletins may exist", but did not satisfy company filters.

On arrival at destination, the ILS was serviceable, but both the VOR and NDB were U/S. The ILS procedure required either the VOR or the NDB.

This "computer says no" culture is repeated with several Southern European en route alternates such as Athens, which we overfly; the computer printout says "Not in route and weather criteria" or words to that effect.

This is a route from bad compliance to complacency.

CHIRP Comment: **One of an operator's responsibilities is to satisfy himself by every reasonable means that the aeronautical radio stations and navigational aids serving the intended route or any planned diversion are adequate for the safe navigation of the aircraft. Another is that every aerodrome at which it is intended to take off or land and any alternate aerodrome at which a landing may be made are suitable for the purpose. The latter includes, in particular, that they will be adequately manned and equipped at the time at which it is reasonably estimated such a take-off or landing will be made ..... to ensure so far as practicable the safety of the aircraft and its passengers. [The Air Navigation Order Part 5; Article 42 refers].**

Also, a reminder - The Air Navigation Order requires that the commander of an aircraft registered in the United Kingdom shall take all reasonable steps to satisfy himself before the aircraft takes off that the flight can safely be made, taking into account the latest information available as to the route and aerodrome to be used, the weather reports and forecasts available and any alternative course of action which can be adopted in case the flight cannot be completed as planned. [ANO Part 5; Article 52(a)].

If the appropriate en route/destination/alternate information is not available electronically, report the matter to Operations in the first instance and request that the relevant information be provided.

THE WRONG SAFETY CULTURE?

Report Text: I am concerned about the ongoing erosion of the safety culture in ####. Colleagues are now becoming afraid to file company Air Safety Reports because of the way that they are "investigated" by local management, who also hold the responsibility for promotion and discipline. On one recent occasion a junior Captain was accosted in the middle of a crowded crew room by a manager waving the ASR, who then proceeded to discuss it in front of everyone.

The fact that ASR's are not confidential and are investigated by the person responsible for discipline means that they are becoming totally discredited amongst the pilot community.

Many approaches have been made to the company; they have been ignored. Very, very worrying.

CHIRP Comment: **The reporter's concern was represented directly to the Head of the Safety Department of the company concerned and subsequently reviewed.**

RADIO FAILURE PROCEDURES

Report Text: I have read with interest the discussion concerning emergency descents. I wonder if I might flag up as a related issue the matter of radio failure procedures.

With emergency descents, there aren't really many options, and at least in the vertical plane, the direction of movement is obvious. With radio failure procedures, this is not the case at all: I suspect that there is a real can of worms here.

Here's an example. An aircraft is departing from one of the airfields in the London TMA, when due to a failure of their equipment, they become unable to transmit or receive on VHF. What happens next? Well, the first thing is that it will probably take some time before the flight crew identify that they may have lost communication, and possibly a few further seconds to confirm that this is the case. Then they are into the communication failure procedure. But which one? There is the ICAO standard procedure. But this procedure is overridden by UK variations. And on top of this, there are airfield specific variations - and these variations are dependent upon whether the aircraft is currently following the SID or (as we more normally are) on a radar heading. Starting from scratch, it wouldn't surprise me if it took a good seven or eight minutes to establish what the correct procedure is - and to be quite honest, I think that it is more likely that most unprepared flight crews would end up using the wrong procedure.

We looked at this in the simulator during recurrent training, and so I have some idea of what the procedure is at my base. There is no way that I would seek to do this from memory, and even having been through the procedure, I can't imagine it would take me much less than three to four minutes from the time of communication loss to getting into the correct procedure. Add to that the fact that certain parts of the procedure are supposedly based on elapsed times (from loss of communication, for example) which are unlikely to have been measured accurately, and it becomes apparent that the actions of even a clued-up crew are likely to be unpredictable.

So what should ATC expect? Anything from aircraft keeping their assigned heading and altitude and disappearing into somebody else's airspace to the aircraft doing exactly what is expected. Perhaps all that LATCC can hope to do is move everybody out of the way as soon as they know that somebody has lost RTF communications.

As with the emergency descent, there are too many possible procedures, and they seem to have been written with no thought as to what would actually happen were the situation to arise.

CHIRP Comment: **The reporter raises a very interesting point. NATS has advised that RTF communications difficulties are not uncommon. Would you be confident that you could handle a RTF communications failure on your next departure?**

If you should experience such a problem, NATS advise that from an ATC perspective, the most important action is to select Mode 7600 as soon as you are aware of a loss of communications; this will alert your controller and those controlling adjacent ATC sectors to your predicament. Also, consider what other methods of two-way communication might be available to you, if you are unable to restore VHF RTF communications.

As a result of the issues raised in this report, CAA (SRG) has elected to undertake a review of the current Loss of RTF Communications procedures.

COMPANY INTEGRATION & TRAINING (1)

Report Text: My employer merged with another operator earlier this year. In the several months during which the integration of the two airlines' operations were planned very little operational information was provided to my pilot colleagues and me, although we would find ourselves exposed to a new & very different operating environment from the date of integration.

A couple of weeks before the integration date we were bombarded with e-mailed memos from management covering new SOPs, new aircraft & differences, new destinations and route briefs, operations over high ground with decompression escape routes, operations in African Inflight Broadcast Areas, new aircraft performance tables, and operations on the Tango Oceanic routes, to name but a few. A heck of a lot of new information & major changes to be absorbed in a short period of time at home during our rest.

In contrast, our new colleagues from the other company were all given two days induction to their new operating environment. Our new colleagues are also receiving line training for their new environment.

We the larger group were given no training time by the company to help absorb the operational and safety aspects of all of the changes. Our pilot group also includes a significant number of recent joiners who are new to the job and have low hours. Apart from one trip to a metric altimeter destination we receive no line training for our new operations. I am particularly concerned that one day soon I may launch off with another colleague to a part of the world that neither of us has ever operated to before and all we will have to keep us safe are a big pile of memos. In other airlines, would operation in areas of the world requiring decompression escape routes, "DIY" ATC in the African Inflight Broadcast Area and operation on the Tango routes in Oceanic Airspace, not require proper training with some ground school and then line training?

This company already operates on the Tango routes occasionally. Apart from a company memo I have never had any formal training for it and on the occasions I have found myself unexpectedly launched into oceanic airspace at short notice and using HF, I and my colleague have not been particularly comfortable with it and have bumbled through.

We also used to benefit from proper annual technical refresher classroom days with excellent trainers providing very useful information not to be found in our manuals. However, now we only get issued with a DVD disc for home study, the quality of which is very poor and merely tells us little more than the number of wings

the aircraft has and presumably just ticks the box required.

The company has experience of training issues from a major incident some years ago and I am concerned that a lot has been forgotten from that. I find it difficult to believe that any proper risk assessment would put our crews in the position that we currently find ourselves in.

(2)

Report Text: I have concerns as to the suitability of continuation training following the absorption of another company into the operation. There have been significant changes to the SOP's in the company, so much so that we all carry a green and red card in our licence to check compatibility with our colleagues; if we are not compatible we cannot fly together.

Our new colleagues cannot fly the (aircraft type) or do short field landings until checked through the company LPC/OPC and then only on their own after 8 sectors of line training. To this end it has now transpired that the company is/has been actively rostering 2 captains on the same check, and also 2 F/O's on the same check; so it's a huge game of musical chairs. I question the learning that this generates especially for the F/O's as they have to act as a "captain" for the other guy in evacuation and low visibility scenarios, which is far from acceptable and could be a very negative training scenario. Captains are less disadvantaged as they are cross-seat qualified.

The company response is a shrug of the collective shoulders and a 'get on with it' mentality; one trainer has been quoted as saying, "rostering of duties is to convenience only the rostering department and has no enhancement to flight training and safety". I concur. I think it is quite wrong especially when some double-ups occur during the same days or very close together, when a little rostering/training overview could prevent this from occurring. We are told it is "legal" but not perfect. How would the flying public perceive this arrogant attitude?

The company is just rushing this amalgamation training through to reduce the impact on the operation of so many people being "differently qualified"; a clear example of get the job done at all costs. It was reported that at a training meeting when the (other company) trainers came across, they were told that we were not interested in how they did things before, this is how it is now, making the ludicrous and dangerous assumption of we know best, despite the fact that most of our company trainers had no knowledge of any of the other company's destinations and the challenges that the other company came across daily. To that end our company dispatched crews with little or no knowledge of the part of the world to which they are operating; the resulting scene in the crew room was one of our company crews hunting down (other company) pilots for some "gen" on the route they were about to operate.

CHIRP Comment: **As in the case of the Engineering Report on Page 4, in a merger of this type the lead company is required to undertake a risk assessment (RA) to identify key areas of risk and to determine appropriate mitigating strategies. In a case where it is proposed that flight crew members will cross-operate, it would be anticipated that the RA would include a survey of routes/destinations in relation to individuals' previous route experience prior to the merger to identify the need for any additional training requirements.**

These two reports are among a number that we have received in which concerns have been raised about the adequacy of the training that has been provided to some flight crew members prior to tasking them to operate to/from destinations with which they are unfamiliar.

The concerns have been passed to the CAA.

AN UPDATE ON SMOKE HOODS

CHIRP Narrative: **Following the publication of a report in the Summer 2007 issue (FEEDBACK 83), in which the reporter questioned whether exposure to smoke generated in smoke hood training exercises had any health and safety consequences, we received a number of comments that were critical of the lack of detail in the CAA advice that we published and also criticised us for "letting the CAA off the hook".**

Further discussions have been held with the CAA Medical Department on this topic. The CAA has pointed out that the information provided in FB 83 was based on their general knowledge of artificial smoke generation. The use of such systems in simulators and ground training is not regulated by the CAA but by the Health and Safety Executive (HSE), as part of the Health and Safety at Work legislation. The advice of the HSE and also the Health Protection Agency, which has the responsibility for protecting people from hazards associated with chemicals, has been sought on the matter and will be published in due course.

The following comment was received on the usefulness of smoke hood training:

Report Text: In response to the report in FEEDBACK Issue 83 re: smoke hoods, the purpose of practising donning a smoke hood is in the event of a fire whilst airborne - it demonstrates how disorientating a smoke filled cabin can be.

Whilst locating and removing a 'body' might not be a realistic scenario, locating and using fire fighting equipment in near zero visibility is a worthwhile training exercise. It was eye-opening to me when doing this for the first time, as the annual drawing of location diagrams really became useful.

LAND AFTER - A COMMENT

CHIRP Narrative: **In the last issue of FEEDBACK a reporter commented on the practice at a major French airport of clearing an aircraft to land while another aircraft was ahead on the approach. The following is one of several similar further comments and is published for the benefit of those who might not be aware of the French practice:**

Report Text: In my experience, a UK 'Land After' is not the equivalent of a 'Clear to Land', issued by #### ATC (while number 2) at all.

A UK 'Land After' always seems to come at the last minute, when the previous aircraft is touching down and you are on a very short final behind, and no further runway incursions are likely to happen in between.

The 'Clear to land' (while still number 2) used by some major French airports can be given at eight miles out. Anything can happen between 8 miles and the landing, so the clearance is somewhat meaningless.

CABIN CREW ROSTERING & DISCRETION

Report Text: During turnaround between 2nd and 3rd sectors of a 4-sector duty, the In Charge discussed with me whether the rostered duty that she was currently flying was legal under the terms of CAP371. The cabin crew are required by the Company to report 75 minutes or 90 minutes prior to Scheduled Departure time and in this instance, this led to a maximum Flight Duty Period of 10 hours based on a report time of 0545 local prior to a scheduled departure time of 0700 local. The rostered duty period however was 10 hours 30 minutes and therefore the cabin crew were concerned that they might have been rostered a duty period in excess of CAP371 limits based on their report time.

When calculating the maximum Flight Duty Period for the crew, I had adopted the normal company procedure of applying the report times for the flight crew to that of the cabin crew in order to determine the maximum allowable duty period under CAP371 limits, which in this case, based on a report time for the flight crew of 0600 local gave the cabin crew a maximum Flight Duty Period of 11 hours 45 minutes, therefore the duty appeared to be perfectly legal.

The problem was no reference to the company procedure of applying a common report time to all crew members could be easily located in the company Operations Manual and in addition, we could pick up new crew members on any sector and it would be inappropriate to apply the flight crew report time to cabin crew members who join on sector 4. I suggested to the In Charge that she reported the matter to Crew Control and cabin crew management. She indicated that she would rather abide by my decision as to whether the duty could be operated legally, but pointed out that if we calculated the maximum allowable FDP based on her report time and not mine, then the duty was not legal and her individual responsibility was to report the matter to the commander.

The reason for this report is that the practice of rostering up to within 30 minutes of the maximum allowable Flight Duty Period is becoming commonplace for the cabin crew and because of the difference in report times between flight crew and cabin crew; it is becoming increasingly difficult to monitor Duty Periods of all crew members. It is also common for cabin crew to be rostered for 4 sectors but for flight crew to be rostered for only 2 sectors. This further complicates matters, particularly for the commander of the 3rd/4th sector, as it will normally be his decision as to whether commander's discretion will be needed to extend a duty period.

I am concerned that if asked by a Flight Ops Inspector to prove that my crew were legally rostered for this duty and "in hours", I would not have sufficient information easily available to me to prove it as I would not be able to easily find reference in the manuals to the Company practice of using a common report time for flight crew and cabin crew. Nor would my crew be able to undertake individual responsibility for their maximum allowable Flight Duty periods as they only have direct access to their individual report time which may vary considerably from that of the flight crew.

CHIRP Comment: **The criteria for determining when a cabin crew member's Flight Duty Period (FDP) should be based on the flight crew report time should be stated in the Company's Approved FTL Scheme; this point was referred to the CAA. Also, it is a CAA requirement that cabin crew should have access to FTL information.**

In spite of the above requirements, cabin crew do not always understand that their actual report time is not necessarily the report time that applies for the calculation of their Flight Duty Period. In circumstances where the cabin crew and flight crew rostered duties are different, such as those outlined in this report, or when a crewmember is called-in from standby and the time of the standby is to be taken into consideration, it would be helpful for the Aircraft Commander to clarify the situation for all concerned before flight. This would enable the In Charge subsequently to notify the new Aircraft Commander of the cabin crew's correct report time to be used in the calculation of their maximum FDP.

CABIN CREW REPORTS

CONTROLLED REST

Report Text: We operate this route with a heavy flight crew due to sector length. During flight, one flight crew member was sat in the cabin asleep (as per their agreement). We were advised that a second flight crew member was having "controlled rest" on the flight deck so we were told not to ring the flight deck. This left two flight crew members asleep and only one on duty.

After returning to the flight deck from his rest in the cabin, the first flight crew member immediately went into "controlled rest".

This happened throughout the whole sector so we only had one flight crew on duty as two were constantly on break either in cabin or with a pillow and blanket on flight deck.

CHIRP Comment: **There may be occasions, for example when a flight crew member has been unable to achieve a good quality of rest in a bunk/cabin seat, when the individual elects to take a further period of 'controlled rest' on the flight deck, provided that the company procedures permit this in the circumstances. If such a case should arise, good practice would be to brief the senior cabin crew member accordingly.**

Any time one flight crew member on the flight deck elects to take 'controlled rest', the cabin crew briefing should include the arrangements for regular checks by or to the cabin crew in accordance with company SOPs, to ensure that the non-resting flight crew member

remains alert and the resting flight crew member does not enter a period of deep sleep.

NOISY LANDING

Report Text: On approach crew were warned that there may be some turbulence during landing. Once the aircraft had actually touched the runway it appeared from inside the cabin that the aircraft was travelling rather fast and that the engines were extremely noisy. All the cabin crew noticed this and some became a little concerned, especially those at the rear doors.

Once we were able to talk to the flight crew, it was explained that this was a normal full reverse thrust landing. The flight crew were surprised that the cabin crew were aware of the different feel of the landing. I think it would be useful to prevent cabin crew from becoming anxious during these landings. This could be easily done if the flight crew notified the In Charge whenever possible if they know this type of landing is probable.

CHIRP Comment: **Some operators use reverse thrust routinely. However, for those operators whose SOPs specify the use of full reverse engine thrust only when necessary or if the Aircraft Commander determines its use to be prudent, whilst it will not always be possible to warn the cabin crew in advance, on occasions where the use of full reverse thrust can be anticipated, briefing the cabin crew as the reporter suggests will avoid undue concern.**

CAA (SRG) FODCOMS

The following CAA (SRG) FODCOMS have been issued since October 2007:

26/2007

Change to UK Instrument Landing System (ILS) Phraseology

27/2007

Changes to the UK High and Medium Level Significant Weather Charts

28/2007

Guidance for Operations on a Runway That Is Notified by NOTAM as 'May Be Slippery When Wet'

29/2007

Requirements for the Wales Rally GB 2007 Event - 29 November 2007 to 2 December 2007

30/2007

Civil Aviation Authority Symposium on the Implementation of EU-OPS - 13 December 2007

31/2007

Training Needs for Cabin Crew Fire Training

32/2007

The Handling of Thrust Levers during Landing with a Deactivated Thrust Reverser for Airbus A318/319/320/321 Aeroplanes

33/2007

CAA Actions to Prevent Illegal Public Transport

34/2007

Aircraft Loading

35/2007

Guidelines for the Notification of Suspected Communicable Disease

36/2007

Winter Operations Update

37/2007

Letter of Consultation: Proposal to Amend the Air Navigation Order 2005. Impact Assessment for the Amendment of Air Navigation Order 2005 Article 25 to Change the Crew Composition Requirements for Helicopters Flying Under and In Accordance with the Terms of a Police Air Operator's Certificate

38/2007

CAA Winter Break 2007/08 - Provision of Emergency Service to AOC Holders

39/2007

Cabin Crew - Crew Resource Management (CRM) Forum - 2008

40/2007

Protective Breathing Equipment (PBE) Training

1/2008

Operations Manual Instructions for the Reconciliation of Fuel Uplift Prior to Flight

2/2008

Variable Maximum Take-off Weight

CAA (SRG) Flight Operations Department Communications are published on the CAA (SRG) website - www.caa.co.uk/default.aspx?categoryid=33 and click on the link 'Search for a CAA Publication'

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