CHIRP FEEDBACK

Issue No: 92 Autumn 2009

EDITORIAL

CHIRP - A FINAL OPPORTUNITY TO COMMENT

In the last Issue of FEEDBACK we invited you to send in your comments on the effectiveness of this Programme. I am pleased to report that the comments received to date have been generally very positive; however, we do need more, if possible.

As many of you know, although this Programme is entirely independent of CAA (SRG) and separately managed, the Programme is funded by a grant from the CAA, which in turn is funded through the charges/levies on UK commercial and general aviation.

You will also be very aware that many sectors of the aviation industry are facing serious business/financial pressures; this in turn places pressure on the CAA financing. In this very difficult financial climate, some senior managers have questioned the relevance of retaining an independent confidential reporting programme on the basis that most UK AOC holders espouse 'open' reporting through their company schemes, operate flight data monitoring schemes and, in several cases, their own confidential reporting schemes.

Against this background, it is most important that the views of pilots, air traffic control officers and engineers are available for consideration by the independent Review Board. Remember that this is <u>your</u> Programme; if you appreciate what we do, take a few minutes to record this; if you think that we could do better, now is your chance to tell us.

Finally, a reminder - we have no executive authority - therefore any changes in policy that we are able to influence sometimes take longer than many would wish, including ourselves. For example, the clarifications to the FTL Guidelines published in FODCOM 10/2009 issued in April 2009 were the culmination of representations over more than three years. Similarly, the appropriateness of the ICAO emergency descent procedure within the UK FIR was first raised through this Programme in 2007; the AIC clarifying the procedure was issued by the CAA in July 2009.

You can submit your comments by several methods: via the 'Comment' button on our website: www.chirp.co.uk, by e-mail to: confidential@chirp.co.uk or by using the attached report form. Every comment received by the Review date will be made available to the Review Board.

EMERGENCY DESCENT PROCEDURES IN THE UK FIR

In 2007 a query was raised through this Programme about the emergency descent procedure to be used by an aircraft in the UK FIR (FEEDBACK Issue 83; Page 7 refers). After being reviewed by the CHIRP Air Transport Advisory Board, the matter was referred to NATS and CAA (SRG) for further consideration.

The recommended emergency descent procedure to be used in the UK has been recently promulgated in Aeronautical Information Circular (Pink 052/2009). The procedure differs from that published in ICAO Doc. 4444 (PANS-ATM) and more recently in ICAO Doc. 7030/EUR - Regional Supplementary Procedures, paragraph 9.1 in one significant respect, stating that ".... If able, pilots should remain on the assigned route or track whilst carrying out the emergency descent; unless to do so otherwise would endanger the aircraft. (Paragraph 2.4.1).

The full text of the AIC is available at www.ais.org.uk. Notification of this preferred action in UK airspace is also to be published in the UK Aeronautical Information Publication - General

MARINE SKY SAIL



This photograph is reproduced courtesy of CHC Helicopter and shows a vessel operating in the Southern North Sea using an experimental 'Skysail'; the skysail is attached to the bow of the vessel. On this occasion the sky sail was at an altitude of around 1,000ft asl and described as 'moving erratically'.

The vessel is one of the first in a research project using skysails to augment traditional forms of propulsion. Collaborative work is ongoing with the designers of the 'Skysail' system and a number of National Aviation Authorities to identify a suitable method of safely integrating skysail activity with offshore aviation

AIR TRANSPORT FEEDBACK is also available on the CHIRP website - www.chirp.co.uk

An Air Transport Safety Newsletter

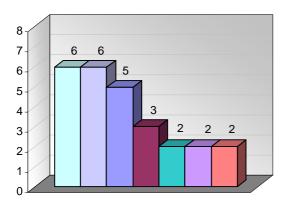
from CHIRP the Confidential Human Factors Incident Reporting Programme

operations. Until such times as the integration issue has been resolved, it is recommended that any sightings of skysails should be reported to ATC to permit other aircraft operating in the area to be alerted to the vessel's presence.

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ATC REPORTS

Most Frequent ATC Issues Received 12 Months to September 2009



| | Air Traffic Management |
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| | (Separation. Level of Service) |
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| | Regulation/Law |
| | (Compliance with/Knowledge of) |
| | Airports |
| | (Runways, Bird Control, Infrastructure) |
| | Duty |
| | (Length, Rest) |

Manning Pressures (1)

Report Text: I and an increasing number of my colleagues are becoming concerned about how this Unit is drifting towards a situation where insufficient staffing numbers seems to becoming the norm. On two occasions there have been reports filed by staff members where the reporter has been pressurised by management not to file the reports. On a recent night shift the Unit ran with only two controllers for a night shift when three is the minimum usually rostered. This situation was apparent to management for several weeks prior to the shift.

We have been and are being more regularly placed in situations whereby, if a controller has an incident, there are insufficient staff members available to relieve the controller from the position regardless of the severity of the incident without actually closing the airspace. Standard management response is that they cannot allow for sickness or incidents in manning but surely once the above situation is reached then there is a safety implication which must take precedence over the financial considerations.

On the night shift mentioned above, if an incident had occurred, then several sectors would have closed, incurring massive costs and delays. Staffing levels are now taking precedence over safety at this Unit which, at least as far as controllers is concerned, is both unacceptable and negligent.

CHIRP Comment: The reporter's comments were referred to the Unit management.

The Unit response stated that the Unit had lost a number of experienced controllers as a result of some staff and services being relocated and had increased training to compensate for this loss. Overall, the Unit staffing levels were considered to be appropriate for the traffic levels, which had suffered a downturn; however, it was acknowledged that a reduction in the number of multiple validated controllers had reduced the flexibility in manning; this was being reviewed.

The Unit Management expressed concern about the reporter's perception that staff had been pressured not to file a report and emphasised that this was not management policy. Should you perceive that you are being placed under pressure not to report a safety related issue, remember that you can submit a confidential MOR directly to CAA (SRG) or, if you would prefer, submit a CHIRP report.

(2)

Report Text: The Operations room at this Unit has seen a noticeable drop of traffic volume since last autumn. Indeed we had a winter with fewer flights and a chance for staff to recharge their batteries before this summer got underway. In the last months the traffic has increased but is manifesting itself as a series of peaks and troughs of traffic throughout the day; these are variable in intensity and duration and only partially predictable, even with our flow management options.

This leads to much splitting and combining of sectors. The safety implications of slow/poorly staffed splits are all too evident. Our television screen notice boards have safety messages running - not least of which is the one reminding us that handovers (and by default splits) are a time when incidents more commonly occur.

Staffing a sector requires a team of three: Tactical Controller, Planner Controller and an ATS Assistant. The team system is under strain, particularly since the addition of new sectors. A number of times where a Local Area Supervisor has called a split recently, there has not been an Assistant out on a bleep (On Call via a telephone bleeper). This is because they have relied on "someone turning up" which led to the sector opening without the Assistant even having arrived to relieve the night shift!

Another problem is that of basic manning, there are a number of people involved in ensuring there are enough staff for a given sector group on a given day. Often the numbers look right but closer inspection shows one or two of the apparent staff are on later shifts and are not available immediately as would first appear, this should be picked up by at least one of the above people before it gets into the Ops room.

These problems need looking at dispassionately: not by those who have a vested interest in the implementation of the Interim Future Area Controller Tool Set initiative (IFACTS), which will be accompanied by a reduction in manning, but by those who wish to keep the operation working safely and smoothly.

Lessons Learned: That's what I am hoping to provoke!

CHIRP Comment: This report was made available to the Unit management with the reporter's consent.

The Unit management acknowledged that there had been some manning problems associated with the handover period between shifts, termed the 'shoulder' period. In view of these, the start of the oncoming shift had been recently advanced by 30 minutes; this appeared to have addressed the problem.

The Unit management had also reviewed the effectiveness of telephone pagers to alert individuals that they were required for duty; individuals were now paged and, if there was no response, they were alerted by a PA broadcast.

The Unit management acknowledged that they were aware that the introduction of IFACTS had led to concerns among some Air Traffic Service Assistants as to their future role/employment.

DISTRACTION - UNFORESEEN SHIFT EXTENSION

Report Text: I was on duty and had been training somebody all morning; the traffic had been extremely busy. My trainee vacated the building and that left me as the sector controller until the afternoon shift arrived to let me go home.

I had been 'plugged in' for 1hr 10 minutes and was preparing to leave to go on to a pre-arranged personal appointment when I discovered that the only valid controller for my sector who could release me would be delayed in commencing their duty due to a childcare problem. On many occasions, staffing permitting, my watch has released individuals early to assist with this type of problem.

Thus, I was required to remain 'plugged in'....getting very annoyed that I was still working past my shift end time....and now was going to be late for my scheduled appointment. Eventually the incoming controller arrived.

The issue of unplugging late is not the main point of this report...it's the fact that I felt that my attention was not totally aimed at the aircraft receiving a service from me. I took the matter up with my manager as this issue has been ongoing for a considerable period of time. I am aware that at least one of my colleagues filed a SCRATCOH bust form regarding a similar incident.....and was advised by a manager that this was not appropriate as SCRATCOH bust forms are for use when a controller exceeds his work time....which I believe he did.

I have been told that other units use a form specifically for use when a controller is late into work and delays another controller from leaving at the end of the shift.

Lessons Learned: I feel a form should be made available for use when a controller works in excess of their shift hours.....and somehow controllers should receive help from their management if other controllers are placed in this position again.

CHIRP Comment: Many ATC Units afford their operational staff considerable flexibility in ending shifts if the traffic load permits; however, if a particular situation has been ongoing for a long time and remains unaddressed, this can lead to frustration and a less flexible attitude.

The issue was discussed with the operational management who advised that there is no specific reporting procedure for a case such as that described. It was suggested that the most appropriate method would be to make an entry in the Watch Log or, if the situation did lead to an individual actually feeling distracted, a Safety Observation should be raised; all Safety Observations were reviewed by management.

It was also pointed out that shift handovers are part of a working practice agreement within the SRATCOH limits. The extension of duty referenced in this report did not involve a breach of the SRATCOH regulations and thus an MOR would not be required; this was confirmed by the CAA.

SUPPLEMENTARY INSTRUCTIONS / ATSINS

The following CAA (SRG) ATS Standards Department ATSINS and Supplementary Instructions (SI) to CAP 493 MATS Part 1 have been issued since **17 July 2009**:

SUPPLEMENTARY INSTRUCTIONS:

Number 2009/10 - Issued: 7 September 2009 -

Effective: 5 October 2009
Mode S ATC Procedures

Number 2009/11 - Issued: 9 September 2009 -

Effective: ImmediatePosition on Identification

Number 2009/12 - Issued: 12 October 2009 -

Effective: 19 November 2009

ATSINS:

Number 163 - Issued 22 July 2009

Introduction of EU-OPS 1 Regarding all Weather Operations

Number 164 - Issued 22 July 2009

Malicious Use of Lasers Against Aircraft and ATS Personnel

Number 165 - Issued 31 July 2009

Implementation in the UK of the European Union (EU) Directive on a Community Air Traffic Controller Licence and Associated Medical Requirements

Number 166 - Issued 3 August 2009

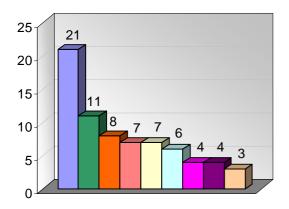
European Requirements to Share MOR Data

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

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

ENGINEER REPORTS

Most Frequent Engineering Issues Received: 12 Months to September 2009





PART 66 LICENSING STANDARDS

Report Text: Could I acquaint you with my recent experience of dealing with the CAA when I had my limitations removed from my EASA Part 66 licence. As with other Section L licence holders I converted a few years ago but had limitations one and nine against all my aircraft types.

My company decided that a properly organised module course with a Part 147 approved organisation would be the way to go. So over about a year I completed the five required modules in two sessions and earlier this year submitted a pack of papers, course certificates and worksheets for all the appropriate work I had carried out over the years in order for my Quality department to add their comments and send in to the CAA on my behalf.

A couple of weeks later I had a letter from the CAA stating that as my module course certificates had not been sent they would be unable to issue a new licence and were in the process of refunding the money. I telephoned the CAA (SRG) straight away; I asked them to hold the refund and I would get the course certificates to them that day. This I did and sat back again to await developments. Another four weeks elapsed and then my new licence arrived but with all the limitations still on it!

I visited the CAA to ask the assessor what was going on; he pointed out that it is actually a two-stage process and on the application form I had only ticked the first stage box. In other words my limitations had been removed from the basic licence but not the aircraft types; this was stage two.

There were some other issues which were pointed out and these were all addressed on the next submission of forms. Several more weeks went by, then a call from my Quality Department informed me that the CAA were not happy with some of my aircraft type course certificates as the company logo had changed; also some early aircraft type course certificates were no longer valid as the courses were not EASA 147 approved. As was stated they were good back in pre- EASA days so they should be honoured today. I am still signing off those aircraft currently.

All was finally accepted but the whole experience left me thinking why on earth I bothered. Not to mention the

costs involved, especially for the company as the Pt 147 courses were not cheap. Fair enough, I (and the company) made some errors with the application forms but I would have thought it blatantly obvious what I was trying to achieve.

It is ironic that a couple of my colleagues have EASA licenses issued by another European country and guess what? They were given full B1 status straight away. My final point is that our CAA insists on six months worth of experience on a new type whereas the rest of Europe seems to accept two weeks.

Level playing field? I think not.

The reporter's comments were referred to the CAA, who provided the following response:

The CAA system, prior to the introduction of JAR-66 and subsequently subsumed into Part 66, had been a complex arrangement of licences with some 27 different subcategories that could be held in any combination. The presentation of the CAA system to the JAA had led to the agreement that a number of limitations had to be applied on conversion. This simply reflected the fact that the UK basic licensing system did not exactly match the new European requirements. The limitations could be removed by passing additional multi-choice exams, a relatively simple process. These could be conducted by either a suitably approved Part 147 organisation or the UK CAA in the normal manner.

The failure in the reporter's application process highlights the importance of making a correct submission and, if in doubt, contacting CAA Personnel Licensing Department for advice. In this case the application had not been supported by the certificates of examination which are an important part of the process. This had been the reason why the basic limitation removal application had been rejected. The CAA's failure to accept some of the reporter's existing type training certificates appears to have been an administrative error, which had been subsequently corrected.

With respect to the reporter's point about other European Licensing Authorities, the assumption that the issue of full B1 licences by other Authorities without any limitations being applied has led to an un-level playing field is not valid. When the requirements for the conversion of licences were considered it became apparent that the system of education and training differed quite substantially across the EU member States. For example, the French State education system provided focused aviation related training and the formality of the German apprenticeship at both a general and industry sector specific level is well known. Regrettably, this was not the case within the UK and the CAA were unable to credit the academic system due to syllabus and examinations standard differences. Also, apprenticeships were largely unfocused in the UK rather than being targeted to meet the licensing syllabus or requirements. For these reasons it was not possible to compare the States on a like-for-like basis.

On the reporter's final point, the UK CAA does not require six months of work experience on all aircraft types prior to licence extension. The requirements are published in Part 66.A.45 and are varied dependant upon the types already held and the level of practical training undertaken on the aircraft type.

CHIRP Comment: We are aware that other engineers have reported experiencing difficulties similar to those reported here.

Whilst the detailed requirements are readily understood by those who deal with such matters on a daily basis, it is not unreasonable to assume that they are perceived as being complex and perhaps somewhat bureaucratic by individuals who encounter them on a one-off basis. As suggested above, if after checking the guidance material available you are unsure of what is required, contact the CAA for advice prior to submitting your application.

COMMENTS ON ENGINEERING EDITORIAL (FB91)

(1) - STAFFING

Report Text: Your engineering editorial in the last issue of FEEDBACK mentions human factors and other points related to errors but you are missing one vital point - Staff shortages and too much management pressure to carry on working. If a number of aircraft can be done by one certifying engineer then why have two?

This area is the main cause of errors and human factors issues!

CHIRP Comment: It is acceptable in circumstances of staff shortages for an engineer to be asked to cover one or more aircraft. The key issue is the nature of the task. The level of supervision required to cover routine turnarounds is different from that involved in supervising several teams of mechanics or overseeing several complex tasks. The situation can only be managed locally and the engineer has to take responsibility for saying no when, in their professional view, the situation becomes too much.

The 'pressure' to maintain on time departures whilst coping with staff shortages is often driven by operational individuals with no appreciation of the risks associated with their demands. However, company managers have to recognise their responsibility and their culpability in the case where an accident or serious incident follows a rushed departure.

The primary purpose of collecting and analysing company MEDA reports in the MEMS programme is to provide objective data as to the causes of maintenance error incidents. As the summary published in the last two issues of FEEDBACK shows, the principal type of error is that associated with installation. As with several other error types, one of the root causes of installation error is pressure; however, this is by no means the only cause and, in many cases, the pressure is not that from management or staff shortages but self-imposed pressure by a well-intentioned engineer.

An important objective in the further development of the MEMS programme is to enable company MEDA investigations to be analysed for objective root cause data. This will support or modify subjective views, such as those expressed in the above and the following comments, and will provide a basis for implementing change/ improvements.

(2) - INDEPENDENT INSPECTIONS

Report Text: As a Licensed Engineer for more than 30 years I like to think that I have been brought up in the "old school" by some great engineers at various companies. I cannot begin to tell you how horrified I was to read about the Maintenance Errors in the CHIRP FEEDBACK Summer 2009. I cannot believe that such errors have occurred when, as you state, we supposedly live in a Human Factors world, which has of course replaced common sense!

So much for Independent Inspections, another example of reduced standards, as shown with those flight control installation errors as with the loose Boroscope plugs, the last Airline that I was involved with included Boroscope Plugs, Engine Turning Covers, MCDs, Steering Components and Escape Slide Installations as a Duplicate Inspection requirement. They kept the Duplicate Inspection standard where two CRS's were required not just one and a so-called 'trained person' to carry out the "independent inspection".

Of course I understand why airlines/maintenance organisations in general run with the Independent Inspection; it's cheaper! As for leaving a torch in an engine intake; panels left insecure; oxygen systems filled with Nitrogen; surely such incidents are all indicative of poor training in the first place because it's cheaper! The loss of engine oil because of a missing engine gearbox component is somewhat alarming in itself, considering what happened to the BM B737 when the engine turning point covers were left off.

I just hope that you will not have cause to publish even more examples of maintenance errors in forthcoming editions of CHIRPS as I for one will then have to consider keeping my feet firmly on the ground.

CHIRP Comment: The CAA continues to recommend that duplicate inspections are applied to system adjustments on flying controls, engine controls and related systems where the performance of the aircraft can be affected by errors during breakdown, reassembly etc. The reason for this and the use of fully qualified staff, capable of signing a CRS, is clear and the purpose critical. A full assessment of the system, including any possible disturbance remote from the area of working, cannot be carried out without the knowledge of the system and the critical points that lie within it.

The use of independent inspections has always been accepted as a second check where incorrect installation has been an issue in the past. Magnetic chip detectors, escape slide installation are examples where the use of two sets of eyes, not necessarily capable of signing the CRS, is of benefit. CRS signatories can be used to perform both parts. However, the fact is that the failure of two staff, the one who did the job (mechanic) and the one that signed it off (engineer) has led to many maintenance errors. In most cases, the evidence suggests that post-installation function checks, which provide another set of defences in the 'Swiss Cheese' model, were not performed

As the reporter notes, there is no room for complacency and inadequacies in training is only one,

albeit an important, element of the maintenance error equation.

We have been advised that an EASA working group is looking into the matter of such inspections to provide further guidance; in the interim the BCAR guidance is as good as anything else in providing that airworthiness assurance.

CAA (SRG) AIRCOMS

The following CAA (SRG) ATS Airworthiness Communications (AIRCOMs) have been issued since **17 July 2009**

2009/06

European Requirements to Share Mandatory Occurrence Reporting (MOR) Data

2009/07

Implementation of Part M

2009/08

Demonstrating Compliance with JAR-OPS 3.110 and ANO Article 19(8) When Carrying Personal Locator Beacons

2009/09

Regulatory Changes Affecting Certain French Certificated Aircraft Under 2730kgs

2009/10

Aircraft Fitted With Alvis Leonides Series Engines

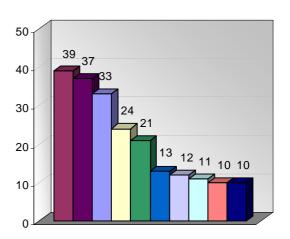
2009/13

Contaminated Halon Supplies

CAA (SRG) AIRCOMS are published on the CAA website (www.caa.co.uk). Any queries can be addressed to Airworthiness Strategy and Policy Department (requirements@caa.co.uk)

FLIGHT CREW REPORTS

Most Frequent Flight Crew Issues Received: 12 Months to September 2009



| Security |
|--|
| (Ground) |
| Company Policies |
| (Absence, Operational, Safety Reporting) |
| Duty |
| (Rosters/Rostering, Rest, Length, Crewing, Disruption) |
| Communications - External |
| (ATC, Regulators/Government) |
| Airports |
| (Runways, Bird Control, Infrastructure) |
| Pressure |
| (Commercial, From Management/Supervision, Time) |
| Documentation |
| (Suitability/Adequacy) |
| Air Traffic Management |
| (Use by Others, Adequacy, Use by Reporter) |
| Relationship Management |
| (Planning, Managers) |
| Procedures |
| (Used by others, Adequacy, Existence) |
| |

FB91 - REDUNDANCY - A COMMENT

Report Text: This was an excellent issue. Seeing that I have (just about) always been a "boss", and have employed air traffic controllers, aircraft engineers, cabin staff and pilots during my working life, which still continues, it might be surprising that I find CHIRP FEEDBACK to be so very interesting and useful.

I would like to comment on one report and that is the one of "Redundancy and Safety". I fully agree with the reporter's comments that it was seriously demoralising and potentially hazardous for key ATCOs to be told that they were at risk of redundancy and just leaving them to digest that news.

I had an instance several years ago when we reduced our scheduled service operations and we knew that we would have to make a very few pilots redundant. Unfortunately our HR manager, an excellent person, called everyone together and told them all that they were at risk of redundancy, even though more than 90% of them were not. Apparently it is a requirement that you do this, otherwise you can find yourself losing the argument at an employment tribunal.

I was appalled, because morale dropped immediately, and I resolved to handle things differently should the situation ever rise again. It is unfair on the staff. Why make them worry for two weeks before you quietly let the actual staff-members know of the decision?

In fact, I don't think we ever properly recovered; people in areas that were unaffected by the redundancy subsequently drifted away because they really did think their jobs were at risk.

Keep up the good work!

ATC CO-OPERATION

Report Text: We operate a corporate jet from a smaller airfield, and regularly position back from the London area, or over the London TMA from Europe. Our base airfield is located outside Controlled Airspace and, in order to achieve a stable final approach, we plan to position ourselves at 9 miles on final approach.

To do this we often need to transit the edge of an adjacent Aerodrome Traffic Zone, but on a significant number of occasions we are denied permission to enter the zone.

On two occasions we have been accused by ATC of entering their zone without permission when it's clear from our onboard equipment that we haven't. On other occasions we have been cleared to enter no more than a mile or two into the zone. Quite how we are expected to achieve this when we are in a relatively high workload situation I don't know.

Overall these restrictions strike me as unnecessary (we never see conflicting traffic on TCAS), and I believe that ATC are being overcautious as it's easier to deny us entry rather than offer any separation. In IMC I believe it also reduces our ability to safely position back to base.

CHIRP Comment: Our enquiry on behalf of the reporter revealed that the ATSU management was unaware of the reported problems and an invitation was extended via us to the reporter's company to contact the ATSU manager to discuss how the company's requirements could be accommodated.

Although it appears to be stating the obvious, if you experience this type of problem, make the time to discuss it with the ATC agency. It is often the case that they will be oblivious to your particular requirements and will be able to agree a mutually acceptable solution.

Also, a reminder: TCAS can only detect aircraft with an operating transponder; it will not show all traffic and thus is not a substitute for a visual lookout.

INSTRUMENT APPROACHES - LOOKOUT

Report Text: We were completing an asymmetric training sortie on final approach into AAA on the published ILS procedure. The ILS approach to AAA is in the open FIR. I was in the right hand seat. The weather was greater than 10 km in VMC.

We had just left the platform level to descend on the ILS when a single engine light aircraft crossed right to left in front of us around 100 feet above. Our TCAS screen was blank and therefore it can only be assumed the light aircraft was not transponder equipped. Given the workload at this point of the training exercise, the aircraft was sighted too late to initiate avoiding action. Also given his height above us, it is probable he had not even seen us as he passed our track.

Lessons Learned: Assuming the pilot of the light aircraft had a valid VFR map, his track was just outside the instrument approach symbology on his map. So he probably had no idea that at his height he was almost passing through the ILS glideslope. Given we were both in the open FIR and he was VFR, the other pilot had every right to fly that track.

However, the question has to be asked, if there was bold symbology on his map warning him of instrument traffic such as a shaded area covering the published holds and inbound IFR tracks, the light aircraft pilot may have taken a different route. VFR maps do not display this type of information and although they are already busy, it should be possible to display this type of information, using colour, to VFR pilots who may have

no idea of the potential danger they are putting themselves in. AAA is not the only airport where commercial traffic carries out instrument approaches within the open FIR. Therefore without making every piece of sky Controlled Airspace, surely a small change such as this to the current VFR charts would enhance safety.

CHIRP Comment: As the reporter notes, UK 1:500,000 (and UK 1:250,000) aeronautical charts include an instrument approach symbol to depict instrument approaches to airfields outside Controlled Airspace and contain much other important information; adding further detail as suggested is unlikely. It is important to remember that irrespective of the symbols GA pilots may elect to cross instrument approach paths that are not within Controlled Airspace using the 'See and avoid' principle.

The same principle of 'See and avoid' applies to aircraft carrying out a practice instrument approach outside Controlled Airspace. It is important to remember that one of the principal responsibilities of the safety pilot is to maintain an effective lookout throughout the approach.

CAA FODCOM 27/2009, issued on 18 August 2009, contains advice on visual scanning techniques to minimise the risk of collision when operating in Classes D, E, F and G airspace.

This report will also be published in GA FEEDBACK with advice to GA pilots.

LEVEL BUST - A QUESTION OF PRIORITIES?

Report Text: I was flying as Captain, left seat, pilot flying. We had been established at FL380 for about ten minutes with the auto pilot engaged and coupled to the FMS on our way to the entry point for our westbound oceanic crossing. I decided to fill out our customs reports for entering the United States.

The First Officer, not flying, was on the radio with Oceanic, recording our clearance. In the process of moving a log book to my lap I bumped the throttle quadrant where the "Go Around" button is located; this disengages the auto pilot and initiates a Go-Around. I had not realised what I had done at that moment, as all I heard was the auto pilot disengage. I re-engaged the auto pilot thinking that all was OK.

I informed the First Officer that I had been the reason the auto pilot had disengaged and that I had reengaged it. The First Officer then noticed that LNAV was not engaged so it was re-engaged and we were again on our way to the Oceanic entry point.

The FMS was commanding .75 Mach when normal cruise is .80 Mach for this phase of flight. I became preoccupied with trying to re-establish normal cruise. It was at about this time that ATC asked our level. It was FL383 and in a slight climb.

It is at this time that I realised what I had done, having initiated a Go-Around function I had overridden the Altitude Hold function. I initiated corrective action to recover back to FL380 but not before the aircraft reached FL384.

Lessons Learned: I have learned that only one person in the cockpit should be heads down and the other should always devote full attention to flying the aircraft. Also, when a problem does arise, investigate well beyond what appears to be the obvious cause.

EMERGENCY FREQUENCY BLOCKED

Report Text: Upon entering VHF range after an eastbound N Atlantic crossing we started to receive constant transmissions on 121.5. It soon became apparent that it was a "Calibrator" aircraft transmitting constant bearing information, from a Navaid, I assume. This persisted for some 40 minutes while we were in range; we eventually de-tuned 121.5 as we started our descent briefing to minimise distraction.

An Air France aircraft transmitted on 121.5 asking the aircraft why he was using 121.5; he was told to check his NOTAMs as the use of 121.5 had been promulgated. A few minutes later another non-UK commercial flight also inquired why they were using 121.5 for non emergency transmissions. I checked our (UK longhaul operator) briefing material and I could find no information about the calibration flight so either the NOTAM was not published or our planning department had missed it.

Bearing in mind AF447 had gone missing presumed crashed only several days previously over the S Atlantic I can understand an AF crew being extra vigilant of inappropriate use of 121.5. Indeed the AF crew member sounded upset by the tone of the response from the calibrator flight.

We are supposed to monitor 121.5 as much as possible; I wonder how many flights de-tuned 121.5 that morning. An aircraft in peril might only be able to transmit very briefly and vital information could be blocked or simply not heard if 121.5 has been de-tuned or had the volume turned right down.

CHIRP Comment: The RAF staff responsible for the Distress and Diversion (D & D) Service in the UK were consulted on this issue.

The calibration referenced in the report had been required following an upgrade of Direction Finding equipment used in the D & D auto triangulation process and had been the subject of a world-wide NOTAM. Such calibrations are normally performed by a series of short transmissions so as to permit an aircraft in distress to transmit a MAYDAY message during the transmission gaps. The RAF was unable to confirm the content of the calibrator's RTF messages.

REPORT TIMES

Report Text: At present our short haul operations are planned with a report time for one hour before STD, long haul 1 hour 15 minutes. We are also given 30 minutes of duty post flight (chocks+30). These times are simply not long enough in our company, especially at the larger bases. It is not possible to produce all of our pre-flight paperwork (10min), digest & plan (10min), Read latest company notices(5min), pass figures to agents (3min) and get through security (10min), walk to the aircraft (10-15min) in the time allocated, as can be seen these

tasks alone account for more than 48 minutes of the allocated time, leaving minimal time to check and prepare the aircraft and get away safely on time.

Most pilots (and the company) are aware of this yet nothing changes. Many pilots will now arrive 20-30 minutes before report because there is so much to do, (on occasions this is violating their minimum rest periods and naturally their duty is longer than recorded). Those pilots that refuse to report early and arrive at the rostered time often find themselves being rushed out of the crew room because the captain has arrived early and done all his/her pre flight work and wants to push back on time (OTP). I think you would agree neither of these scenarios is safe or ideal.

Likewise our duty period ends at chocks plus 30 minutes, again this is not an accurate reflection at many bases. I was relieved to see the FODCOM 10/2009 issued by the CAA earlier this year, an extract is below relating to report times:

Report times (and post-flight duty times) are specified in FTL Schemes and are intended to give crew members sufficient time to complete all pre- or post-flight duties. The guidance suggests, for large companies, one hour as a minimum for pre-flight duties with half an hour for post-flight duties. However, the CAA occasionally receives reports that indicate that operators are very reluctant to change report times even if there has been a considerable change in circumstances at the report location (e.g. in security or crew baggage handling requirements). FOIs will expect operators to demonstrate that report times will allow all required duties to be accomplished within the specified times under normal circumstances. If a significant number of operators prove unable to do so, the CAA may consider raising the minimum allowable report time.'

There are many possible solutions, some as simple as adding 10 minutes extra to report times (as per other operators who operate from the same bases as we do), it is all we need. Alternatively, have someone employed in the crew rooms to produce all our preflight paperwork, as used to exist in the days before extreme cost cutting. However, it appears it is false hope - I'm very disappointed that there appears to have been no visible change from the company in order to comply with this.

Please could you tell me how long the company has in order to make the changes required and how long will it be before the CAA stops protecting the operators and forces them do to something, and protect the pilots on matters such as this. As a simple intermediary step I would have expected the company to issue a notice to all pilots reminding them that in accordance with the recent FODCOM that they are not to report early and abide with the rosters and any pilot who does report early should duly note this on the relevant documentation.

CHIRP Comment: This is one of a number of reports received in the recent past on the topic of report times and the ability of flight crew members to complete all of their required company tasks routinely within the allotted pre-flight period. Recent reports have been sourced from only a small number of AOC holders and generally involve one or more of the following factors,

company dispatch policy/procedures, airport security and the report location.

The CAA has confirmed that part of the task of the CAA Flight Operations Inspector (FOI) assigned to oversee a company's operations is to assess the adequacy of that company's report times; however, the principal responsibility is that of the operator to review whether report times are appropriate, particularly after introducing significant changes. Conducting such a review is not difficult and many operators monitor this aspect of their operations but the anecdotal evidence suggests that a small number of operators do not.

In some cases reported to this Programme, relatively simple measures would ameliorate some of the reported difficulties, such as improved access to electronic data, computer workstations or improved printer facilities. In other cases, reporters assert that management pressure has been applied to encourage crew members to report early routinely, suggesting that the promulgated report times may be insufficient to achieve an on-time departure on a regular basis. In either case, if an operator elects not to address such issues, significant problems should be also apparent to the FOI, if they follow the same pre-flight procedures, and permit the reasonableness of the report time to be assessed. Disidentified summaries of recent reports received on this topic have been forwarded to the CAA.

Finally, as a point of detail FODCOM 10/2009 does not preclude individuals electing to report early.

FLIGHT TIME LIMITATIONS

Report Text: A planned four-sector day AAA (UK) - BBB (Southern Europe) - AAA (UK) then AAA (UK) - CCC (Southern Europe) - AAA (UK). The aircraft was delayed on the previous sector inbound to UK, so we were late leaving UK on our first sector for Southern Europe.

On our return flight from Southern Europe it was apparent that discretion would be required to complete both the third and fourth sectors UK - Southern Europe - UK. We informed Operations as soon as practicable that we would not be able to offer discretion, as prior to this duty, we both had completed several consecutive long Flight Duty Periods and we were both very tired.

We received no reply from Crewing with regard to the flight crew standing down. On contacting Operations advising of our ETA at AAA, we again stated that we were unable to offer discretion. Operations subsequently responded advising that no Captain's discretion would be required as the ETD for next sector would permit the two remaining sectors to be completed within the maximum FDP. On checking we realised that the ETD for the next sector assumed a 14-minute turnaround at AAA based on our ETA. [turnarounds are normally scheduled for 30 or 35 minutes].

After arriving on chocks approximately ten minutes later than our ETA, we phoned Operations, who informed me that we would have to position to CCC and then operate the last sector from CCC (Southern Europe) back to AAA. Another flight crew would operate the sector AAA - CCC. Operations stated that we were able to operate as our FDP was now based on 3 sectors not 4 sectors.

CHIRP Comment: The circumstances of this report were discussed with the CAA Flight Operations Inspectorate, who advised that the company's response to the reporter electing not to exercise discretion in positioning the crew on the third of four sectors was not good practice with respect to the operator's general responsibilities for managing fatigue but was technically permitted within the company's FTL Scheme and CAP 371.

From a human factors perspective, it is arguably more tiring for a crew to position in the main cabin of a holiday flight than to operate the aircraft; thus the operator's decision, albeit technically legal, might be viewed as a less than subtle way of persuading an aircraft commander to exercise discretion on the next occasion that he/she would otherwise elect not to. If this were to be the case, the action by Operations would represent a potential future flight safety risk.

SAFETY REPORTING POLICY

Report Text: Our company is increasingly using the threat of disciplinary action when investigating the details of company safety report events. It is so bad that I am now no longer submitting any safety reports unless they do not concern how I have operated the aircraft. I recently have had two events that would merit input to the flight safety review of the airline but I fear that I may be disciplined if I report the incidents.

The problem is that if you submit a safety report the investigating officer believes he is entitled to pull the whole flight data for the entire flight and not the relevant data relating to the incident. For example if a go-around is flown one might be asked to explain why you flew a certain speed 100nm from destination! It's a complete blame culture. The management believe that they are reacting to the safety events in the business but, as no one is filing any safety reports, they are missing what is really going on and cannot effectively manage areas of ongoing high risk. In some cases First Officers are dragged into the office if a safety report is submitted in order to gain as much extra information as possible before the Captain has to account for him/herself.

I have also heard that during command line training new captains have been advised not to file a safety report unless it appeared on the list of events that required to be reported; otherwise they could render themselves liable to being disciplined.

I seek a guarantee of no disciplinary action being taken except in cases of gross misconduct or, if this cannot be given, the introduction of a confidential reporting system within the airline.

CHIRP Comment: With the reporter's consent, the concerns were raised with the company, who subsequently provided a detailed response.

The company policy relating to the use of data or information recorded by the Flight Data Monitoring programme had been negotiated and agreed with the Pilots' Company Council and, in the case of company safety report investigations, was strictly limited to the specific ASR event.

Company safety investigations were always conducted separately from administrative/disciplinary procedures and some management functions had been recently restructured to enhance this policy.

The company kept under review the number of company safety reports submitted; the overall number had not reduced significantly. Notwithstanding this, an independent safety audit of company bases was shortly to be undertaken.

In CHIRP's view, this report is a reminder of the importance of ensuring that company safety and disciplinary policies are segregated and that this is clearly understood by all relevant employee groups.

SAFETY IS OUR ABSOLUTE PRIORITY?

(1)

Report Text: I reported as the operating Captain. About an hour into a four-hour flight the Senior Cabin Crew Member (SCCM) reported feeling unwell. Shortly after this the individual was physically sick in the toilet. I suggested that the SCCM sit down for the remainder of the flight and allow the No.2 to control the cabin. The individual was very reluctant to do as they would then have to include this in the post flight debrief.

On further questioning the SCCM stated that they had been unable to operate a flight a couple of weeks previously because of illness and was concerned at being unwell again so soon afterwards. Cabin crew members have historically been called into the office for an interview if they are ill with any frequency and this is perceived (possibly incorrectly) by many individuals as a criticism of them declaring themselves sick. This has been made much worse recently with the management announcing that they wish to make some crew redundant and, amongst other factors, the individual's sickness record will be taken into account in deciding who gets the axe. I believe that this can only have a detrimental effect on flight safety with crew members operating whilst they are unfit for duty.

Lessons Learned: Remove illness from the list of factors deciding who is made redundant. Remove the need for an interview with a CC manager following unavoidable time off due to sickness.

(2)

Report Text: Further to the recent CHIRP discussion regarding Cabin Crew fitness to operate, my airline is selecting cabin crew for temporary basing on the basis of their sickness record. This is having the effect of encouraging those who wish to take a temporary base to operate whilst they're patently unwell. The incentive for a temporary base is a significant financial increment; a junior cabin crew member can triple their take home pay. When choosing who to select for a temporary basing opportunity, I understand managers simply check if an individual has missed duties through sickness and disbars them if they have. This is grossly lazy management and has the potential to compromise safety as noted above. Whilst no one is suggesting malingerers should be rewarded, equally the public's

right to expect the highest standards of safety on commercial aircraft shouldn't be compromised by poorly considered sickness management policies.

CHIRP Comment: The management of sickness absence is not, in itself, a Regulatory matter and the operation of a sickness management policy by an operator is entirely reasonable.

However, as most if not all UK AOC Holders espouse flight safety as a key business priority, management practices such as those described above, which have the effect, whether intended or not, to pressure individuals to report for duty when otherwise they would elect not to do so, might lead to a conclusion that safety is not in actuality considered to be an imperative.

WINTER OPERATIONS

The following three reports are a reminder of some of the winter problems:

DE-ICING (1)

Report Text: Early morning at a Northern UK regional airport; the aircraft had frosted up overnight and had been de-iced prior to arrival of crew. On walk round it was noted that the underside of both wings had not been de-iced and on further inspection neither had the underside of the tailplane. The de-icing team leader stated that he understood that contamination on the underside of wings was OK up to 3mm.

I explained that this related to frost formation from cold soaked fuel, not on the entire wing and tailplane. He was not aware of this but happily de-iced the affected areas as I requested. I filed a company safety report pointing out that this gap in knowledge might be more widespread than just one airport and suggesting that it would be worth promulgating to all de-icing crews across our company network etc.

On following up on the company actions in response to my safety report, I discovered that the fault had been pinned down to the computer based training CD-Rom that all ground crews have to study (as far as I am aware unsupervised), which stated that frost on underside of wing is OK without going into the detail of fuel cold soaking etc. The company stated that its intended action to resolve this was to correct the CBT which will be reissued prior to next winter.

For an item as safety critical as de-icing I do not think this action is sufficient, since it relies upon the crew studying the CBT and being able to pick up the subtle difference from what they have been taught to date.

CHIRP Comment: With the reporter's consent the operator was contacted to confirm that the action taken to address the reported lack of knowledge was considered to be appropriate.

The company noted that the aircraft had been anti-iced correctly in accordance with the company procedures prior to the flight crew's arrival; however, the flight crew inspection had revealed some light frost on the underside of the control surfaces/stabiliser due to a rare occurrence (at that location) of freezing fog; this was not permitted in this aircraft type's certification.

Whilst both flight and ground crew procedures included this information, the training had lacked the detail that the underwing frost permitted by the manufacturer for this aircraft type was restricted to the 'cold fuel' underwing areas only; the training information had been amended to include this detail. The company also affirmed that the delivery of the amended information to all de-icing staff was considered to an appropriate response.

This report serves as a useful reminder for flight crew to review the anti/de-icing procedures for your aircraft type and to check, whenever possible, that anti/de-icing has been carried out in accordance with your company procedures.

(2)

This report is published courtesy of our US counterpart ASRS from their CALLBACK newsletter (No 348, December 2008):

Report Text: ...Aircraft de-iced with Type 1 to remove surface ice, followed by Type 4 fluid. Light freezing rain falling at airport, and aircraft was covered with ice from inbound flight...The de-icer called via interphone with deice info.

During pushback, flight attendant calls cockpit to report the passengers are concerned about 'ice on the wing.' After pushback, we receive another call from a flight attendant indicating she sees ice on the wing. Because our holdover window was fairly short, we initiated taxi toward Runway 01R. Prior to leaving the ramp, I asked the relief pilot to examine the wings because there was no sense going to the end of the runway if, in fact, there was ice on the wing. The First Officer returned to the cockpit and reported that the right wing was clean, but that the left wing had ice adhering to the leading edge. We returned to the gate for de-icing, and this time it was performed properly.

CABIN CREW REPORTS

(3)

The following report was submitted by an off-duty cabin crew member and has also been published in the Autumn issue of Cabin Crew FEEDBACK to raise cabin crew awareness.

Report Text: I was flying as a passenger on a non-UK airline. My company (UK AOC holder) has a policy that if it is snowing, all aircraft must be de-iced prior to departure.

On the outbound flight from BBB we boarded during a light snow shower. Although no snow had accumulated on the wings, the Captain informed us that we would have a delayed departure while we were waiting to be desired.

On the return flight to the UK the aircraft arrived during a heavy snow flurry which continued whilst we boarded. It continued to snow and ceased shortly before the front and rear doors were closed. We then started to taxi with snow visible on the wings.

I was several rows behind the overwing exit and noticed that the left wing surfaces were covered in snow (see attached picture taken later after 20 mins into flight):



I presumed that based on my experience with my company and also previously on the outbound flight that there would be a delay while we were de-iced. After the safety demonstration, I asked the Senior Cabin Crew Member if it was normal to leave without being de-iced whilst there was snow on the wings?, to which they immediately replied without looking at the wing, "the Captain says it's OK" (or words to that effect).

We entered the runway shortly afterwards, accelerated and took-off with the vast majority of the snow remaining coated to the wing. The flight proceeded with no problems although ice remained formed on the wing in certain areas. The wing was not visibly clear of snow/ice with approximately 10 mins to landing at BBB.

I was concerned that the Senior Cabin Crew Member did not respond to a flight safety observation from a passenger.

It might also be worth noting that the return flight was early and we pushed-back approx 10-15 mins before the schedule, this meant that sufficient time was available to de-ice without picking-up a delay.

CHIRP Comment: The operator concerned was subject to regulation by EASA. EU-OPS 1.345 (b) states:

A commander shall not commence take-off unless the external surfaces are clear of any deposit which might adversely affect the performance and/or controllability of the aeroplane except as permitted in the Aeroplane Flight

The reporter's concern, together with the photographic evidence, was forwarded to the management of the operator concerned. It should be noted that it is not possible to confirm that the flight crew were advised or aware of the wing surface condition.

The following comment has been published in Cabin Crew FEEDBACK:

It is imperative that if cabin crew see or are advised of any form of contamination on the wing this information is passed to the Captain as soon as possible.

EU-OPS states that that:

"cabin crew must be trained in the awareness of the effects of surface contamination; and the need to inform the flight crew of any observed surface contamination"

Note: Several UK operators have requested to use this photograph in their winter operations training.

EXCESS BAGGAGE

Report Text: Full passenger load on this flight to the USA. Most but not all passengers had boarded and the Senior Cabin Crew Member (SCCM) was informed that all overhead bins and wardrobes were full.

More passengers boarded so the SCCM stopped the baggage at the door, crew members had also brought some bags to the boarding door from other passengers inside the cabin to be tagged and put in the hold. The items consisted of seven wheelie bags, a guitar in a big black case and a pushchair. The SCCM informed the Dispatcher that we were unable to stow these items safely in the cabin (these items had already been tagged) and they needed to go in the hold. The SCCM was informed that the hold was closed and the ground team had left and it would take 20 minutes to get them back to re-open the hold which would create a delay.

The SCCM informed the Captain that we were unable to stow some baggage and was informed to "stow it anywhere as we need to get going". The Captain then took two wheelie bags and the guitar to stow in the flight deck - unsecurely! The remaining bags were stowed in toilets and empty catering stowages in the galley.

The ground staff had let too many bags through, some exceeded the maximum dimensions for cabin baggage and some were very heavy for crew to be dealing with, let alone leaving them in unapproved stowages. The SCCM was powerless to override commercial pressure for an on-time departure to ensure the safe stowage of bags and was not supported by the Captain. Two Business Class passengers voiced their concerns to the SCCM about the amount of baggage on board - what was he/she to say to them?

Lessons Learned: Ground staff need to intercept oversize/overweight bags. Next time, hopefully the SCCM might have a Captain that is more supportive without worrying about punctuality.

CHIRP Comment: This is another example of the commercial 'tail' (pressure for an On Time Departure) wagging the flight safety 'dog'.

Put bluntly, the stowage of excess bags in unapproved on-board stowages and on the flight deck is not legal. More importantly, if moderate/severe turbulence is encountered, inadequately restrained bags on the flight deck could present a serious flight safety hazard such as impeding the use of flight controls or possibly causing injury. Thus, the basis on which the aircraft commander elected to override the SCCM is difficult to understand.

Failing to control cabin baggage is a self-inflicted problem and one that is managed effectively by many

other UK operators through their loading procedures. The allocation of a 'delay' against the flight/cabin crew as a result of an upstream failure to manage the problem, combined with the underfloor holds having been 'closed up', is unacceptable on the basis of the flight safety risk that unrestrained baggage in the cabin represents.

CAA (SRG) FODCOMS

The following CAA (SRG) FODCOMS have been issued since 17 July 2009

21/2009

Reporting of Suspected Hard/Heavy Landings

22/2009

Training in the Use of Emergency Equipment

23/2009

Letter of Intent: Proposal to Amend the Air Navigation Order 2005. Proposal to Amend the Air Navigation Order to Bring Unmanned Aircraft of 7kg Mass or Less Within the Scope of Regulatory Oversight

24/2009

Rescue and Firefighting Services (RFFS) Category Required at a Nominated Diversion Aerodrome (NDA) within the United Kingdom

25/2009

Aerodrome Rescue and Firefighting (RFFS) Category Required for Cargo Aeroplanes Carrying Dangerous Goods

26/2009

European Requirements to Share Information Contained in Mandatory Occurrence Reports (MORs)

27/2009

Collision Avoidance - Use of and Limitations Associated with the See-And-Avoid-Principle

28/2009

Cabin Crew Medical Assessments

29/2009 - Superseded

30/2009

Contaminated Halon Supplies

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

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 e-mail the CAA at:

flightoperationssafety@caa.co.uk

ADDRESS CHANGES

If you receive FEEDBACK as a licensed pilot/ATCO/maintenance engineer please notify Personnel Licensing at the CAA of your change of address and not CHIRP. Please complete a change of address form which is available to download from the CAA website and fax/post to:

Civil Aviation Authority
Personnel Licensing Department
Licensing Operations
Aviation House
Gatwick Airport South
West Sussex RH6 0YR
Fax: 01293 573996

The Change of address form is available from: www.caa.co.uk/docs/175/srg_fcl_changeofaddress.pdf

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

Flight Crewfclweb@caa.co.uk
ATCO/FISOats.licensing@caa.co.uk
Maintenance Engineereldweb@caa.co.uk

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| | | | ff who will remove | all information su | uch as dates/loc | ations/names th | at might identi | fy you. Bear | |
| our narrative will be reviewed by mind the following topics when | preparing your narra | | | | | | | | |
| | | - auinmen | t • Situational Awar | eness • Weather | Task Allocation | • Teamwork • Tra | aining • Sleen P | atterns | |

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PILOT/FLIGHT CREW REPORT FORM

CHIRP is totally independent of the Civil Aviation Authority and any Company/Airline

| Name: Address: Post Code Tel: e-mail: Indicates Mandatory Fields | | | | | | | 2. 0 N 3. <i>(</i> | Your personal details are required only to enable us to contact you for further details about any part of your report. Please do not submit anonymous reports. On closing, this Report Form will be returned to you. NO RECORD OF YOUR NAME AND ADDRESS WILL BE KEPT CHIRP is a reporting programme for safety-related issues. We regret we are unable to accept reports that relate to industrial relations issues. | | | | | |
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| | | | | | | | | | | | | | |
| | | | acknowledg | | | | | | mprehensive | | I do not requ | | |
| Closi | iig ie | Spor | | | | | | | E EVENT/SITUATI | | onse nom e | | |
| You | RSELF | - CREV | w Position | | | | | THE F | LIGHT/EVENT | | | | |
| CAPTAIN | | FIRST | T OFFICER | | DATE 0 | F OCCURRENCE | | | TIME | | | (LOCAL/GMT) | |
| PILOT FLYING | | PILO | T NOT FLYING | | LOCATIO | ON | | | HEIGHT/ALT/FL | | | | |
| LIGHT ENGINEER | | Отне | ER CREW MEMBER | ₽ □ | TYPE O | FATC SERVICE | | | Day | | NIGHT | | |
| | THE | AIRCF | RAFT | | | TYPE OF FLIGHT | | | | TYPE OF | OPERATION | | |
| YPE/SERIES | | | | | IFR | | VFR | | PASSENGER | | TRAINING | | |
| lumber of Crew | | | | | OTHER: | | | | FREIGHT | | OTHER: | | |
| Ехр | RIENC | E/QUA | ALIFICATION | | Weather | | | | FLIGHT PHASE | | | | |
| OTAL HOURS | | | | HRS | VMC | | IMC | | TAXI | | TAKE-OFF | | |
| OURS ON TYPE | | | | HRS | RAIN | | Fog | | CLIMB | | CRUISE | | |
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| THER QUALIFICATION | ONS: | | | | OTHER: | | | | LANDING | | Go Around | | |
| | | THE C | COMPANY | | | | | My Main Points Are: | | | | | |
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| mind the followi | ng top | ics wh | I by a member on the preparing yo | of the <i>CH</i> our narra | IRP star tive: | ff who will remo | ve all informa | tion such a | ARE WELCOME: s dates/locations/ k Allocation • Team | | J | | |
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continue on a separate piece of paper, if necessary

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