CHIRP FEEDBACK

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EDITORIAL

Is CHIRP Past Its 'Sell By' Date?

Recently, we received information advising us that the management of a UK AOC holder had sought the views of its pilot community as to whether, in view of the development of a Safety Management System, a 'just' culture and the ability to submit confidential or anonymous reports through a company scheme, there was a continuing need to report issues through this Programme.

The report stated that the flight crew responses to the survey submitted over the next 18 days, with one exception, had expressed strong support for the continuation of this Programme and this had led to the survey being withdrawn earlier than had been originally planned.

Whilst we at CHIRP are most grateful for the strong expressions of support received from the respondents to this survey, it serves as an important reminder that this Programme is funded by the Civil Aviation Authority, which in turn is funded by your companies.   Thus, our funding is very closely scrutinised year-on-year, as are the types of issues that are reported to us and the manner in which we deal with them.

One example is the printing/distribution of this newsletter in hard copy, which is a significant element of our operating costs.   The cost effectiveness of distributing hard copy FEEDBACK has been queried on the basis that many pilots 'bin' the newsletter on receipt. This is not apparent from the responses to the above query and previous surveys of user groups; however, pressure to reduce further the cost of the Programme will continue.

It should also be remembered that the existence of a voluntary reporting programme such as this is uncomfortable for some senior managers as it offers an independent means of evaluating safety-related concerns reported to us and, where necessary, ensuring that these are appropriately represented/reviewed.   The continuation of the Programme in its present form will depend largely on your continued support and that of your colleagues.

Peter Tait

DEPARTMENT FOR TRANSPORT CONSULTATION DOCUMENT
'BETTER REGULATION FOR AVIATION SECURITY'

On 14 July 2011 the Department for Transport published a consultation document containing proposals for the future regulation of aviation security in the UK. The detailed proposals include one relating to confidential reporting by staff. This proposal [Page 20; Para 4.40] states as follows:

Confidential reporting by staff

4.40 The ability of staff to be able to report security concerns on a confidential basis provides an additional check on performance and another layer of assurance to the Regulator (and the public). The Department believes that all aviation staff should be able to raise their concerns regarding aviation security on a confidential basis and in the expectation that their report is properly investigated. Although the industry often has its own internal schemes for security matters, not all staff have access to such schemes. In contrast, an industry-wide scheme, the Confidential Human Factors Incident Reporting Programme (CHIRP), allows anyone working in the aviation sector to report any safety incidents confidentially. Further details on CHIRP can be found at Annex B. The Department considers it feasible to extend CHIRP to cover aviation security.

Question 13. Do you agree or disagree that there should be an extension of the Confidential Human Factors Incident Reporting Programme (CHIRP) scheme to cover aviation security? Are there any significant considerations you believe need to be taken into account? If so, what are they?

The document is published on the Department's website at: http://www.dft.gov.uk/consultations/dft-2011-21.

If you wish to comment on this or any other proposal in the consultation document, the deadline for comments to DfT is 7 November 2011

ATC REPORTS

SCRATCOH & New Technologies

Report Text: At the moment we operate under enhanced relief on a number of sectors, with some the standard two hours. Following the introduction of Electronic Flight Data (EFD) we now have to visually scan four Visual Display Units (VDUs). The strip display on one of the screens is particularly hard to scan because some of the fonts are too small. As a result more concentration is required to control traffic, which creates increased fatigue and eye strain. After about one hour I usually have a physical urge to look away from the strip display because my eyes cannot look at it anymore. This is exacerbated by normal circadian rhythms, so early mornings and ends of afternoon shifts are particularly tough - especially given the high levels of traffic we have

at those times. I have to concentrate harder on EFD at those times to eliminate any mistakes that may occur as a result of reduced personal performance levels.

Comments to this effect have been made to unit management through Human Factor Surveys, but because SCRATCOH is UK wide, there is a natural limit to their influence over the matter.

My belief is that a busy hour and a half, even two hours, on EFD is more fatiguing than a similar period on paper strips. The likelihood of someone making an error is therefore higher than at a similar point on paper strips, which are 'gentler' on the eyes. Most of my colleagues feel that they are more fatigued after a shift now, so this is a general problem.

Has any research been done into this? I feel that this matter has been 'missed' and that SCRATCOH's application post-EFD will be significantly tested over the coming months with increased summer traffic, in addition to staffing levels becoming 'tighter' on the unit after the withdrawal of a voluntary additional attendance agreement.

CHIRP Comment: **This report was one of several expressing a range of concerns about the way in which the new technology was being introduced. With the reporters' consent these concerns were represented to the Unit management at a senior level. The Unit management advised that a prior decision had been taken to conduct a review of the implementation plan, and subsequently provided the following response together with a more detailed report related to the specific concerns:**

The implementation of EFD was reviewed after nine weeks of live operation. This review included a human factors assessment, measures of safety impact and capacity capability. The review concluded that although controllers were able to control aircraft in a safe manner the introduction of EFD had resulted in reduced sector capacities. Focused development is now taking place to deliver improvements and changes to the way we interact with electronic data. These changes will include improvements in EFD functionality, team working, our method of operation, interaction with the different equipment and procedures. A phased introduction of these improvements is planned with a view to having full EFD capability by summer 2012.

ENGINEER REPORTS

LACK OF MANPOWER AND TRAINING

Report Text: I work for an organisation that carries out base maintenance which had recently gone through a rapid major expansion. This is good as more opportunities and jobs are created.

However, due to the rate of expansion we are left with a situation that manpower levels are dangerously low on maintenance checks with little or no supervision. There is a considerable amount of stress and pressure put on the engineers and supervisors to get the aircraft out on time by the management, who after numerous warnings have not done anything about the situation.

New staff are being employed but they have little or no experience on the type of aircraft. Some of the new staff have not even completed a basic induction or a familiarisation course. Due to the shortages they are let loose on the aircraft as soon as they are employed, with no guidance given. We have enquired about setting up a familiarisation course as part of the induction process but have been told that due to lack of manpower it's not possible.

The quality of work has suffered as a result and the overall morale at work is really low, not helped by other on-going industrial issues. The situation had become difficult but now was only going to get worse.

Lessons learned: I guess with aviation you just have to wait for a disaster to take place to make any changes. These issues have been raised with management but nothing has been done so far.

CHIRP Comment: **The reporter's concerns were represented to CAA (Safety Regulation Group) and also discussed by the CHIRP Air Transport Advisory Board (ATAB). The ATAB concluded that in a situation such as that described, there was a management responsibility to conduct a risk assessment to ensure that the rate of increase in capacity aligned with the availability/hiring of appropriately qualified staff to ensure that the required regulatory standards could be maintained.**

An initial review by the CAA revealed that the organisation's hangar capacity had been increased by approximately 40% over a short period of time to cater for new maintenance contracts, which were being undertaken. However, the management's man/hour plan did not appear to match the planned increase in workload. The CAA elected to carry out a more detailed investigation to ensure that the available manning and individuals' experience on type and competence satisfied the requirements for the organisation's Part 145 approval, and to monitor this on an ongoing basis.

MANAGEMENT POLICY FOR SAFETY AND QUALITY

Report Text: A Company proposal to reorganise the quality and safety reporting structure is flawed in concept and displays a lack of understanding of the relevant civil regulatory requirements.

Two key areas of concern are:

1. The proposed Operator's Quality System structure is not compliant with EU-OPS and supporting regulation.
2. The proposed structure is not in accordance with the concept of an effective Safety Management System.

The proposal includes combining the Quality & Safety roles within the organisation. However, Individual job descriptions within the proposed structure are confusing and contain inaccurate and undesirable expectations of post-holders; they also demonstrate a lack of understanding of key quality/safety roles and the regulatory requirements regarding their functionality.

Discussions have been held with senior managers, pointing out some of the areas of difficulty and the possibility that these would not be acceptable to the Regulator; however, these have been ignored.

Lesson Learned:

1. Safety policies driven by commercial interest should not override the need to meet regulatory compliance.
2. Opinions of individuals employed as knowledgeable subject matter experts should not be disregarded in favour of commercial interests and could compromise the legal position that the senior executive team is obliged to protect.

CHIRP Comment: The concerns expressed in this report arose from a strategic policy change by an organisation that was seeking Regulatory approval for a commercial air transport operation.

The concerns were reviewed by the ATAB. The Board concluded that if the situation is as reported the organisation's focus on a commercially driven strategy appeared to have ignored the advice of middle managers with relevant expertise. CAA representatives emphasised that the relevant approvals would not be issued if the CAA was not assured as to the company safety and quality policies and noted that the company's plans, as projected, appeared to display a lack of familiarity with the pertinent regulatory requirements.

Following further discussions with the reporters, CHIRP undertook to provide the CAA with further clarification of the issues. The CAA Regional Office responsible for oversight elected to reinforce with the company management the requirements necessary for the issue of an AOC together with Part M and Part 145 approvals.

This report is a reminder that whilst a company's financial viability is fundamental to a business, a robust internal quality and safety oversight process must also be considered to be fundamental, not merely an 'add on' to meet Regulatory compliance.

EXTENDED SHIFT PATTERNS

Report Text: The company has introduced a shift working pattern for contracted engineers with twelve-hour shifts for twelve days 'ON' with two days OFF, before recommencing a further twelve days of duty. In addition, both permanent and contract engineers are being "encouraged" to sign a Working Time Directive [WTD] Opt-out clause.

Managers say this is all right; however their point of view might be clouded by financial incentives i.e. bonuses for achieving targets.

CHIRP Comment: The EC WTD is enacted in the UK through the Working Time Regulations (WTR). The WTR contains an 'opt out' clause. This clause permits a work pattern of more than 48 hours in any one week but only if an average of less than 48hours/week can be achieved over a 17-week period. Working in excess of this is not permitted for any employees, either permanent or contracted staff.

Individuals over 18 years of age, who wish to work more than 48 hours a week can choose to opt out of the WTR 48-hour limit; however, this must be voluntary, on an individual basis and in writing unless it has been negotiated as a joint agreement with the whole workforce under the WTR. An individual can cancel the 'opt out' whenever they want, even if it is part of an employment contract, however, the employer must be given advance notice of this intent and depending on the contractual obligation this period will be a minimum of 7 days but could be up to three months.

For individuals who are contracted to work for more than one employer, the total combined hours worked should not exceed the 48-hour average limit.

It should be noted that there are specific provisions in the WTR for night and shift working that also need to be taken into account.

The responsibility for ensuring compliance with the WTR rests with the Health and Safety Executive not the CAA; however, the working pattern described in this report is also contrary to CAA guidance on shift working practices (CAA Paper 2002/06). This has been notified to the company concerned.

FLIGHT CREW REPORTS

ATC UNDER STRESS?

Report Text: On a recent Bank Holiday we were transferred to a new frequency. It was clear immediately that the frequency was very busy and we struggled to get our initial call in.

The controller was speaking very fast (due to the busy frequency) to several crews for whom English was not their first language. Several incorrect read backs were made by one crew, who mistook a cleared Heading for a cleared Flight level. The controller appeared to become agitated with the crew and shortly afterwards I heard him admonish a different crew.

While this is speculation, it seems to be frequently the case that on Bank Holidays some UK ATC frequencies are much busier than normal, as several sectors are combined together, possibly due to lower staffing levels. This results in situations such as that we experienced and has clear safety implications, not only for the pilots but also for the stressed controller either of whom could have been in a position to make mistakes.

I am not laying any blame on the individual controller as he was obviously in a stressful situation, but clearly he should not have been in this position. I have reported this in the hope that it can be investigated internally to establish from the ATC side what lessons should be learned.

CHIRP Comment: Details of this report were passed to the ATSU concerned. A subsequent Unit investigation confirmed a peak in traffic levels and R/T transmissions at the reported time but established that this was for a short duration and was within the maximum permitted capacity.

Notwithstanding this, the Unit is raising awareness among controllers of the potential for workload to build unexpectedly on sectors and the mitigating actions that can be taken. In addition, the Unit has initiated a review of options for reducing further the complexity and thus the RT workload for the sector concerned.

This report is a reminder of the importance of the use of standard RTF phraseology and the speed of delivery in assisting understanding by crews for whom English is not their native language.

PERFORMANCE SOFTWARE UPDATES

Report Text: The Company recently rolled out new software for the laptop used in the flight deck. One of its primary uses is to calculate the Take Off performance of the aircraft in conjunction with the loading of the aircraft. It removes the need for paper charts to calculate performance.

The new software differs significantly in its interface from the last version which we have been using since the introduction of the aircraft several years ago. Information is inputted by the non-flying pilot in a different way and the presentation of the information is very different. The software is more powerful than the version before and offers useful new features.

However, the company has not implemented any formal training for the use of the new software. This is safety-critical performance which is being calculated. One wrong parameter could lead to a serious accident.

The company has pioneered the use of electronic media to disseminate information to its pilots. Company manuals are provided and updated periodically on CD-ROMs and occasionally other new procedures or topics are covered in the same way. Crews are required to sign for the CD-ROMs to show that they have received them. Moreover, the company "chase" those pilots who haven't yet signed for the CD-ROMs, such is importance placed on having an audit trail for training.

It is worrying that there is no such requirement for the new software. This is the most critical piece of software we use, up to six times a day, with minimal turnaround times, and there is no audit trail for its training. It was decided by the company that this would be self-directed learning from a PowerPoint document available on the company intranet.

I am concerned that in the event of an accident, attributed to incorrect performance due to lack of formal training, there would be serious repercussions for both the pilots and the company. To have no audit trail for training, relying solely on pilots to be able to "figure it out", with no formal appraisal of pilots' understanding of the new software seems short-sighted and penny pinching. The company insists that "Safety Is Our Number One Priority", yet this process seems to contradict this mantra.

Copies of the new software were placed on the laptops prior to its introduction, but it proved largely inadequate as it was "beta" software which didn't work properly and needed to be used in conjunction with the document on the intranet. There is some feeling within the pilot group that the software still isn't "finished" and that we are effectively beta testers in a "live" environment.

Lessons Learned: When the company introduced differently-configured aircraft, pilots who were to fly the different aircraft had to receive training on the equipment differences. This amounted mainly to oxygen masks and lifejackets. The company sent trainers to each affected base to make sure that pilots had seen (and when appropriate tried on) the different equipment. In the same way, the new software should

have been trained to a small number of pilots who could have acted as a mentor group to go through a presentation and brief hands-on session in each base. This should have been rostered, rather than left to chance that every pilot would understand fully the new software from a document on the intranet.

The training given by the company has been historically very good, and I am very worried that the lack of a training audit trail leaves gaping holes in usually robust, consistent and safety-focused training.

CHIRP Comment: The reporter's comments were passed to the operator's Head of Safety. Subsequently, the company provided a detailed response outlining the risk assessment, training package and lead times associated with the introduction of the new software. The company was also monitoring feedback from crews and had included the reporter's comments. The company was reconsidering whether it would be appropriate to mandate some form of 'sign-off' process to provide positive verification that this and similar training packages had been read and understood.

Changes/upgrades such as those described often present an operator with the training dilemma of whether to conduct formal training or to issue a CBT self-study package. The benefits to the company of the latter are obvious; however, it might be argued that the calculation of critical performance data electronically provides a greater opportunity for a gross error than the use of tabular data and thus increases the importance of training and use of robust gross error checks. An entry/calculation error that results in a performance related incident, for example a tailscrape, can easily outweigh the perceived training cost benefits of self-study. Thus it is important that a Safety Management System assesses all of the relevant risks/benefits associated with the introduction of new procedures.

TAKE-OFF CLEARANCE CONFUSION

Report Text: Taxying out to the runway holding point at a major UK airport, no queue, no aircraft on approach but one other aircraft taxying out just behind us. Whilst still taxying towards the holding point we were cleared by the Tower controller to line up, then the other aircraft was cleared to line up after we had departed. In other words a very unusual situation at this airport, as we did not need to stop before entering the active runway.

"Below the line" checks carried out including the reworded challenge and response item: "Cabin" "Secure for Take Off" (Previously the call was just "Secure").

Checks completed and (as required by company) the statement "Check list complete - cleared for Take Off" (as opposed to "Line up only") made by me.

We both believed we had been cleared for take off. As the First Officer was advancing the throttles the Tower controller cleared us for take off (we had obviously not been previously cleared).

There was no problem. We did not take off without clearance, but the fact remains that we had both believed we had been cleared.

Maybe (probably) because of the new wording, the First Officer saying the words "Take Off" and me hearing

someone say "Take Off" (to me) had convinced us both that we had been cleared.

These words should NEVER be used until an aircraft is actually cleared. The very good reason is that at Tenerife the worst ever accident occurred for just this reason, yet we are now required by SOPs to say them before every take off.

This check list change is a complete nonsense as the state of cabin "Secure" is the same for both take off and landing, the extra words are completely unnecessary and meaningless (even if someone was confused about whether we were on the ground or not, which seems unlikely). I was aware of the problem and thought my awareness was my defence, it wasn't!

Lessons Learned: Change the check list! Now!

CHIRP Comment: **This report is a good Human Factors lesson in that the reporter (the user) has identified a safety issue that had not been apparent to the author of the SOP change.**

It is relevant to note that ATC phraseology restricts the use of the word 'take-off' to the ATC instruction 'Cleared for take-off'; the word 'departure' is used in other ATC phrases/instructions.

USE OF 121.5 MHZ (FB97) - A COMMENT

Report Text: Another great read but I am dismayed by one article.

Firstly my background: Experienced airline pilot with a major UK airline and light aircraft flying instructor, at one time a Chief Flying Instructor.

Re the item on the "correct" use of 121.5: As an instructor I am strongly aware of the great benefit students get from Practice PAN calls. As an airline pilot I am equally aware that I can turn it off if I no longer wish to listen to practice PANS!

But my dismay was in your comment that "... A national policy on the use of 121.5 would appear to be a priority". NO!!!!!!!!!!! The priority now is to clear up our laughing stock airspace!

We have created airspace so impenetrably complex that even the CAA is marketing a special GPS to help PPLs get through it!! Can no one else see the absurdity in this?

Our current airspace is a mess that serves no one well. THIS should be our priority. Whingeing airline pilots can use the 'Select' switch.

CHIRP Comment: **In relation to the reporter's concern about the priority for simplifying the UK airspace structure, the 'Future Airspace Strategy for the UK' draft document was published by the Civil Aviation Authority in November 2010 and provided a two-month consultation period for all stakeholders to comment on the proposals for the modernisation of UK airspace.**

The AWARE GPS airspace warning device is not marketed by the CAA; the equipment was developed commercially with the full endorsement of NATS in order to address the year-on-year increase in Controlled Airspace infringements.

We do not endorse the reporter's suggestion that air transport pilots deselect 121.5MHz as this would

increase the risk of not reselecting the frequency with the consequent risk of an interception in the event of a subsequent loss of contact with ATC. Thus we continue to support the efforts to find an alternative solution.

COMPANY CONFIDENTIAL REPORTING

Report Text: Our Company has seen fit to appoint a member of the CRM team to a management position. This position, by its very nature, obligates the incumbent to hold specific responsibilities within the Disciplinary process. That the seemingly obvious dangers of this action have been overlooked by both the Management and CRM communities, and attempts by various means to engage in constructive dialogue on the subject have been repressed, is the subject of some considerable concern to many line pilots.

The Company's Confidential Reporting Scheme previously operated under the premise that reports were submitted to a member of the CRM team, who would disidentify them before forwarding them for Management attention. The system, in its current form, has therefore been unquestionably and irrevocably compromised in the eyes of many of the pilots.

There seems to be no acknowledgement that safety based reporting systems are "owned" by the pilots that would use them and that if, for whatever reason, they're not considered effective by the pilots, rather than by the Management and their CRM team, then they effectively don't exist, except in compliance with a regulatory imperative. Perhaps the Management and CRM communities need to ask themselves if they are satisfied with mere regulatory compliance or whether they would like to aspire to build a tangible safety culture.

The Company has previously expressed "disappointment" that its pilots have opted to make their confidential reports via the CHIRP system rather than Company reporting scheme. At the time this sentiment was expressed, numerous discussions took place on flight decks and Company's pilots' fora, the sentiment of which tended to imply that little confidence was placed in either the effectiveness or the robustness of the protections that the Company scheme offered. This latest act of disregard for pilots' wishes, in respect to Confidential Reporting, can only serve to reinforce the view held by some that the system exists more for the purpose of suppressing, rather than acting upon, safety reports.

It was recently suggested that the catalyst for the retention of CRM duties for the recently promoted Manager was to facilitate the bolstering of an inadequate emolument for the latter position. If true, this serves to yet further undermine the integrity of both the individual concerned (as a CRM entity) and the commitment to a real safety culture of the Company Management.

Perhaps it is time to remove the emolument from CRM positions thus removing the incentive for those who are motivated by financial gain, or a step "up the ladder" in Management, and let the pursuit of a safer airline be its own reward for those who choose to occupy the positions.

CHIRP Comment: As described in this report, the role of members of the CRM team would appear to be inconsistent with that of a line manager. Following an individual's appointment to a line management position, reassigning the responsibility for the management of the company confidential reporting scheme to non-management pilots would accord with good practice and maintain the confidence of line pilots in the effectiveness of the scheme. This view has been represented to the company's management.

MANAGEMENT DISTRACTION (1)

Report Text: On reporting for duty prior to departure, a senior manager/director was present to 'allegedly' answer any questions we had concerning looming industrial action.

It became quickly evident that 'listening' was not part of the manager's brief and was an overt propaganda mission.

At a time when concentration is vital and time short, a 30-minute 'confrontational' tête à tête is a complete abrogation of the company's responsibility to facilitate flight safety.

Once on the flight deck, despite making a deliberate attempt to put the matter to the back of our minds, it was obvious from comments made that we were all still conscious of the meeting and the ensuing threats/ suggestions. Had there been an incident on take off, an examination of the CVR would have revealed the esteem in which the management were held.

I have spoken with colleagues of similar situations where the atmosphere became so heated, the manager returned to ask them if they wished to stand down from the flight.

Lessons Learned: This type of 'meeting' should be specifically prohibited pre flight.

Ignoring the psychological pressure that may ensue, it prevents us using the valuable time for briefing.

CHIRP Comment: Crew briefing locations can provide managers with the opportunity to interface with line pilots and to hold brief informal meetings. However, where such meetings lead to flight crew members being distracted from their primary pre-flight duties or are allowed to develop into confrontational situations, the potential flight safety implications become obvious and should be recognised by managers.

It is not clear whether these meetings were the result of a well-intentioned management initiative or an ill-advised attempt to influence pilot opinion. Whichever the case, the unintended consequence would appear to have been an increased degree of disaffection with the process.

MANAGEMENT DISTRACTION (2)

Report Text: I recently managed to do something I have never done in more than ten years of flying; I forgot to do the after take off checks; on the day, not something dangerous in itself, but indicative of a far deeper problem.

Some time ago my company had a management change and since this happened there has been a constant attack on allowances and terms and conditions; this has resulted in a very negative feeling amongst the workforce. The usual reasons of increasing efficiency and profitability have been trotted out as the reason and I have no problem with this. If my employer is doing well that usually means my benefits increase; the proverbial 'Win - win' situation. However, in this case many of the changes are so petty and insignificant they almost seem personal. Not only that but basic documentation such as operation manuals and Company manuals which have not changed for some time are suddenly being withdrawn only to appear with amendments obviously added solely in order for the management to be able to ride rough shod over generally accepted practices in order for bonuses to be paid.

The net result is a workforce that is deeply demoralised and this is starting to affect the way we work. My colleagues are all professionals and feel as I do that this situation should not be allowed to infringe on actions and behaviour on the flight deck yet we are still human at the end of the day and the constant and unremitting attacks on our profession and way of life are making a mark. Our Flight Safety Department say 'Leave it out of the flight deck' but it is having such a profound effect on us that that is no longer an option.

I am writing this because under UK Labour Law we have absolutely no protection against this sort of behaviour but someone has to be able to do something to make these people see and understand the potential for something far more serious to happen.

Dialogue is the way forward not spreadsheets and profit forecasts before it is too late. We are not unreasonable but neither are we stupid!

CHIRP Comment: This report was one of several received. The concerns expressed by this and other reporters were discussed with the CAA and subsequently were the subject of discussions between the CAA and the operator concerned.

LONG DUTY (1) - LOSS OF SA

Report Text: Just back from a two-week holiday; well rested. Straight into 0500Z standby block.

Called at 0500Z to operate UK to Caribbean (AAA) and then position to Caribbean (BBB). Planned Duty - 15hr 05mins.

Late out of XXX (UK) and with 3 pilots so I should have 3 hours rest to be able to extend duty day. My rest disturbed by small children screaming in adjacent cabin.

Into AAA, then position on charter twin turboprop to BBB. Got to BBB and waited for crew bus and now off duty after 20h 20m duty and feeling tired. To hotel and in bed by 0200Z - shattered.

6 hours sleep watched TV and then another 5 hours. A quiet day and couldn't sleep prior to check-out but felt OK.

On duty 2230Z at airport and I was tired. I did all I could to work a bit slower and methodically as PNF. We pushed back for the easterly runway at 0016Z. The

previous ATIS had a surface wind of 070/07 and we had checked it at 2355Z and got busy so we did not get a 0000Z ATIS. As we taxied for the easterly runway we taxied close to a horizontal well lit windsock - I thought nothing of it until one of the F/Os pointed out it was favouring the other runway. I was so tired I had lost all situational awareness - I had assumed the windsock favoured the easterly runway. I realised how unfit I was for duty - usually in long haul you can crank your brain up a gear and it works - on this occasion I had nothing left.

I realise now that a duty of 20 hours plus needs a longer recovery and I should have delayed the flight. When I had queried the duty with Crewing the day before the attitude was very much 'it's legal' - I realise I am not a machine and that I may have to make decisions re: my duty time as the limits are being reached.

So the result - humbled we taxied for the other runway and departed successfully for UK. My crew rest was the best I have ever had in the plane ... and I felt very different after it.

Rostering provides only 2 days off after this trip. I found I needed 3 before I felt fit again.

CHIRP Comment: This report is a good example of a UK-Caribbean-UK schedule that theoretically should provide individuals with adequate in-flight/stopover rest but which can, in circumstances such as those described, be potentially fatiguing in spite of an individual taking reasonable steps to plan their rest appropriately.

It is also a reminder of why CAP 371 recommends that rest periods of between 18 and 30 hours be avoided especially after long flights crossing many time zones.

It is perhaps surprising that UK AOC holders do not provide more information to flight crew members on good practice in preparing themselves for a long flight duty period and methods of optimising the use of rest periods.

LONG DUTY (2) - UNCONTROLLED REST

Report Text: Caribbean 'bullet'; return night flight eastbound over the Atlantic; three hours to UK landing.

My eyes opened and my body woke with a start. The aircraft was flying what it had been told to do; all systems normal. There were three other aircraft indicating on TCAS, one of them was opposite direction 1,000' below us. I looked across to the right hand seat and behind at the jumpseat. Both crew members were still asleep.

Our company uses the '3rd pilot on the jump-seat' loophole to avoid the two-pilot sector factorisation that would otherwise be required on long-haul routes. How long had I been asleep? I looked at the stopwatch it was running at 23mins, so it was at least a couple. I had looked at it 3 mins ago as I felt my eyes beginning to close debating whether I could stay awake and let my colleagues grab another 10 mins nap. I now felt more alert and in control and so allowed them to continue their slumber. Five minutes later they began to stir and I subsequently handed control back to the

F/O whose landing it was. I told them what had happened. Neither appeared surprised.

The Caribbean bullet consisted of an 11-hour day flight, a 24-hour rest period then a 9-hour night flight home. I had got a local night sleep in the hotel and then tried to get a further pre-flight rest that was disturbed. This is a quite typical duty within the scope of our company's mixed long/short haul operation.

Lessons Learned: It's the first time for me that this has happened hence this report. My company have a controlled rest policy. This is a good principle generally but it's not enough on the bullets. With an FTL 3-pilot requirement I believe we need a crew rest facility so the 3rd pilot can get proper rest. Until they do this I feel that 3 pilot ops should be suspended.

CHIRP Comment: The comments associated with the previous report apply similarly to this report.

In addition, although CAP 371 permits the use of an appropriately qualified third pilot occupying a flight deck jump-seat to avoid the limitations associated with two crew long range operations (CAP 371 Section A; Para. 14.2), the benefits of this practice in the absence of some form of rest facility remain open to question. Some operators have acknowledged this and provide the option of a cabin seat for a resting flight crew member.

SECURITY VS PRESSURE TO DEPART

Report Text: We were called to operate a charter flight to/from a Scottish airport with a short turnaround due to a delay on the previous flight. This was compounded by a lack of handling agent staff and the high security risk/procedures for Public Charter flights.

One crew member was preoccupied with escorting the inbound passengers off the apron, followed by the early arrival of the next charter passengers, all of whom needed screening and full baggage/liquid checks as per the heightened procedures.

The aircraft was parked on a poorly lit apron and a secure zone was set up around the aircraft by a third-party security agent. This caused great issues with normal fuelling/catering/servicing of the aircraft, as each time a crewmember left or re-boarded the aircraft a body search and ID confirmation was required. Fuelling was completed and the receipt handed to the pilot on board by the refueller, who was familiar to us. When I, passengers and baggage finally arrived at the aircraft we were already behind schedule. Security hustled the passengers into aircraft and door was closed.

A normal taxi and take off followed but during the climb a quiet banging was heard at the fuselage midpoint which lasted for less than a minute. As non-handling pilot I elected to go into cabin and investigate. No further noises or indications were heard or seen. Flight continued to an uneventful landing at our destination.

On arrival it was noted that one fuel cap access panel door was open and the cap was missing, engine damage was also noted.

In hindsight, a contributory factor was the fact that the flights were conducted by two highly experienced

captains, possibly causing issues over who was doing what and where on the ground.

Handling was also an issue, with no assistance in a high workload, short time frame scenario. This led to only one pilot ever being on board until doors were closed for departure. In addition, as we operate frequently into/out of this airport, we were familiar with the refuellers and relied upon their usual procedures.

Finally, the high security resulted in an unnatural 'urge' not to go outside aircraft as this meant a lot of hassle and time wasted when weather/de-icing and catering was becoming an issue.

Lessons Learned: Unfortunately, aviation security for the airlines has fed down to the corporate level and we now have a system where corporate pilots are not only having to deal with airline style pre-planning checks and procedures ground-side but also monitoring fuelling, catering, toilet servicing security on board airside. All of which in an airline environment is covered by separate individuals. This often places the two-crew operation into a single crew operation, effectively doubling our workload and causing a lack of communication.

In this instance it has cost heavily in the wallet and trust but thankfully not to passengers' safety!

When pressure mounts from passengers, slots or your company, placing your trust in ground crew, however familiar or well acquainted can be easy but checking for yourself is the only sure way.

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

CABIN CREW REPORTS

CABIN CREW - POSITIONING OR OPERATING?

Report Text: I was rostered to position by taxi from AAA (UK) to BBB (UK2), then to position in the aircraft to a European destination and operate back to AAA.

As I was the only cabin crew on board I questioned the company if it was correct for me to position on the aircraft instead of being part of the operating crew. I was told that because I had no responsibility on board for that specific sector and company procedures do not require a crew member to be on board for Fire Watching purposes I was actually a pax.

Theoretically how can I be a pax on a non-commercial flight; who would be responsible in case of an emergency to operate the doors?

Can you please advise me if it was legal for the company to position me on such flight or should it have been an operating flight?

CHIRP Comment: If on a specific sector the only passengers are employees of the company and there is no freight other than 'company' freight onboard, then the flight may be classed as 'non-revenue'. In this

case, there is no requirement for cabin crew to be carried to undertake safety-related duties; cabin crew members on board are thus regarded as 'positioning'.

In the absence of operating cabin crew members, the flight crew would assume the responsibility to arm/disarm the cabin door and conduct safety briefings.

However, from a 'Duty of Care' perspective, an operator might elect to use operating cabin crew. If any cabin crew member is required to arm/disarm the doors, the sector must count as an operating sector for that crew member.

ADDRESS CHANGES