CHIRP Air Transport FEEDBACK

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The CHIRP Trustees would like to introduce our new Chief Executive, Ken Fairbank, to the readers of FEEDBACK during his first month in the appointment and wish him every success in carrying the safety mission forward.

Capt. David Harrison, Chair of CHIRP Trustees

EDITORIAL

I have been a grateful recipient and reader of Air Transport FEEDBACK for many years now, so it gives me great pleasure to be writing this, my first editorial as CHIRP's new Chief Executive. I have been involved with Flight Safety in various ways for many years, including nearly 13 years at the AAIB, a part of which I spent as an advisor to CHIRP's General Aviation Advisory Board. Further back, I spent time on the secretariat of the UK Airprox Board and (even further back) as a Flight Safety Officer in the RAF. Above all, I've been flying for 40 years and suppose I must have seen and learnt a lot in that time (although it doesn't always show). Working with our highly experienced Advisory Board members, I intend to ensure that the CHIRP Aviation Programme remains relevant and worthwhile in our dynamic and often challenging industry.

I would like to express my sincere thanks to my predecessor, Ian Dugmore, who has retired after more than 5 years as Chief Executive. I had the pleasure of sharing an all-too-brief handover with Ian, during which time his dedication and passion towards CHIRP were clear to see. So was his sense of humour. As well as his 'front of house' duties, Ian has worked hard to ensure that CHIRP moves with the times and remains lean and efficient while staying true to its core values. Thank you Ian.

The CHIRP Programmes are focussed on improving safety standards. Individual reports help us address specific issues and hopefully end in some form of closure for the reporter. On a bigger scale, suitable reports make it into FEEDBACK, which reaches into thousands of flight decks, crew rooms and control rooms. I want to ensure that FEEDBACK continues to 'do what it says on the tin' while remaining informative and educational for its many readers. So when you sit down to write a CHIRP report, I urge you to share not only what happened or what was wrong, but why you think it happened, how it affected you and your colleagues, what you did to mitigate the risks - and why you're still here to tell the tale. The 'H' continues to stand for Human Factors! Those of you who, like me, grew up on '*I learned about flying from that*' articles will know what I'm getting at. And we're all still learning.

Ken Fairbank - Chief Executive

ENGINEERING EDITORIAL

I would like to raise a concern that we receive from time to time from engineers and something all of us deal with during our careers:

How do I supervise the work of another person working on the same A/C or even on another A/C nearby for which I am responsible, in terms of signing off the work done?

This could become more of an issue as the number of engineers is reducing and the number of A/C go up year on year, requiring the fully licensed type engineers to oversee others' work almost routinely in some circumstances on an increasingly more frequent basis.

The regulations are clear enough on this subject. As below:

Engineering Supervision: Failure to supervise work correctly can result in the suspension, limit or revocation of the engineer's licence as detailed in Part-66. B.500 Revocation, suspension or limitation of the aircraft maintenance licence:

> *The competent authority shall suspend, limit or revoke the aircraft maintenance licence where it has identified a safety issue or if it has clear evidence that the person has carried out or been involved in one or more of the following activities:*
>
> *Issuing a certificate of release to service knowing that the maintenance specified on the certificate of release to service has not been carried out or without verifying that such maintenance has been carried out.*

The control and management of the paperwork and the activities of the mechanics is the direct responsibility of the Licensed Aircraft Engineer (LAE) assigned to a task. CAP 562 states:

> *Leaflet H-20 Para 1.3: The certifying engineer shall be responsible for the condition, assembly and functioning of the aircraft or its components for maintenance that has been certified under the privileges of a Type Rated Licence or an authorisation.*
>
> *Leaflet H-20 Para 1.5: When issuing a Certificate of Release to Service for work performed by others, the certifying engineer assumes responsibility. The certifying engineer must have inspected a sufficiently representative sample of the work and the associated documentation and be satisfied with the competence of the persons who have performed the work.*

With the above excerpts in mind it is easy to see how we could potentially be creating a HF issue if we don't start to manage the relationships in the work place better. A lot of engineers work hard to achieve a licence and then they obtain a type rating and before they know it, they are dealing with an aircraft which is fine in isolation as they have trained for this over several years. What they have not been trained on in most cases is how to manage a team, how to manage other people's work and supervise it.

A modern-day aircraft maintenance environment involves complex systems and different people on board such as cleaners, caterers and crew and more than one engineering team in some circumstances. Should the industry be paying more attention to this aspect of maintenance and doing more to ensure that the person signing the CRS has the capability and confidence to manage the work and also the people involved? Some can do this with no great issue but others can find it difficult and even stressful to challenge the standard of work of others in a work environment especially if they feel it could cause confrontation between colleagues.

In practice this means the engineer has some discretion on how he/she oversees the work of others and much depends on the engineer's confidence in his/her individual team members and the nature of the task.

Companies should be alert to the proficiency of their staff at leading a team, offering training if necessary to ensure it is adequate for the role they perform to allow people to both give and receive requests for staged inspection updates, information or even criticism. Planners need to be realistic in drafting work schedules and time must be allowed to put controls in place to ensure that the LAE can be confident that all work is satisfactorily completed. Any engineer who finds himself/herself under pressure to cut corners should voice their concerns and, if necessary, report the issue formally through their Company reporting schemes.

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Terry Dudley – Deputy Director (Engineering)

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COMMENT ON FEEDBACK EDITION 129 – INAPPROPRIATE OPERATIONAL FLYING TRAINING

Report Text: In response to your report regarding role play whilst line training new Commanders, I would like to add further real experience of poor practice.

Within my current airline (which may be the same as the previous report) whilst I was also undergoing LHS training an attempt to go high on the approach was made (a colleague also informed me of a missed approach generated by this practice). Wrong altimetry was also set, my response was "have you done that deliberately?" received with a wry smile. Trust was completely destroyed, I watched this character very carefully from then on, not for any training value but purely to trap this unsafe practice and go home to the sanctuary of my family.

I agree wholeheartedly with the previous report that deliberate mistakes within role play have no place within modern highly automated active commercial operations and should be confined to skilled simulator training. Fortunately, our [Operations Manual – Training] states for our Training Captains:

> *"you should act as a competent friendly co-pilot lacking initiative and do not make any deliberate errors".*

The same document completely contradicts this rule and encourages unsafe practice generating a deliberate error by stating:

> *"If you are high on the approach don't take action until the trainee notices and gives guidance to resolve the issue".*

The response from the airline representative within your report is also disturbing. Rather than a veiled criticism of the reporter for not taking their concerns for this practice direct to the management, the management may need to look inwards and study why Pilots in this company have to go to CHIRP for a listening ear.

We must all remember that being human, we make errors. Error will occur naturally at some stage on any course. Action slip, lapse, mistake and violations should however be guarded against and subsequently understood at all levels. The best Pilots with the best CRM knowledge are not immune to error (including training pilots) and therefore should not reduce levels of safety with fare paying passengers on board by deliberate actions in the misplaced strive for "evidence-based feedback".

Operations Manuals should be re-written to bring them in line with the current operational environment, removing ambiguity and truly outlawing deliberate errors within active commercial operations.

CHIRP **Comment:** Flight crew training should be focussed on safe and efficient operations as a crew. While a Training Captain might be tempted to introduce deliberate errors, this is not in keeping with the crew concept. If the action is contrary to the Operations Manuals, then it would represent a deliberate violation of procedures. Apart from the obvious safety concern, the practice runs the risk of alienating the trainee, as occurred in this case.

EXHAUST FUMES IN COCKPIT AND CABIN

Edited Report Text: I'm employed flying helicopters to Oil & Gas installations offshore. On a normal day, before departure, the crew refuels the aircraft, which normally has an APU running during the refuel. The start is conducted when the passengers are on board after the refuel.

A few months ago, my operator introduced a standard operation to park the aircraft as conveniently as possible for the refueller. Where we would park the aircraft into the wind before, the aircraft is now parked in the same way regardless of the wind direction.

During the refuel and APU running process, the exhaust fumes often enter the cockpit and cabin. But worse, during the engine start the exhaust fumes of the main engines enter the cockpit and cabin as well. My operator has introduced a 'ventilation OFF' start procedure as a standard to avoid Fume events. This does not help in the slightest way.

On a few occasions the fumes made me feel very lightheaded and gave me a sick feeling. When I asked my colleague, he felt the same while looking pale and distracted. It takes some time to recover from the feeling, but the smell of the fumes goes away after a few minutes. I'm concerned that this is because of the levels of blood poisoning and harmful substances that may have entered the body at that stage. We sometimes have to wait on the spot before a taxi clearance can be given, which makes things worse.

My employer has an internal reporting procedure, where these Fumes events have been raised. The reports do not seem to be taken seriously and the trial procedure has now been implemented in the new Company Operations Manual. Because the procedure is now in the Operations Manual, pilots feel unable to differ from it.

I'm very concerned that this procedure endangers the passengers, crew and other airspace users. The levels of CO in the cockpit could be very high on some occasions, which could seriously affect the crew's ability to perform their duties.

I hope you will be able to give me advice on how to deal with this. I feel my employer does not take the reports as seriously as it should. As the CAA has approved the procedure in the new Operations Manual, I hope the CAA can intervene before anything bad happens.

In future, I will not follow the CAA accepted company procedure when I feel it endangers the flight and the airspace I'm about to operate in. A helicopter should be started into the wind, or as close to the wind direction as possible.

Operator's Comment: A Flying Staff Instruction (FSI) was issued concerning out-of-wind starts. This was subsequently incorporated into the Operations Manual with revised wording: *"If the aircraft is parked facing out-of-wind such that there is a possibility of exhaust fumes entering the aircraft cockpit or cabin during the start, and it cannot be moved to a better spot, close all windows, doors, and air vents, and switch off heater blowers and / or air conditioning systems until the engines have been started and the rotor system is at idle or flight RPM".* Whilst it is not explicitly stated that the Commander request the aircraft to be repositioned, this is not considered necessary as safety/comfort of the passengers is implicit within the aircraft Commander's responsibilities.

CHIRP **Comment:** The initial FSI as seen by CHIRP did not mention the option of repositioning the aircraft and a recommendation was made that it be re-issued to make it clear that aircraft Commanders have the discretion to move their aircraft to reduce the potential for APU and engine exhaust fumes to enter the cabin.

Ensuring that an aircraft was appropriately positioned is a routine responsibility for aircraft Commanders and CHIRP agreed with the Operator's comments in this respect.

ATCOs' RT CALLS

Report Text: This report is a general one, the time and date given is the most recent example where the subject of the report recently occurred (it was during my annual Licence Proficiency check, after an ILS approach, with an examiner on board).

I operate a two-pilot helicopter based at a large and often very busy civilian airport. We fly to "Class A" performance and aim to operate in accordance with the sterile cockpit principle, for well publicised reasons.

A "Clear Area" (runway) approach for the type we operate has a Landing Decision Point (LDP) of 80 feet agl and 25 kts IAS. Beyond that point on the approach, an engine malfunction would require a landing on the runway because there is likely to be insufficient power to achieve a hover or to climb away. 80 feet agl is therefore a point where the pilot needs to fully concentrate on either landing or achieving a stable hover, from where either hover or ground taxiing can be commenced to clear the runway.

Increasingly often, ATC transmit our subsequent taxiing instructions on short finals, sometimes including a frequency change to "Ground". As instructions there is a requirement for these to be read back in full. This is an unacceptable distraction at a critical stage of flight.

The pilot flying calls "LDP" across the cockpit so that the other pilot is aware of what his immediate actions would be in the event of an engine failure. An untimely transmission from ATC completely disrupts this cross-cockpit communication. I have noticed that ATC certainly seem to totally understand the "sterile cockpit" environment of fixed wing aircraft but inexplicably, do not seem to consider this same factor for helicopters.

ATCOs should delay transmitting taxi instructions to helicopters until after they have cleared the runway, or at least after landing, certainly not on short finals.

British Helicopter Association Comment: This is a common one for helicopter operators. The solution is to go and have a liaison visit with the tower and tell them your concerns and how you operate. Because helicopters do not follow the normal instrument arrivals, ATC may not realise that crews need a 'sterile' period during the late stages of an approach. Very often we are turning onto the final approach heading, at a low height, having come from 90 degrees to the runway. Certainly, taxi instructions should not be given from the time the helicopter enters finals until it is in a stable hover. It makes no difference whether the aircraft is being flown multi or single pilot.

ATC Comment: This is a busy airport equipped with a single main taxiway running parallel to, and along the entire length of the runway. There are several aprons spanning the entire south side of the airport and entry/egress from these aprons is via a multitude of access points. As a consequence, aircraft are not generally allowed to choose the point at which they vacate, as this may well bring them into conflict with aircraft taxiing in the opposite direction for departure and there is an insufficient amount of safe space between the runway exits and the main taxiway to safely hold aircraft. We also have some exit points towards the mid-point of the runway that are also used as holds for departure. Consequently, if a specific exit is required, aircraft are usually given instructions on where to vacate prior to being given landing clearance, to allow them to plan for the required braking action and also to allow for an uninterrupted approach and landing. However, due to the dynamic nature of the traffic and the small traffic gaps that a single runway operation requires, it is sometimes necessary to instruct pilots upon completion of their landing roll where they are required to vacate and controllers are trained to time this call accordingly.

In the case of helicopters, it is not always apparent when the landing manoeuvre has been completed and taxi manoeuvre commences as helicopters seldom come to rest either in a hover or on the runway and often transition from landing straight into taxiing off the runway. In this instance Controllers will make a judgement as to when it is likely to be safe and prudent to issue taxi instructions but this may sometimes be prior to them vacating the runway if the traffic situation requires it.

It is not clear from the report at exactly what point the reporter received the taxi instructions but we would be surprised if this was 'late on the approach' and is far more likely to be when the aircraft is abeam the tower (approximately half way down the runway) which is where our ATCOs generally make the necessary call.

The report will be included in the next standards bulletin together with re-iteration of the importance of timely taxi instructions, in particular those relating to helicopter movements. Equally, pilots need to be aware that if they receive an instruction from ATC that is poorly timed or inappropriate, the use of "Stand-by" is always available. Working with many different operators, experience has shown that there is very little standardisation in cockpit procedures and very often, a period that is regarded as 'sterile' by one operator may well be considered to be 'opportune' by another.

We appreciate this kind of feedback and it's always good to hear the other side of the story.

CHIRP **Comment:** A sterile cockpit for critical phases of flight is a sound principle. In reality, controllers frequently issue instructions or guidance when on final approach. These transmissions may be helpful - for example a wind check, the position of marshallers or the location of the exit taxi way, which, taking into account the great flexibility of a helicopter, may allow the final approach to be modified to minimise a possible long hover-taxi. However, such calls should not be made during the critical final phase of the approach. Frequency changes in the late stage of flight or the hover can be a problem for single-pilot helicopters that do not have a cyclic frequency select button – or who have not pre-programmed their radio to the ground frequency! This report, and the two Comments above, provide a good reminder of the differences between fixed wing and helicopter operations. Also, that a bit of awareness can go a long way; if ATC procedures cause pilots a problem, and vice versa, it is a good idea to discuss them and find a solution that works for both parties.

WHEN IS A HOSPITAL FLIGHT A CAT A FLIGHT?

Report Text: I have had a few instances recently involving flights that have turned out to have category A priority, but this was unknown to me at the time, nor was the information available.

I recall a number of years ago (although I stand to be corrected) that operators would add 'CAT/A' to Field 18 of their flight plan if they were a CAT A hospital flight. Unfortunately, this no longer seems to happen, nor, to my surprise, is there a requirement from CAP694 (UK Flight Planning Guide) for it to be added. This would have provided the best and earliest means for ATC to have identified a flight as CAT A.

The only information available from Field 18 of the flight plan is the flights status (STS/HOSP, STS/MEDEVAC etc). Again this, unfortunately, does not provide enough information. CAP694 defines STS/HOSP as "Non-urgent flights will continue to use STS/HOSP indicating that special handling is required". What is or what should be the level of this special handling? An operator could even still use STS/HOSP if it is a positioning flight! If the operator uses 'STS/HOSP AFTMX', things are a little clearer with CAP694 stating "The combined use of STS/HOSP with STS/AFTMX will indicate to ATS

that the flight is required to operate without delay and so justify exemption from ATFM. Such flights may be afforded additional priority that the traffic situation allows". But again, this isn't clear enough. It's certainly not saying it's a CAT A flight; it just merely allows it 'higher priority' but only if the traffic situation allows.

Most hospital flights (at least at our unit) are carried out by aircraft such as DA42's, PA31's, BE20's or occasionally Learjets and Citations. The former of these aircraft are comparatively slow. I was vectoring a DA42 once on what turned out to be a CAT A organ transplant flight (I was not aware of this at the time, nor did the pilot inform me initially, nor was there any indication on their flight plan). It was a slightly busy session and due to the aircraft's speed and other faster traffic, I vectored the DA42 to be number 3 with a small delaying vector to position them behind other traffic. It was at this stage the pilot informed me "you do realise I'm a CAT A organ transplant flight?" Well no I didn't! I adjusted my plan to enable the aircraft to become number 2, but this complicated the traffic situation. This had me asking 'why didn't the pilot just inform me on initial contact?' This would have solved the situation for me immediately and enabled me to work the traffic situation more efficiently. I regret to say that we have also had similar situations since.

None of us wants to unnecessarily delay CAT A flights. I believe there are a few simple things that can be done to prevent this from happening, but I would be interested in what CHIRP's thoughts on this are.

Suggested solutions:

      1) Have operators put the relevant category of flight in Field 18 of their FPL's

      2) Encourage pilots to inform ATC on initial contact that they are a CAT A flight.

CHIRP **Comment:** The allocation of flight categories is considered to be an ATC issue and is not a flight planning consideration. Detail on flight categories is contained in CAP 493 – MATS Pt 1. ATC allocation of flight category is based on what is included in field 18 of the flight plan under STS/ which indicates that special handling is required. If STS/MEDEVAC or a combination of both STS/HOSP and STS/ATFMX is included, this indicates that the flight cannot accept any unnecessary delay and basically means that the safety of human life is at risk. This can include positioning flights and the carriage of organs for transplant. If the traffic situation allows, ATC will allocate CAT A to such flights but it is up to ATC and not the operator to determine the flight category. Therefore, an operator cannot insert a flight category into field 18 of the flight plan, they can only use STS to indicate the level of special handling required. There is nothing to stop a pilot ensuring that ATC is aware of the special handling required when R/T communication is established but the flight plan should have already done this job. Full details for the use of STS/ in the flight plan are contained in the AIP in ENR 1.9 and the process for applying for the use of ATFMX is also included in AIC Yellow 2/2014.

CHIRP's view is that it is unsatisfactory for controllers to be expected to interpret the remarks in Section 18 of Flight Plans; it would be more sensible to include 'Cat A' then include the flight status indicator (STS/HOSP, STS/MEDEVAC etc) to explain why. Since Section 18 of the Flight Plan may not be immediately visible to controllers using electronic flight strips, pilots are encouraged to make ATCUs aware of their CAT A status on first contacting the unit.

The report and CHIRP comment were passed to the CAA with a request that consideration be given to publicising the issue among the pilot community and stressing the necessity of declaring CAT A status on first contact. CHIRP was subsequently advised by the CAA that the matter was being addressed.

HLA TRAINING/FAMILIARISATION

Report Text: My operator has been conducting HLA Oceanic training under the guise of "Familiarisation" for a while now. This used to be conducted by LTCs under a training programme following a lesson plan followed by sign-off, enabling the crew member to now fly with other qualified crew members on oceanic routes. They have since changed this from Training to Familiarisation meaning that once a Line Captain like myself has operated 6 sectors oceanic, we are now classed as "qualified" to conduct these famil flights. I, like a lot of others I have spoken to, am not comfortable conducting these flights with an unqualified crew member on these procedural more complex route structures plus the fact as these used to be training flights we have been supplied the same "lesson plan" (now changed name) as the LTCs would have used and have been notified by the training

department via a "Training Instruction" memo, as to how to conduct these flights. Any words to do with Training or Student have literally been scored out and replaced with Familiarisation and Observer.

Personally, as a Line Captain, I'd rather not fly with an "Observer" in the other crew seat. The company have said the regulator approved this process however have not provided this approval to us. I would be interested to learn if this Approval exists with the NAA and the legalities to flying oceanic airspace as a normal Line Captain with an unqualified or unfamiliar crew member. Procedures and Emergencies etc. in this airspace are more complex and demanding than the domestic alternative and I think it's unfair to lay this extra responsibility on us. Especially as we have not been trained to conduct these types of flights nor do we receive any further remuneration as LTCs would.

Operator's Comment: There are no grounds for raising the Company's NAA-approved procedures for pilot NAT HLA Route Familiarisation training as a safety issue. The approval process for this change considered the difficulty and safety implication of the task and the Company was satisfied that the new training procedure was suitable and did not compromise safety. This process was discussed in detail with the NAA at the time of the relevant Training Instruction proposal.

CHIRP **Comment:** We have been unable to find any formal training requirements for flights in North Atlantic High-Level Airspace; ICAO Doc 007 provides little guidance but operators should detail their training requirements in their Ops Manuals. Operating 'Tango routes' is generally straightforward but there is the potential for complications and many operators include an aide memoire in the QRH. Pilots who do not gain experience of HLA ops during their line training should have little difficulty learning the procedures during routine flights with a non-training Captain. The experience can be likened to operating into an unfamiliar airport for the first time.

Concerning the issue of legality when flying these routes with an unfamiliar crew member (CHIRP would not consider them to be 'unqualified'), reference should be made to an article on Vicarious Liability which appeared in [Air Transport FEEDBACK 126](#).

CAPTAINS FLYING AS FIRST OFFICERS

Report Text: Several months ago, an opportunity arose at our airline for regular line Captains to volunteer to fly as First Officers for two months to cover an alleged shortfall. Both seats had been working particularly hard for several years and I feel this was a move to avoid paying extra overtime to the First Officer community.

Having recently flown with several volunteers who moved temporarily to become a First Officer I found several problems that I believe are adversely impacting on safety:

 - They still wear a Captain's uniform and so it makes it difficult to immediately identify who is in command of the aircraft. This leads to many instances of confusion with ground staff and cabin crew who were changing frequently in this large organisation.

- They are regular line Captains and have not had the extra experience as Training Captains have done in the past as to how to effectively operate from both seats.

- There was no extra CRM training provided and it is very difficult to immediately adjust your mind-set as to how to operate as an effective First Officer when you have been a Captain for 20 years. This can lead to a very ineffective cockpit authority gradient, especially when the legal PIC is much less experienced than the right-hand seat occupant.

In my opinion, this was simply a move by the management to avoid paying a small overtime bill to the First Officer community. No care or consideration was made to the safety impact and in the future either this experiment should be abandoned or perhaps some time spent on the human factors implications of the problems highlighted above.

Operator Comment: There are occasions where Captains operating as First Officers in the right-hand seat (RHS) still wear 4 stripes. This is not an issue, as long as the Commander makes it clear to whoever needs to know, where command authority lies. This would be covered as part of the joint briefing with cabin crew. Similarly, it is not unusual for Training Captains to operate in the RHS during training sectors, without issue.

The appropriate training to operate in the RHS for the role referred to in this report is provided in the simulator and during RHS line training. Captains are used to operating with FOs of all experience levels (some immediately out of training) and managing the differing experience levels of RHS operation; this is a fundamental aspect of the Captain's role.

CHIRP **Comment:** It has been common practice for very many years for airline Captains to fly in the RHS and the Captains doing so for this operator were volunteers. Although it is a legal requirement that one pilot is declared the Aircraft Commander, there are CRM issues associated with having a Captain in the RHS as the dynamics on the flight deck are altered, particularly when the aircraft commander in the LHS is relatively inexperienced in the role. This underlines the necessity for appropriate training for Captains occupying the RHS; provided this training is undertaken and Captains occupying the RHS do so with the correct attitude, there should be no safety concerns.

POSSIBLE FAILURE OF OPEN REPORTING CULTURE

Edited Report Text: Having night stopped we collected an aircraft to return to home base. The First Officer was acting as P1. Having checked the tech log, he informed me he couldn't find a MEL reference as it appeared that it didn't exist. The fault had occurred on the previous sector and it looked to me like a simple mistake had been made by engineers when copying the reference from the MEL and transposing some figures (in this case a 5 should have been a 3). I contacted our engineering department and they confirmed the correct MEL reference allowing us to dispatch. It was agreed with engineering that I would place the aircraft unserviceable at home base to allow the tech log to be updated with the correct reference. An Air Safety Report was filed in accordance with the company operations manual.

On arrival at home base the aircraft was met by an engineer. When the engineer found out that an ASR had been filed, they became quite upset and agitated. I asked why. The engineer eluded that they feared some kind of reprisal from management or the quality assurance department. They also explained to me that as a department they were very stretched manpower wise and that they were being continually pressured to dispatch aircraft. This is not the first time I have witnessed this response and have seen it before from pilots, cabin crew and engineers in the past.

I feel that current drive on costs within the business is now affecting flight safety. Current unrealistic flight schedules, a squeeze on manpower and unrealistic targets have led to a breakdown in open reporting and the ability to learn from mistakes.

Operator's Comment: This appears to be a simple MEL transcription error. It appears that the correct action was taken at the time, with Maintenance Control confirming the appropriate deferral authority.

We can confidently state that there are NO punitive measures in place from Engineering Quality or Engineering senior management for ASRs being raised - we do monitor that such reports are responded to in a timely and appropriate manner (in accordance with corporate procedures) but it would be inappropriate for us to seek to influence the raising of GORs/OSRs/ASRs themselves.

Furthermore, all Engineering Leadership Team members join continuation training (mandated refresher) sessions where we reiterate the importance of getting it right over time pressure of a departure.

Reporting culture is monitored at all SMS Safety Boards all the way through to Board level. There are no adverse trends in this area and the Company as a whole regularly promote the need for open and honest reporting. Everyone in the safety 'chain' is responsible for promoting an effective safety culture, so it is pleasing to see that in this case, the flight crew reported what they were told by the attendant Engineer.

CHIRP **Comment:** The Operator's reassurance that no punitive measures were taken against engineers as a result of ASRs being raised was welcomed and it appeared that the engineer was misinformed. However, the reported pressure on engineers was coherent with other reports about this Operator. The Operator made a good point in its comment about the reporter's role in the safety chain.

REPORTING CPDLC STATUS

[CPDLC: Controller-Pilot Data Link Communications]

Report Text: On an extremely regular basis pilots report that they are either logged on to CPDLC or are equipped or that they are equipped but unable to log on. The whole point of CPDLC is to reduce R/T and these extra transmissions are entirely counterproductive. As radar controllers we can see equipage state and login status on our radar and our tools will only offer us the option of sending a message by CPDLC if all requirements have been met. If we can use it, we might. If we can't, we obviously won't. I don't know if it is aircrew procedures that require these reports or if it is just something

that has evolved as the use of the new technology increases but it would be appreciated, especially as traffic levels build again next summer, if they stopped.

CHIRP Comment: CPDLC was originally mandated for February 2015 and many operators had started to equip and use CPDLC beforehand. During this period there was a requirement to state that you were using CPDLC as most aircraft were not so equipped and only a few ANSPs could use it. The mandate was subsequently delayed until February 2020; more ANSPs have come online since then and the requirement to state that you are equipped/using CPDLC has gone.

Because we have not reached the mandate date, the use of CPDLC is still variable and its usage is not yet as straightforward as it is likely to become over time. It is understood that in the UK it's use is still down to user-preference. Consequently, some ATCUs use it a lot and some not at all, as they are not required to. The same goes for most of Europe (probably with the exception of Maastricht who were one of the first and use it by default).

There is little guidance in CAP413 regarding CPDLC and operators have produced different SOPs regarding usage and reporting. An amendment of CAP413 for when the use of CPDLC is mandatory would appear to be the best solution. The CAA is aware of this report and the proposed solution.

APPARENT LANDING BELOW MINIMUMS

Report Text: For at least two weeks or more there was no CAT II approach into the airport concerned. Over a 5-day period I diverted twice because weather was very marginal meaning RVR that were around 600 m, but Vertical Visibility (VV) was less than 100 feet making approach impossible. On one occasion I flew to the airport 2 times did 5 Go Arounds from minimums with no contact. All aircraft with a certain Operator landed without any problems saying that they were in contact with approach lights at minimums which was not true (at least 10 aircraft). It's weird that all other Operator's crews did GA from minimums with no contact and diverted. It's not the first time something like this happens. It's very easy not to follow the rules and land below minimums using autopilot but is it safe?

Aviation is all about safety and something has to be done otherwise one day the Operator concerned might not be so lucky.

CAA Comment: The reporter states that VV was less than 100 feet making approach impossible. This statement is incorrect in that CAT.OP.MPA.305 only precludes an approach being commenced based on RVR and not cloud base. The reporter states that the RVR was around 600m which would have been fine for an approach as it is standard 550m required for CAT I in accordance with the published procedure. Due to the nature of low cloud which is amorphous and not consistent or defined it is impossible for the reporter to know what the cloud was like at decision height for those aircraft at the time and the weather reports from that period show fluctuating weather. Given the numbers of successful approaches by one Operator is does potentially raise suspicion but, by the same token, it would mean that it would have to be a company-wide deliberate violation of the rules. The Operator has been asked to comment accordingly.

EASA Comment: The report was passed to Air Ops for such action as is deemed appropriate.

CHIRP Comment: The report concerned a foreign airport and was submitted by a pilot working for a foreign AOC-holder but concerned a different foreign AOC-holder. While the report appeared to contain a certain amount of speculation as to the actions of the crews of the Operator concerned, the overall situation did nevertheless appear unusual. It was agreed that the report should be forwarded to the CAA and EASA.

POSSIBLE LOSS OF SEPARATION

Edited Report Text: On a date in November in near LVP conditions with strong crosswinds, a very experienced controller (examiner and OJTI) established a Citation on the ILS at just under 4 miles. While handing over the position to another very experienced controller, the off-going controller turned an Airbus with a significantly higher speed on to the ILS. Both controllers, who were managers and spent minimal time working operationally, were slow to pick up the mistake which resulted in a loss of separation - 2.6 miles at touchdown.

The incident was discussed at unit level but not otherwise reported. I believe this was because both controllers held managerial positions and a similar incident had occurred recently at the same unit.

Unit Comment: A Review of the radar recordings was carried out. The required separation was 3 nm at the point the first aircraft touched down but it could not be established definitively whether or not separation was lost as the actual point of touchdown could not be accurately determined. The first aircraft, the Citation, was established on the ILS at about 8 nm. When the second aircraft was establishing, the Citation was at about 4 nm. The initial spacing was approximately 6 nm but the 'catch up' that occurred was greater than the approach controller anticipated. The second aircraft was instructed to reduce speed but the distance between the two aircraft continued to reduce. When the first aircraft's height readout indicated that it was close to (or actually) touching down, the separation was greater than 3 nm. Just before the landing aircraft disappeared completely from radar the separation was less than 3 nm – without an accurate landing time it is impossible to tell whether or not separation was lost.

Other experienced controllers were watching the inbound aircraft, any one of whom could have issued a go-around instruction if they believed that the succeeding aircraft was not safely positioned. No such instruction was issued, nor was an MOR filed, which is required if any member of staff feels that safety has been compromised. The unit operates a 'Just Culture' where reporting is actively encouraged. Filing an MOR automatically triggers an investigation within the Just Culture framework. The reporter in this case was perfectly entitled to raise an MOR, and in fact should have done if they felt that safety was compromised, or indeed, if they felt the incident should be fully investigated.

Although no MOR was filed, some concern was raised by the Unit Training Manager at the time of this incident, due to the minimum spacing being used when the weather conditions were less than optimum (conditions at the time were: 170/18kts 10km+ BKN005). As a result, a unit-wide safety bulletin was issued to all controllers, along with a presentation reminding controllers of weather effects on aircraft on final approach and appropriate use of defensive controlling techniques.

It was determined that the controllers, who were both very experienced, had satisfied all the requirements for competency and currency according to the Unit Competency Scheme. The Unit Training Manager discussed the situation which led to his original concerns with the controllers (who both held management positions within ATC) and recorded notes in the appropriate records.

CHIRP **Comment:** The incident may not have involved a loss of separation, although the achieved separation at touchdown was less than intended and may not have been appropriate in the prevailing conditions. The reporter felt that, as both the Approach Controllers held managerial positions, this may have been due to a lack of recent operational practice. However, the Unit investigation determined that both controllers fulfilled all competency and currency standards required under the Unit's Competency Scheme.

Although no MOR was filed, the unit recognised this as an undesirable event and appears to have taken appropriate actions. It is worth reiterating that controllers have a responsibility to report circumstances in which safety was, or may have been, compromised.

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Future CHIRP Drone Programme plans

With the rapid expansion of drone flying and numbers of drone operators, there is a growing need to establish a confidential drone reporting programme. Working alongside the CAA and NATS, CHIRP intends to launch such a programme later this year, more details of which will be published in due course.

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