

# CHIRP FEEDBACK

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## EDITORIAL

When I was invited to implement the recommendations of an independent review of CHIRP in 1995 the UK commercial air transport industry was significantly different to that of today.

At that time the operational efficiency of airlines had benefited from the technological advances and improved technical reliability of the first generation of 'advanced flight deck' types that had been developed and introduced to service during the 1980s. However, scheduled operations were still broadly separated into short and long haul operations, and charter operations were less diverse than more recent developments such as extended range operations and common type ratings now permit.

However, there was a growing awareness that the introduction of the new generation of aircraft had not been accompanied by a significant decline in the commercial air transport fatal accident rate that had been anticipated. One of the initiatives to understand why accidents such as that involving an A300-600 aircraft at Nagoya in April 1994 were continuing to occur was the FAA Human Factors Team study to evaluate the flight crew/flight deck automation interfaces of the then current generation of transport category aircraft, many of which remain in service today.

The report titled 'The Interfaces between Flightcrews and Modern Flight Deck Systems', published in June 1996, highlighted a number of areas of concern related to the flight crew management of automated systems. These included the level of pilot understanding, differing levels of confidence in determining the use of automation or manual intervention, deficiencies in the design of some autopilot systems and inadequacies in the information promulgated in manufacturers' Flight Manuals available to flight crews through Operations Manuals. The report also expressed concern about a lack of situational awareness among flight crews regarding the automation mode, the aircraft flight path/energy level and variations in key automation interfaces.

So what progress has been made since the report was published?

From a design perspective the development of Enhanced GPWS systems and Vertical Situation Indicator displays, combined with the adoption of Continuous Descent Non-Precision Final approaches has mitigated the risk of Controlled Flight Into Terrain (CFIT) accidents, one of the major categories of large commercial jet hull losses. More recently the development of landing performance tools to assist crews to assess more accurately their aircraft's capability in the conditions pertaining should mitigate

the risk of runway excursions, another significant cause of large commercial air transport major accidents. Clearly, these and other similar technological initiatives are to be welcomed.

From an operational perspective, recent changes have included the development and implementation of Safety Management Systems (SMS) and more latterly Fatigue Risk Management Systems (FRMS). One of the principal objectives of SMS and FRMS is to permit Accountable Managers and Nominated Post Holders to identify potential areas of risk in their operation and develop effective mitigations to reduce the risk to as low as reasonably possible. This objective, if achieved, will permit the Regulator to make further changes to the current oversight methodology for UK AOC Holders including, where appropriate, adopting a risk-based oversight policy.

It might be anticipated that these management tools would enable all operators to review and address some of the human performance issues, which were identified in the FAA Study and remain equally relevant today. Regrettably, the evidence from reports received through this Programme has been that in some cases these management systems are used more to justify cost and operating 'efficiencies' rather than enhancing operational safety, which all too often is assumed.

We have highlighted many examples both in previous issues of this newsletter and directly to the Civil Aviation Authority. These have included the level of training associated with the introduction of new safety critical systems/procedures, the manner in which some operators elected to introduce electronic data/information, the justification for the use of 'remote learning' methods (often in individuals' own time) as a substitute for formal classroom training, and the commercially and operationally expedient decision to charge passengers for hold baggage without developing effective procedures for the control of carry-on luggage.

In the case of FRMS, allegations of subtle and sometimes less than subtle pressure by some managers on individuals not to report 'fatigue' negates the very basis for an FRMS. This also leads to a more recent related issue reported to us; the use of sickness as one of the criteria for the assessment of individuals for redundancy. This is covered in more detail on Pages 5/6 of this issue; however, it is worth pointing out here that its use indicates a lack of understanding among some Accountable Managers of the downstream consequences among flight crew members of such a policy and a lack of awareness within the Civil Aviation Authority of the potentially deleterious impact on flight safety of flight crew members operating a duty when unfit. Relying on the individual's licence holder responsibility to report 'fit for duty' is simply a 'cop out'; Accountable Managers, Nominated Post Holders and

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the CAA should acknowledge that an HR driven policy based on Government guidelines for ground-based staff is ill-conceived for individuals with flight safety critical roles.

In the eighteen years that I have been associated with the Programme, with the assistance of my engineering colleague Mick Skinner, Admin/Cabin Crew managers Kirsty Arnold and more recently Stephanie Colbourne, we have responded to more than 3,500 reports submitted by flight crew, licensed aircraft engineers, air traffic control officers and a further 1,700 reports from cabin crew members. Each report has received an individual response, and we have published 72 issues of FEEDBACK. This will be my last issue as I will be handing over the role of Chief Executive in September to Air Commodore Ian Dugmore RAF (Rtd), who has been selected to take over the Programme.

We have dealt with a wide range of safety issues over the years; in some cases we have been successful in promoting change; regrettably, in others we have not been able to influence the relevant agencies. I will leave it to others to judge the effectiveness of the Programme under my stewardship but I would like to take this opportunity to acknowledge the range of expertise and specialist assistance that has been available to me from the membership of the CHIRP Air Transport Advisory Board since 1996, and to thank all of you who have contributed to the Programme.

A final thought - During my career in aviation the reliability of commercial aircraft has increased to a point where in-flight emergencies are now extremely rare. However, as a former test pilot, I am very aware that should a serious emergency situation occur a successful outcome will invariably depend on the professionalism and teamwork of each and every member of the crew on both sides of the flight deck door. I also know that the pain and distress arising from a major aircraft accident is not confined to those who are directly involved but can extend to those who are accountable. Recent tragedies in other domains, some of which were perceived as having well developed safety systems, serve as reminders that there is a growing expectation among the public that organisations and Accountable Managers should be held responsible for their policies/decisions. The pursuit of commercial objectives on the basis that 'safety is a given' is no longer a viable argument.

Are you doing everything that you can to ensure a safe operation? Commercial success is a business imperative but so is safety.

My very best wishes to you all.

Peter Tait

## ATC REPORTS

### FURTHER COMMENT ON ELECTRONIC FLIGHT DATA (FB106)

**Report Text:** This is a response to the article in FEEDBACK 106 entitled (1) 'A Reflection on Electronic ATC Flight Data'.

At our unit we have had electronic flight data for some while. It was a struggle to introduce it, vast amounts of

money were spent and there was at least one false start, which resulted in it being removed for some while for redevelopment. The current version is a vast improvement over the previous and credit must go to those responsible for this improvement. There is no doubt that we are all more familiar and more confident with the system.

The problem is that our traffic levels are much lower than they have been in the past. Even when our sectors are 'bandboxed' (*combined*), the traffic levels we are currently experiencing as controllers are nothing like as busy as they were say several years ago. So, although we are coping with the new system with these traffic levels, many of us would not be so confident should traffic levels increase. We do of course still get busy sessions, but not for so long, or so busy. So currently, although we sometimes get caught out, we are able to make the system work.

Even after all the improvements, to display, scan and to interact with the electronic flight data system takes more time, is more distracting and is prone to more errors than with the paper system that it replaced. There are also problems when training, due to limited visibility of the screens.

As a result of having to make the system work, I have noticed that strip data is not kept as up to date as before, or as accurately. The fallback process, which is invoked should the electronic flight data system fail, involves writing out strips by hand from a recent photo of the electronic data. This is something I just hope I don't have to do in anger in the middle of a busy session.

I totally agree with the list of comments made in the report referenced above.

In summary, I don't think I can remember such a clear situation of profit versus safety, with profit winning.

**CHIRP Comment:** It is apparent from this and other similar comments that, notwithstanding the technical improvements that have been introduced, some controllers perceive that they are not able to achieve a level of operational efficiency using electronic flight data that is comparable to using the previous hard copy information.

It is not possible for us to assess why this might be the case or how widely these views are shared among operational staff; however, we have represented these concerns both to senior operational and safety managers. We have been advised that there is no evidence from safety events of this being a significant problem; therefore it is important that if you experience similar difficulties to those reported to us, you should report the matter directly or, if unable, submit a confidential report.

### RUNWAY LEAD-OFF LIGHTS - A DIFFERENT QUESTION

**Report Text:** Following on from the comments about lead-off lights in CHIRP 106, I would like to ask a slightly different question of the pilot community.

Unlike the subject airport in the original article, at our airport we have the luxury of being able to select the

lead-off lights for every exit at once. Sometimes though for various reasons we want a specific arrival to vacate at a later lead-off than the first one. Usual practice is to advise the pilot by telling them to vacate at, for example, the 2nd rapid exit, whilst keeping the lead-off lights lit at the first. Thus it is obvious where the 2nd exit is. Do pilots prefer this, or would it better to extinguish the lights at the first and simply name the exit we want them to use?

Hope that makes sense.

P.S. Excellent magazine and service, thanks for all your hard work.

**CHIRP Comment:** The consensus view of the flight crew members of the CHIRP Air Transport Advisory Board was that if the airfield lighting system is capable of showing multiple exits, all available exits should be lit. However, it is important to communicate any instruction with clarity regardless of the lighting configuration.

We welcome the views of other flight crew members on this matter.

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## CONTINUOUS DESCENT ARRIVAL VS ATC INSTRUCTIONS

**Report Text:** There was a strong SW wind at 3,000ft. Not less than 2.5 nm spacing was in operation.

Aircraft A was transferred to me turning downwind descending to 4,000ft. It was quickly apparent the aircraft was not on the correct heading, flying 150 degrees rather than 115 degrees. This put the aircraft in direct conflict with two aircraft; one on final approach and a second, Aircraft B, on an establishing heading.

Aircraft A was instructed to stop descent at 5,000ft and turn left onto an ENE heading. This action prevented any further conflict with the aircraft already on final approach. Aircraft B, on the establishing heading, was instructed to descend to 3,000ft and expedite descent. At this point Aircraft B was at 5,400ft and descending with Aircraft A at FLO63. Aircraft A was further instructed to reduce speed to 180kts. My assessment of the situation was such that with Aircraft B expediting and already below Aircraft A, plus Aircraft A slowing down and stopping at 5,000ft the conflict would be resolved rapidly by achieving 1,000ft separation before the rate of turn of Aircraft A would even be considered an issue.

However, on monitoring Aircraft B, it was apparent that the crew were not increasing the rate of descent despite having read back the instruction, so I instructed Aircraft B to turn left away from Aircraft A to ensure standard separation was achieved. A standard operating procedure was resumed shortly after and Aircraft B was re-established on the ILS and instructed to descend. At an appropriate point Aircraft B was instructed to reduce speed to 160kts.

Subsequently, I had the opportunity to discuss the above situation with one of the pilots of Aircraft B. It appeared that the Pilot Flying had commented that their planned continuous descent had been inconvenienced by what the pilot believed to be my

mistake and had made little attempt to expedite descent and later to comply with the instruction to reduce speed on final approach to 160kts. To say I was horrified by this non-compliance by a UK airline would understate the matter. Had avoiding action been necessary could I have relied on compliance with those instructions? The primary role of an ATCO is to provide standard separation. I have no obligation to provide an explanation to my instructions, although this is invariably done where time allows; nor do I expect an airline's continuous descent procedure to interfere with my task of maintaining separation. Had I altered my instruction to Aircraft B with "due to human error on the part of another pilot/controller, avoiding action..." would the Pilot Flying have been more accommodating? In addition, based on the Pilot Flying's assumption that I had been at fault, did this alter his compliance with my instructions? I believe that whether ATCO or pilot, assigning blame has no place when resolving issues of aircraft separation.

Non-compliance of speeds on final approach is a continuing and increasingly common issue. From the Air Traffic standpoint, these instructions are issued to provide separation to aircraft on final approach, especially important where efficient use of final approach will reduce delays. There is clearly a mismatch between controller's instructions versus aircraft performance in terms of use of flap and dropping of gear on final approach. On the whole, close monitoring of speeds with the use of Mode S help prevent safety issues caused by this non-compliance of final approach speeds, however, there still remains potential for safety related incidents where controller intervention is not effected quickly enough.

Lessons Learned:

1. Comply promptly with any ATC instruction as a potential loss of separation might be involved. If you are unable to comply, tell ATC.
2. Controllers are mindful of continuous descents when issuing instructions. The use of "expedite" is not used lightly. Pilot compliance with this instruction will help the controller in various scenarios, from reducing the airborne delay, right through to resolving a confliction.
3. Avoid assigning blame during resolution of an incident. This may cloud judgement and may be based on incorrect assumptions.
4. In depth discussions between the airline body and air traffic control providers need to be initiated on how to best tackle the need for compliance with final approach speeds that compliment the best use of flap and dropping of gear for aircraft.

**CHIRP Comment:** Ignoring an ATC instruction to 'expedite' is unacceptable; ATC separation may require a deviation from your optimum continuous descent profile. It is worth remembering that in the event of an incident/loss of separation all of the required flight data is available to determine whether ATC instructions were actually complied with.

The use of speed control on final approach is an essential tool in enabling ATC to achieve the required spacing and maintain the landing rate. A speed instruction issued by an ATCO to a pilot in order to

maintain separation on final approach has exactly the same intent as a level change or heading instruction issued to maintain separation in other phases of flight. There is an increasing trend of non-compliance with speed control on final approach and anecdotal evidence suggests that some pilots may be using TCAS to assess their spacing in the final approach sequence. It is relevant to note that non-compliance is more frequently associated with flight crews that should be very familiar with the required speed profile than with non-UK operators.

## ENGINEER REPORTS

### A COMMENT ON HUMAN ERROR

**Report Text:** Throughout my career as a Licensed Aircraft Engineer (LAE) in various roles, I came to believe that aviation was the best structured and disciplined organisation with regard to safety. This was achieved by rules and procedures that everyone strictly followed.

From the AAIB Special Bulletin S3/2013 it would appear that the mechanic and the LAE who certified the fan cowl latches failed in this regard and, regrettably, I'm sure that they will pay the price.

However, my point is that the philosophy within the industry was always to learn by mistakes and find effective ways to avoid reoccurrence. I believe that the airframe manufacturer has recorded a significant number of previous similar incidents. One also wonders how many have there been with similarly configured twin-jets.

On the principle above and given the consequential damage that occurred, surely the manufacturers and regulators must now be prevailed upon to find a better solution to this situation than a human procedure; perhaps in the form of a clearly visible indicator or a flight deck warning. It cannot be beyond them to engineer this out of the system.

Incidentally, I do hope that the Flight Crew are not involved in the recriminations (walk-round check). They should and must be able to rely on engineering to do their job.

**CHIRP Comment:** The UK Maintenance Error Management System (UK-MEMS), in which CHIRP manages the database and analyses the data, currently comprises 29 member organisations. The principal focus of MEMS is the investigation of maintenance errors by member companies, the identification of root causes, the mitigation of the risk of further errors and the sharing of information with other members.

A key feature of MEMS is encouraging individuals to report their errors. This requires management to ensure that a 'Just Culture' exists within an organisation which does not punish an individual, except in cases of gross negligence or a wilful act.

The AAIB Special Bulletin referenced above states that as at July 2012 the aircraft manufacturer had recorded that there had been 32 reported fan cowl detachment events, 80% of which had occurred during the take off phase of flight. A recent review of CAA Mandatory

Occurrence Reports (MORs) undertaken on behalf of the MEMS Group identified 19 events involving a detached panel in the past seven years

It is important not to presume the findings and recommendations of the ongoing AAIB investigation into the detachment of the engine cowl doors during take-off; however, a general Human Factors point related to human error is worthy of mention.

Where any condition is assured solely by a visual inspection/check it will remain vulnerable to human error notwithstanding the frequency of alerts/warnings issued. Thus, the consequence of human error and the effectiveness of other safety barriers must be carefully assessed particularly in cases where there might be potentially hazardous flight safety implications.

## FLIGHT CREW REPORTS

### INSTRUMENT APPROACHES IN CLASS 'G' AIRSPACE (FB105) - A FURTHER COMMENT

**Report Text:** I note the comments on GA aircraft infringing Instrument Approach patterns in class G airspace.

I have always taught avoidance of airfield instrument patterns and that pre-flight preparation is required to ascertain the extent of aerodrome instrument traffic patterns. I believe that this is required by CAP 393 Air Navigation: The Order and Regulations; Section 2 - The Rules of the Air Regulations; Section 4 Rule 12 (1) (a) and that the rule applies to traffic patterns outside of designated Aerodrome Traffic Zones.

Perhaps you may consider publishing reference to this rule in order to increase general awareness of the requirement.

**CHIRP Comment:** The Rules of the Air Regulations Section 4; Rule 12 (1) states that an aircraft "...flying in the vicinity of what the commander of the aircraft knows or reasonably ought to know, to be an aerodrome shall conform to the pattern of traffic formed by other aircraft intending to land at that aerodrome or keep clear of the airspace in which the pattern is formed, and make all turns to the left unless ground signal otherwise indicate."

As we have commented previously, it is a matter of good airmanship to plan and fly your route to avoid wherever possible, airfield traffic patterns, gliding/parachuting/microlight sites and any other potential hazards.

### ANOTHER EXAMPLE OF RISK SHIFT?

**Report Text:** The reported braking action was between poor and medium, with a reported crosswind consistently above the limit for the reported runway conditions. Despite this several company aircraft landed and departed. Departures occurred even after a few radio communications queried whether the current conditions were out of limits for company operations.

Lessons Learned: I am inclined to say that perceived pressure from the company to get the job done may have influenced some crews' decision-making. Reducing the commercial pressure on aircraft commanders would be a good first step (this is difficult

to achieve, all written material already confirms that there should be no pressure on commanders, but it is somehow written in between the lines that we better not delay the flights or cause any extra costs.)

**CHIRP Comment:** Aircraft manufacturers normally promulgate 'maximum demonstrated' crosswind values at which control of the aircraft was not found to be limiting. Operators are required to publish maximum crosswind limits in the Operations Manual. These may be equal to or less than the manufacturer's maximum demonstrated limit and also may be different for operators of the same aircraft type.

There is a natural tendency on the part of some individuals to justify their decision to operate outside the company Operations Manual limits on the basis that it is in the company's interest and also that their previous experience of continuing to operate in similar conditions has not resulted in any handling/performance difficulty.

In the conditions described, reduced braking action and a crosswind above the limit for the runway condition, a failure of the critical engine at or slightly above  $V_1$  may be beyond the capability of the operating crew to maintain directional control. It is worth considering carefully how you and your company would view such a situation.

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## LEVEL BUST

**Report Text:** We were conducting an eastbound transatlantic flight to a European destination and were en route towards the oceanic entry point, approx 30 minutes out. We were under radar control with Moncton Centre.

The Pilot Flying (PF) had left his seat briefly for physical needs. While the PF was away from his seat I received our oceanic clearance from Gander oceanic clearance delivery frequency on Comm 1. Our cleared route was as filed but our cleared level was FL430 instead of FL410.

I understood the clearance as clearance to climb to FL430 and did not request climb clearance from Moncton Centre. I initiated climb to FL430. At about FL418 Moncton picked up the mistake. Moncton then approved further climb to FL430.

Lessons Learned: An oceanic re-clearance of route, altitude or speed is NOT a clearance to change route, altitude or speed without further coordination by ATC!

Suggestion: An advisory from Oceanic Clearance Delivery Freq e.g. "Please contact Moncton Centre for climb clearance to FL430" would have prevented the mistake.

**CHIRP Comment:** The 'Lesson Learned' from this report is a useful reminder to those less familiar with Minimum Navigation Performance Specifications (Oceanic) Airspace operations.

NATS has produced an excellent video on Shanwick Oceanic Operations, which contains useful information and guidance for flight crew involved in MNPS operations. The video is available at: <http://www.youtube.com/watch?v=EJTjwW5ZYas> or search under 'Targeting Risk within the Shanwick OCA'.

## REDUNDANCY CRITERIA

The following reports are a selection of those received on this topic and involve more than one operator.

### (1)

**Report Text:** I have noticed a greater number of cabin crew and pilots within my company reporting to work who are obviously feeling 'under the weather' and not really fit to fly. This is due to the 'fear' culture that has been instilled following a recent redundancy process. Along with other measures, sickness was included within the company's criteria that were used to select individuals for potential redundancy within certain 'At Risk' groups.

As a direct result of the inclusion of sickness in the criteria for redundancy, I believe that pilots and cabin crew are now reporting for work when for the same ailment before the redundancy process they would have called in sick on the basis that they were not fit to fly. We are now in the position where people are clearly bringing sickness to work, when last year there would have been no doubt in their mind to call sick or unfit to fly. Pilots and cabin crew are now incredibly worried about personal sickness in case the risk of redundancy should rear its ugly head again in the future and the same criteria are applied. I have asked our union to consult the company on this matter, and re-state our licence/fit to fly responsibilities to them. Alas I have not received a reply as yet.

By having redundancy assessment criteria that include sickness we are now hindering both flight safety as well as the detrimental effect of the company's responsibility of care towards its employees that are tasked with flying duties. We need an assurance from the company that sickness will not be taken into account in any future pilot or cabin crew redundancy for those with flying duties. This is a clear matter of flight safety. For years cabin crew have been reporting when sick because they are afraid of the subsequent disciplinary if they call in sick, but the same is now becoming true of pilots.

As a workforce, my understanding is that pilots have one of the lowest sickness levels of any profession and yet my employer could potentially penalise us in the future for having something like blocked ears, a cold or having our medical temporarily suspended by the CAA for something like kidney stones, a hernia or a broken bone. I am not able to fly with a cold, it is dangerous, and it is clearly against the terms of my licence and company policy on presenting oneself to a duty as fit to fly. However, with many ailments it would be the case that I would be fit to perform ground based or office duties. I quite agree that there is a disciplinary issue if someone is taking phantom sickness; however, there is an HR disciplinary procedure to deal with such matters.

I would be grateful if CHIRP would raise this concern as a matter of priority.

### (2)

**Report Text:** Recently my company management announced their intention to reduce the pilot workforce. My colleagues and I were given a formal notification that

our jobs were at risk and that, at the end of the three-month consultation period, I could be made redundant.

Over the next few weeks I noticed a worrying increase in my error rate at work. I was making silly mistakes at the time, something I can only put down to being distracted and fearful about losing my job. Over time my error rate started to return to normal; however, there was a noticeable atmosphere in the crew room and the flight deck as a result of the threat of redundancy hanging over us all.

Towards the end date for the consultation period Flight Operations managers started phoning up pilots who were formally at risk to tell them that they had been "provisionally selected for redundancy". As I was still formally at risk, the fact that individuals were communicating that they were receiving these phone calls weighed heavily on my mind. By the time I went to bed at 10pm I still hadn't had a phone call, and so I had no idea if I was about to be selected.

What followed could only be described as one of the worst night's sleep I have ever had. I was tossing and turning all night, with my mind running around worrying about whether I was going to have a job tomorrow, how I was going to cope, etc. I estimate I got to sleep somewhere around 2 - 2:30am and my alarm went off at 4:30am for my early flight. When I woke up I felt absolutely awful. I felt tired, I felt stressed and quite frankly I felt unfit for duty. However, I didn't phone in sick, I went to work, where several other crewmembers commented how unwell I looked.

The main reason I didn't want to phone in sick is that the company had let it be known that sickness would form a significant part of the matrix for selecting pilots for redundancy. As I am relatively junior I didn't want to do anything that would increase my likelihood of being selected for redundancy. I felt trapped into reporting for duty, as phoning in sick could seriously jeopardise my prospects for continued employment. In hindsight I should have phoned in sick as I was in no fit state to fly, I was far too worked up and stressed, a state of mind not helped by talking to other crews and finding out that a lot of them had been phoned the previous day and told that they were no longer at risk. I finally received a phone call telling me that I was no longer at risk after I had finished my duty.

Overall the company's handling of this redundancy process has been appalling. Phoning up some of the pilots to tell them one way or the other, but not phoning up the others on the same day has caused unnecessary stress and anxiety to several pilots, myself included and had a seriously detrimental affect on my abilities to discharge my duties.

Additionally, by using sickness as a metric for redundancy, I feel that I am being pressured to report for duty when I feel I may be medically unfit, in direct contravention of the CAA regulations, due to fear over my job security.

### (3)

**Report Text:** I am writing to voice my concerns relating to safety. Late on a Friday afternoon the company announced that there would be a significant but

unspecified reduction in the number of flight crew members.

You can imagine the atmosphere on the Flight Deck during the weekend schedule! Also, I found sleep extremely difficult to achieve, as I had nobody to talk to over the weekend, and no specific detail as to how this announcement might affect me or my colleagues. In my humble opinion, such bombshells should not be issued late on a Friday afternoon, just before management go home.

After such an announcement, support should be provided, for example, by managers coming into the office over the weekend to field questions etc.

I am still waiting to hear my potential fate, although fortunately getting some useful rest again between flying duties. I sincerely hope my managers' weekends were less fraught than my own.

### (4)

**Report Text:** At present, our cabin crew are under consultation and the company system is being used. Therefore, sickness is being used as one of the selection criteria for redundancy. This is causing undue pressure for those who are genuinely unfit to fly. I have now already had occasions where cabin crew were not fit to fly but have flown due to fear of redundancy, at the detriment of flight safety (in effectively reducing the useful crew compliment).

Some captains have had to off-load cabin crew down-route due to their illness. Management have confirmed, on our company forums, that even operations and hospitalisations are being included.

**CHIRP Comment:** If a company plans to make 20 or more employees redundant within any 90-day period at a single establishment, the management is required to comply with the Government requirements for 'collective consultation'; these include a period for consultation and the procedure for notifying staff that they are 'at risk'. It is to be expected that the 'at risk' notification will be unsettling for some individuals but this can be minimised by effective management of the notification process.

The Government guidelines for 'fair reasons' for redundancy include any of the following:

- Skills, qualifications and aptitude.
- Standard of work and/or performance
- Length of service
- Attendance
- Disciplinary record

However, the above guidelines are based on the general workforce and it could be argued that in the case of a group of employees who are required by the Civil Aviation Authority to self-certify their fitness to fly on grounds of public safety, the use of attendance/sickness record as one of the redundancy criteria is inappropriate and potentially detrimental to passenger safety. The reports received on this topic have involved primarily pilots and cabin crew but the issues could apply equally to engineers or anyone with a safety critical role.

The use of attendance was referred to the CAA Flight Operations Inspectorate but was deemed to be an

employment issue in which the Authority was not minded to intervene. Subsequently the matter was raised with the Head Flight Operations CAA (SRG) and the Chief Medical Officer; the latter provided the following response:

"From time to time CHIRP is notified of potential redundancies being announced by an operator and concerns are expressed about sickness absence being used as one of the factors used to determine which pilots will be made redundant. Criteria for redundancy are a matter for the employer. Maintaining a safe operation is a matter for everyone. There is a legal obligation on the holder of a pilot's licence not to exercise the privileges of their licence if they are aware of a decrease in medical fitness, take medication or receive treatment that is likely to jeopardise flight safety (Reference: Part MED, MED.A.020). In this circumstance the Regulation states that they 'shall' seek aeromedical advice. It would be worth discussing with any operator who wishes to use sickness absence as a criterion, the provision of access to an Aeromedical Examiner to facilitate this advice to ensure the operator is not inadvertently encouraging unfit flight crew to fly. This would be an example of good Safety Management, would provide reassurance to flight crew and enable management to support the return of flight crew to duty as soon as possible."

It is disappointing that Accountable Managers and Nominated Post Holders would not appear to have either recognised or acknowledged the potential conflict inherent in the use of attendance/sickness record as a criterion for redundancy. The evidence from confidential reports is that its use will deter some individuals with a critical flight safety role from electing not to report for duty when unfit on the basis that this might adversely affect them in a future redundancy programme.

If an operator has an effective Safety Management System in place, it would not be unreasonable for the CAA to expect the relevant Nominated Post Holder to be able to demonstrate that the risk of an individual reporting for duty when unfit as a result of a redundancy policy had been assessed and adequately mitigated.

We continue to pursue this matter with the CAA.

## OFF DUTY TIMES

**Report Text:** Increasingly, my employer has been using rail positioning, particularly back to base after a flight duty period, to save money. Recently, I was rostered for such a duty. The company Operations Manual states that the Off-duty time occurs at arrival time i.e. the scheduled arrival of the train.

My recent experience was as follows: the train was late, a huge mass of people then queued for the next available shuttle bus from the railway station to the airport (they are not in the same place, unlike some other UK airports).

It took a while for a bus to arrive; when it did, it was full and so I waited for a second, all of which added 30/40 minutes 'undeclared' extra to the duty.

Of course, I can ring up and amend my off duty time - as I will always do now, late train or not - in disgust at this obtuse form of rostering, but why should I? The company know that positioning by rail to a station not at the airport requires an additional time margin that we should not have to fight for.

Just another example of careless (creative?) rostering.

**CHIRP Comment:** Similar situations regarding the recording of Off-duty times have been raised before. It is important that any occasion where the actual Off-duty time differs significantly from that rostered, you should inform your company. Operators are required to track the actual Off-duty times against the planned times to assess whether an additional buffer should be added to the planned times.

Planned/scheduled duties should be based on reasonable assumptions and where this is shown not the case, operators should be called to account. In this particular case, the time taken routinely from the arrival of the train to the point at which the individual signs off should be relatively easy for the operator to establish and the CAA to validate.

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](mailto:flightoperationssafety@caa.co.uk)

## CABIN CREW REPORTS

### NITS BRIEFINGS AND ALERT CALLS

**Report Text:** We arrived at the aircraft and were told that there was a problem with it. We did not know what the nature of the problem was; as a result we were delayed with passengers onboard for approximately 30 minutes. Finally the Captain spoke to the passengers; the problem, we still didn't know what exactly, had been fixed and we were ready to go. A short time after take-off in the climb, the Captain made the ALERT call. I looked at my colleague, who decided to take the NITS briefing and was ready with pen and paper. After about 3 more minutes, the SCCM arrived in the galley and said: 'It's OK, it's not an emergency landing, we're OK, but here is the NITS brief anyway - NATURE = the gear doesn't retract, INTENTIONS= getting clearance from air traffic and go back to base, TIME = as soon as we get clearance to land, SPECIFIC INSTRUCTIONS = none'.

The SCCM returned to the front galley, and a few minutes later the Captain announced we were going back to base because 'there was still a problem with the aircraft and the engineers needed to look at it'.

The Captain then made the landing call to the cabin crew. We finally landed, disembarked the passengers, and gathered at the front of the aircraft. We expected some kind of a debrief. The Captain said that it wasn't a real emergency, when I asked him why the ALERT call was used; he replied that it was to ensure all the trolleys were secured and that we were sitting down. We hadn't left our seats, as the seatbelt sign was still on and there

is a camera in the flight deck for them to check this. I told him that the passengers were asking us what the problem was and that he should have informed them, to which he replied they didn't need to know. The SCCM made a phone call to management, advising that we would operate to the original destination once a new aircraft had been organised and that all cabin crew were okay. So, we operated the flight, we were not debriefed, we were not asked how we were and most of all I am still unclear about whether the correct procedure was used.

Is it correct practice to use an emergency code/procedure for a non-emergency situation or just to make sure we are seated with trolleys secured? Doesn't this bring confusion and uncertainty to the current safety procedure and cause unnecessary stress and worry to the people onboard; the crew and passengers? After a situation like this, shouldn't some kind of official debrief take place? Surely we can all learn from non-emergency situations as well. Shouldn't management make sure that this didn't affect any of the crew on board (duty of care)?

Clarification on emergency procedures is needed. Both the cabin crew and the passengers should have been informed what the problem was. A proper debrief should take place for situations like this.

**CHIRP Comment:** Although the use of NITS [NATURE-INTENTION(S)-TIME-SPECIAL INSTRUCTIONS] briefings and ALERT calls are covered during cabin crew training, many cabin crew members associate their use solely with an inflight emergency situation.

In the event of a non-normal situation such as that described in this report, which placed the aircraft at no additional risk other than necessitating a return to the departure airfield, the use of an ALERT call to trigger the actions that cabin crew members are required to undertake will depend on what is stipulated in your company Operations Manual.

In the circumstances described, the Captain acted correctly in issuing a NITS briefing to the SCCM, thus allowing the flight crew to plan the unscheduled return to the airfield. However, in the event that the Captain should elect not to inform the passengers of the situation so as to not cause any unnecessary distress, it is worth considering including this information in the NITS brief so that it can be communicated to the cabin crew.

After any situation in which an ALERT call/NITS briefing is issued, it is good practice to hold a post-flight debrief to ensure that both the flight and crew cabin crew understand what happened and are able to discuss any difficulties experienced.

One final point; in the event that an aircraft has a pre-flight technical delay it is worth considering whether the nature of the problem should be communicated to the SCCM and thence, should the need arise, to the cabin crew.

Note: This report has also been published in Cabin Crew FEEDBACK together with a reminder as to the purpose and intent of the NITS briefing. Cabin crew have been reminded that the flight crew's primary task in any emergency/non-normal situation is to fly the aircraft and deal with the situation; therefore, it might

not always be possible to issue a NITS briefing to the SCCM immediately after an ALERT call.

## CABIN AIRFLOW

**Report Text:** The cabin air was stuffy especially towards the middle of the aircraft, some increased breathing and heart rates were noticed by the cabin crew. On checking the airflow was set to 'low', presumably to save fuel, the air quality was noticeably poor, and breathing had accelerated to compensate. This is a very common occurrence with this particular type of aircraft. Cabin crew often ask to adjust the air conditioning to make the air quality better but rarely the airflow is adjusted to normal. We are not only worried about our own air quality and health issues, but surely this can put strain on passenger's hearts and lungs. 'Normal' airflow setting needs to be mandated.

**CHIRP Comment:** This and other similar reports submitted by cabin crew members indicate that there is a lack of understanding among sections of the cabin crew community that flight crew Standard Operating Procedures will always ensure that there is sufficient airflow through the main passenger cabin to maintain a safe level of ventilation for both passengers and cabin crew.

Similarly, there is uncertainty as to the use of recirculated air in those aircraft types that have this facility.

Cabin Crew members have been advised that if there are any concerns relating to the cabin conditions, the correct course of action is to report the matter to the SCCM and, if deemed necessary, to the Captain.

If the problems should persist on a particular aircraft a report should be entered in the Technical Log to permit the matter to be investigated.

## ADDRESS CHANGED?

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](http://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 Crew ..... [fclweb@caa.co.uk](mailto:fclweb@caa.co.uk)  
ATCO/FISO ..... [ats.licensing@caa.co.uk](mailto:ats.licensing@caa.co.uk)  
Maintenance Engineer..... [eldweb@caa.co.uk](mailto:eldweb@caa.co.uk)