

CHIRP

Air Transport **FEEDBACK**

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EDITORIAL

We have received 3 reports recently that included concerns over the use of Commander's Discretion (to use EASA terminology).

One reporter questioned the use of Discretion when flights are delayed at the direction of the company. The Commander had been asked to complete a Discretion Report for one of the crew's consecutive early/late duties and was concerned that this would constitute a violation. Had the crew been rostered into discretion it would have been improper behaviour by the rostering department. However, the crew were delayed once the duty period had begun and Commander's discretion was permissible.

In another report about pressure to fly when unfit, a reporter was concerned that his company had notified its staff that Commanders might be asked to explain their decisions retrospectively in the event of declining to extend a Flight Duty Period (FDP) using Discretion. CHIRP's view is that the Commander is responsible for the safety of the aircraft and his/her decision should not be challenged. However, if a Commander has made a conscious decision not to operate to the discretionary maximum FDP, there must have been a specific reason; it is reasonable for the Commander to be asked subsequently to explain the factors that contributed to his decision in order to inform the crewing department and allow corrective scheduling action to be taken.

The third report was about a 4-sector duty in which delays during the first 2 sectors made it inevitable that one of the crew members would go into discretion by a few minutes on the final sector. Anticipating further delays during the 3rd and 4th sectors, the crew member declined to go into Discretion. The crew member was replaced after the 2nd sector but found his roster for the following days had been changed and become more demanding. Although the reporter considered that the changes to his roster were so draconian that they constituted as punishment, it seems more likely that the reporter was simply caught up in the turbulent downstream effects of bringing in a crew member from standby to replace him. And this is the rub: the knock-on effects of declining to operate to the limit of FDP allowed under Discretion may be less desirable than using Discretion. Of course the Commander will not have the full picture and cannot be expected to take his/her decision on potential knock on effects; nor is it clear why the reporter did not wish to go into Discretion in this case. However, it is worth reiterating that Discretion is called '**Commander's** Discretion' because it is the Commander's decision to make; the Commander is required to seek the crew's input but only to determine their potential for discretion based on their previous rosters and to determine their alertness levels, as indicated below.

The CAA has produced a publication that draws together the strands of the EASA Regulations on Flight Time Limitations: '[EASA FTL Regulations Combined Document](#)'. Of relevance to the reports referred to above, the regulations cover reporting requirements by the Commander and the operator, the requirement for a non-punitive process for the use of Discretion, and the Commander's responsibilities with respect to making a decision about Discretion. Page 19, sub-para (f) of the Document is reproduced below:

Unforeseen circumstances in flight operations – Commander's discretion

(1) The conditions to modify the limits on flight duty, duty and rest periods by the Commander in the case of unforeseen circumstances in flight operations, which start at or after the reporting time, shall comply with the following:

(i) the maximum daily FDP which results after applying points (b) [maximum daily FDP tables] and (e) [Maximum daily FDP with the use of extensions due to in-flight rest] of point ORO.FTL.205 or point ORO.FTL.220 [Split duties] may not be increased by more than 2 hours unless the flight crew has been augmented, in which case the maximum flight duty period may be increased by not more than 3 hours;

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(ii) if on the final sector within an FDP the allowed increase is exceeded because of unforeseen circumstances after take-off, the flight may continue to the planned destination or alternate aerodrome; and

(iii) the rest period following the FDP may be reduced but can never be less than 10 hours.

(2) In case of unforeseen circumstances which could lead to severe fatigue, the Commander shall reduce the actual flight duty period and/or increase the rest period in order to eliminate any detrimental effect on flight safety.

(3) The Commander shall consult all crew members on their alertness levels before deciding the modifications under subparagraphs 1 and 2.

(4) The Commander shall submit a report to the operator when an FDP is increased or a rest period is reduced at his or her discretion.

(5) Where the increase of an FDP or reduction of a rest period exceeds 1 hour, a copy of the report, to which the operator shall add its comments, shall be sent by the operator to the competent authority not later than 28 days after the event.

(6) The operator shall implement a non-punitive process for the use of the discretion described under this provision and shall describe it in the operations manual.

Security. Changing subjects, we have received 2 reports about airport security checks on Flight Crew (at 2 different UK airports). The first involved a member of the security team pursuing a pilot into the crew room to berate him publicly for using the incorrect staff entrance to the office suites. The second involved a protracted search by a member of the security staff with an aggressive demeanour. Both incidents resulted in the reporters feeling distressed and distracted; both reporters said they found themselves dwelling on the incident during their subsequent flights. The relevant airport authority in the first incident agrees that the reported behaviour was unacceptable but could find no record of the incident to support an investigation; the authority asks that any crew member experiencing this kind of behaviour report it to the Customer Service Duty Manager for that Terminal at the time or as soon as is practicably possible. There is a log at every security supervisor's point; if time is pressing crew members can insist on an entry being made in the log to record that there has been an incident with intention of following it up later. All crew members should also be aware that they have the option of submitting an MOR for any incident at security that creates a potential risk to flight safety. Although CHIRP routinely copies information about airport security to the CAA, the submission of an MOR could have greater impact in light of the CAA assuming more responsibility for aviation security.

Ian Dugmore - Chief Executive

ENGINEERING INTRODUCTION

Welcome to the latest edition of FEEDBACK. Several of the recipients took the opportunity to send in comments following the last edition of Air Transport FEEDBACK. This is a welcome development. The purpose of FEEDBACK is to allow people to learn from issues raised by others. Any debate or discussion on FEEDBACK therefore increases its validity.

I have also been able to brief a number of groups and staff at several organisations to explain what we do at CHIRP and how we do it. Raising reports is easier than ever with the new website and web-based applications. This allows reporters a speedier way to raise issues to be investigated. The inclusion of the MEMS (Maintenance Error Management System) reports has been a welcome addition and the organisations who make up the MEMS group believe there is a need to do more to promulgate cross company learning as part of an ongoing Human Factors strategy.

One of the big questions that keeps reoccurring is "What can I do to make a difference with regard to Safety"? Regardless of your position within your company every person has a part to play in ensuring that safety is not taken for granted. It is only by being vigilant and focussed that safety is maintained. Invariably when it falls down it is when people are distracted, under pressure or are set unrealistic expectations. This applies to Managers, Planners and Technical engineers as much as to front line productive staff.

The improved health (and growth) of the industry in the UK is creating some difficulties as organisations struggle with the need for more staff. On the positive side many companies have restored apprenticeship schemes. While these schemes look different to the traditional apprenticeships, that many of us were a part of, they are essential in trying to address both the current and future shortfalls for skilled engineers.

Given all of the above and having reviewed data from several sources, CHIRP reports, Civil Aviation Authority MOR's (Mandatory Occurrence Reports) and also company MEMs reports, here are three things that we could all do that would make a difference toward maintaining aviation safety standards.

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First, remain focussed and vigilant, lapses in concentration result in many of the events that we see contributing to incidents or safety near misses.

Second, do not put undue pressure on yourself or others, this can result in cutting corners, taking shortcuts, or failing to follow the correct process or procedures. As engineers we are professional, have a high degree of integrity and need to ensure we follow the correct procedures, task (work) cards or Maintenance Manual extracts.

Third, ensure you are communicating effectively, this includes both written and verbal communication. The communication link is vital whether it is with other team members directly or with other staff via handovers or work /task staging. This is particularly critical when the task you are working on is interrupted part way through for whatever reason. Do not assume you will be back soon so you can leave the task part complete without an effective handover or stage sheet being actioned. Most of the communication failures result from assumptions that others understand what is required from them. If in any doubt, take the time to ensure others fully understand what is expected of them.

With all of the above, hopefully you will find the reports included this time round as beneficial as previously. I look forward to hearing from you.

Bruce Hunter - Deputy Director (Engineering)

ENGINEERING REPORTS

CERTIFICATION OF UNDERCARRIAGE INDICATION DEFECT

Report Text: The reporter submitted a 27 page report which was also sent to the UK CAA as an MOR. The reporter felt there was a great benefit, from publication, to other engineers who may find themselves in a similar position regarding the certification of work post defect rectification.

The report refers to the release to service of a UK registered aircraft following an undercarriage retraction fault without having the gear retraction and extension checks performed. The maintenance organisation while operating with an EASA part 145 are based overseas and come under the jurisdiction of a foreign NAA.

The aircraft arrived on station with numerous fault messages displayed. Troubleshooting and a review of the Post Flight Report showed problems with the gear sensors. Further detailed investigation revealed that parts of the nose landing gear linkage for the proximity system showed signs of wear. The airline was contacted and an airline work order was raised to change the parts identified as suspect.

Both during and following the work package there was communication between the reporter and the airline regarding the status of the work and the need, in the reporter's view, to conduct an undercarriage swing to verify full serviceability of the system and to certify the work as completed. The airline, following discussions with the manufacturer, asked for a variety of checks to be undertaken on the indication system. These were all actioned with satisfactory outcomes.

Following a lengthy period the airline (having consulted with the manufacturer) decided that the aircraft did not require a full undercarriage swing to enable release to service and asked that the maintenance organisation issue a declaration of serviceability.

Several certifying engineers, who had worked the aircraft, felt collectively that this was not the right decision and that they would not be prepared to certify the release to service. There followed a period of protracted debate between the operator and the maintenance organisation that involved the certifying engineers on station. What becomes apparent is that while there was a lot of communication there appeared to be a lack of focus on issue resolution from the parties involved. Clearly the engineers involved felt under a lot of pressure to clear the defect. However, none of the engineers who were involved felt 100% sure that the defect was fully rectified, hence the view that a gear swing was needed.

The UK CAA have conducted a thorough investigation and concluded the following. The Airline technical department (in conjunction with the manufacturer) made the correct decisions regarding the need for an undercarriage swing and complied with the requirements of their AOC. They have contacted the foreign NAA who will be conducting detailed audits of the maintenance organisation regarding this incident. They also concluded that they felt the engineers were right to express their concerns regarding the release to service and that with better support the whole episode could have been resolved without the conflict that occurred.

CHIRP Comment: This report highlights the complex nature of aircraft maintenance and why the reporter felt it was important to help others. The key issue here is communication and conflict resolution.

The airline's Technical department, following involvement from the manufacturer, made what was determined to be the appropriate technical decision for the aircraft. Clearly what would have ensured the success of this would be the engagement of the engineers on station managing the defect. This it would appear, fell between the cracks.

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Line engineers can sometimes have a difficult task to balance the technical requirements for function checks with the work that has been carried out. When engineering departments make technical decisions that overrule the line engineers they should try to ensure they communicate effectively why they have taken these decisions and must ensure they take all the available information into account.

The maintenance organisation could and should have been more supportive in terms of the management of the situation for the line engineers. The UK CAA should be praised for the thoroughness with which they have investigated this issue and also the steps they have taken with the foreign based NAA regarding ongoing actions.

ENG MEMS – MEDA REPORT 1

[Note MEMS = [Maintenance Error Management System](#). MEDA = [Maintenance Error Decision Aid](#).]

Incident Summary - The Aircraft was on a heavy maintenance input and several teams were busy working in the flight deck area. Three tasks were being worked simultaneously. Two engineers were assigned to the task of checking the APU fire bottle squib circuit test. Engineer A, who was in the flight deck, believed that engineer B had disconnected the squib and was set-up to perform the check. Engineer A pulled the fire handle and fired the APU fire bottle which discharged.

Interruptions/Communications- Engineer B indicated that he did not have the task sheet available as Engineer A had them despite the fact that one was working in the flight deck the other was at the tail area. There were six people on the intercom system and the flight deck was very busy with a number of activities taking place simultaneously, this resulted in avoidable distractions and poor communication.

Root Cause Analysis

Distractions – The engineer lost his train of thought at important stages of the work due to numerous people on the intercom system.

Organisational Factors- The company identified that the method of operation (when performing function checks at the end of the check) was not an isolated one and that there was some degree of this being the accepted norm.

CHIRP Comment: This event highlights some routine HF related problems. As well as looking at the individual HF errors, the organisation involved has taken steps to ensure there is a more co-ordinated approach to carrying out checks and functions. This applies particularly at busy times - typically towards the end of the maintenance input.

While this is an easy mistake to make, it can serve as a lesson to ensure we have put processes and communications in place when carrying out function checks.

ISSUES WITH AIRPORT AUTHORITIES

Report Text: Driving back to the control office at 0500 after a very long night shift having completed troubleshooting on two wiring defects on an aircraft I'd worked on, my mind wandered on a quiet section of road at XXX. "Did I do this, did I do that, am I sure I put all the fasteners back on that panel" etc. etc. The next thing I know, there is an Airfield Operations man (locally referred to as a "yellow peril") in the middle of the road signalling for me to stop. The upshot was, that he'd caught me speeding. I was doing 31mph in a 20 mph zone. The "officer" took my ADP, and gave me six points on my licence.

This has now resulted in a "note to file" with my employer, and the additional worry that if I get six more points in the next 3 years, I could lose my job. I fully understand about driving safely around the airport, rules are rules after all. These are my first penalty points in nearly 14 years of driving at XXX. Surely the airport authority should give some sort of dispensation to night shift workers who may have a lot more on their minds than looking at a speedo making sure they don't go faster than 20mph? If the weather conditions/visibility was poor or I was near other road users or driving adjacent to aircraft, I could have understood his attitude towards me. But no, even though I posed no danger to any other human, vehicle or aircraft and listening to my humble apology and explanation, he went right ahead and stamped his authority.

We all have important jobs to do at the airport, but it shouldn't mean we lose our humanity, compassion or understanding of the effects of "Human Factors" when carrying out our duties. In the aviation world we hear about circadian rhythm, poor response time when tired and all the other "problems" associated with night work. Maybe all personnel in all companies working in a 24/7 environment should consider this before showing a "red card"!!

CHIRP Comment: We have empathy with the reporter and his situation of juggling priorities and multi-tasking. However no matter what the circumstances, it is vital to maintain situational awareness when driving in the airside environment; adhering to the speed limit contributes to the key obligation to avoid collisions with people and aircraft. The reporter is happy for the report to be published to remind others of the hazards of driving while distracted around the airport environment.

FLIGHT CREW REPORTS

LVOs AND LVPs

Commenting on a previous edition of FEEDBACK, a reader asked for clarification of the regulations in *Part Ops SPA.LVO.115 Aerodrome related requirements*:

- (a) *The operator shall not use an aerodrome for LVOs below a visibility of 800 m unless:*
- (1) *the aerodrome has been approved for such operations by the State of the aerodrome; and*
 - (2) *low visibility procedures (LVP) have been established.*

CHIRP Comment: At first sight the regulation could be interpreted to mean that approaches could not be made unless LVPs were in operation. That interpretation would be incorrect. An approach may be flown with the visibility below 800m but a Low Visibility Ops approach may not be made if the visibility is below 800m unless LVPs have been established. The CAA comments that the issue is addressed as follows:

Part Ops SPA.LVO.125 Operating procedures:

- (a) *The operator shall establish procedures and instructions to be used for LVOs. These procedures shall be included in the operations manual or procedures manual and contain the duties of flight crew members during taxiing, take-off, approach, flare, landing, rollout and missed approach operations, as appropriate.*
- (b) *Prior to commencing an LVO, the pilot-in-command/commander shall be satisfied that:*
- (1) *the status of the visual and non-visual facilities is sufficient;*
 - (2) *appropriate LVPs are in force according to information received from air traffic services (ATS); and*
 - (3) *flight crew members are properly qualified.*

It is the Commanders responsibility to assure themselves that LVPs or other protection means are in operation prior to commencing an approach. Currently UK Aerodromes are in transition from being UK Licenced to EASA Certificated. CAP 168 states that the aerodrome operator verifies to ATC that all appropriate measures are in place before LVPs are declared. ATC is then responsible for advising pilots of the status of those LVPs. The EASA Aerodrome regulations do not change this requirement.

OPPORTUNITY TO EAT

Report Text: May I please bring to your attention the rostering surrounding the late night stops at []. Essentially these start with an intensive five sector day with a 12.20z check in and off duty at 21.05z. The turnarounds are all 30 minutes whilst the flights are short, intensive and demanding of high concentration by both pilots at all times. Three of the sectors route to or from a CAT B Restricted airfield that requires extra attention.

I believe there is not enough time on or between the sectors for any of the crew to take any sort of break for food. BALPA has suggested the Captain increases the length of one of the turnarounds so crew can be fed which seems the obvious solution but surely [] should not be putting us in a position like this. At the moment, the nominated hotel does not provide any food after 11pm local time (if flights arrive on time then this is the earliest you can expect to arrive). Not even room service.

CHIRP Comment: Flight crew need to eat adequately or appropriately during the day. Currently, operators are only required to meet EU OPS requirements for nutrition (in Subpart Q), which is the same as EASA ORO.FTL.240 sub para (a). The operator has indicated that it allows the decisions on these break times to rest with the Commander and Cabin Manager. The operator has stated that it currently complies with EASA ORO.FTL.240 Nutrition: (a) *During the FDP there shall be the opportunity for a meal and drink in order to avoid any detriment to a crew member's performance, especially when the FDP exceeds 6 hours.* The operator also stated that the rosters and opportunities to eat before and after this duty are relevant, and the reporter is justified in being disappointed that the hotel does not provide food at the end of a relatively demanding day; this has been highlighted to the relevant department who are looking into this issue.

BEFORE TAXI ACTIONS

Report Text: After we obtained the start-up clearance we completed all the before start actions and check-lists. The marshaller was far in front of the aircraft, with no headset; it was self-manoeuvring as usual in this airport and unlike most airports we use. After start-up, despite being both familiar with the airport, we then discussed the need to be careful at the start of taxi, emphasising the need to watch the right wing as we turned left through 180° close to a retracted air bridge. This took our attention away from the before taxi flow cue: marshaller waving with the pin or

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waving with the chocks. As a matter of fact there was no waving at all, since the ground crew follows us to show wings clear until the turn is completed. After getting taxi clearance, I looked at the right wing to confirm "clear right". The Captain confirmed "clear left", and started the taxi. He should have advanced the thrust levers to >[x] % as per company policy for a take-off config alarm check. This was not done and I didn't notice, still trying to make out the details of the right wing against the glare of the setting sun, which took me a few seconds. Once I did, I noticed the slats were not extended. I then looked at the flap lever (UP), start switches (OFF), and called STOP. The aircraft was stopped immediately, after less than a metre taxi. I informed the Captain we didn't do the before taxi actions and checks, which we then proceeded to complete before continuing normally.

Lessons Learned: This left us dumbfounded as to how easily such critical part of the set-up can be missed. I have seen items missed on flows, but this was caught by check-lists. However, in this situation, and because the usual chain of events didn't unfold (no waving from marshaller, missed the chocks being shown) the whole flow, and check-list were skipped.

I take as a lesson you can't ever be complacent. Anything different, unfamiliar can perturb routines (including flows) insidiously. This was also an absolutely standard day, with good weather. Somehow I developed a habit of checking the slats are extended when calling clear right, which in that case saved us the embarrassment of stopping in the middle of our taxi upon noticing (at best). I think this very simple check could be added to SOPs, as it's really easy to execute, with a high risk mitigation. Even nowadays it happens (rarely) that a crew reaches the runway with flaps up, only noticing when setting take-off thrust.

CHIRP Comment: We are grateful for this open and honest report. Had they not detected their error themselves, there were safety barriers still in place to prevent this crew taking off without setting the flaps. It is difficult to identify the cause of the incident with certainty and it is likely that a combination of factors contributed. There was no interruption by ATC on the RT – a common cause of interrupted checks - but the discussion about the wingtip clearance could have provided a distraction in addition to the absence of the cue from the ground crew showing the undercarriage pin or chocks. Whatever the reason, a key lesson is to be mindful of our human vulnerability to distractions and changes to standard routines.

AUGMENTED CREW PROCEDURES

Report Text: Crew consisting of 1 operating Captain, 1 operating First Officer, 1 augmenting Captain and 1 augmenting First Officer. Arriving at the aircraft, both operating and augmenting crew stayed in the flight deck, instead of conducting the walk around and setup of rest area, as is customary. As a result, the flight deck was crowded, and the safety and security checks could not be completed in the normal fashion by the FO. Safety and security checks had to be completed much later, which disturbed the normal pre-flight sequence. As the FO sat down to start flight deck preparation and setup, the augmenting Captain, who was still in the flight deck, started to make selections on the MCP & radio tuning panels. He proceeded to go through system pages on the Multi-Function Display, and make entries on ACARS pages. All of this interfering with the pre-flight duties of the FO. While the FO was loading FMC and calculating take-off performance, the augmenting Captain kept querying entries and selections, and making irrelevant comments. During final flight deck preparations and taxi out, the augmenting Captain kept interfering with checklists, performance calculations and prompting the operating crew on non-essential and irrelevant issues.

Lessons Learned: My observation is that the augmenting Captain was trying to help, but not realising the interference and distraction that he was creating. As a very assertive individual it was hard to correct him without de-grading CRM for the remainder of this Ultra Long Range flight. Due to operating crew managing to stick to the SOP's, and the fact that no non-normal events took place, there were no deviations or errors as a result. The flight proceeded normally to destination without any events. I do feel that the threat level was increased substantially, and could easily have led to errors. I suggest a clearer description of augmenting crew members' tasks in the OM, with focus on appropriate behaviour and presence during pre-flight setup and duties on the ground. It would also be a good idea to incorporate augmented operations in CRM initial and recurrent training.

CHIRP Comment: We saw in the previous report the potential implications of disruption to SOPs and normal routines. In this report the augmenting Captain was probably trying to be helpful and should have been firmly dissuaded if his actions were having the opposite effect. Crews and augmenting crews should stick to the SOPs. If the augmenting crew want to help further they should ask how they might assist and limit themselves to those areas.

SEA STATE FORECASTING

Report Text: Post CAP 1145 [Safety Review Of Offshore Public Transport Helicopter Operations], a sea state limit has been placed stopping CAT operations overseas greater than sea state 6, or 6 metres. We reported for duty one hour before flight as requested. There were no managers present despite the knowledge that the weather (sea state) was due to deteriorate during the afternoon. The Met Office website 12:00Z forecast for the sea off the Aberdeen coast

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showed a maximum wave height of 4.5 metres, the 18:00Z forecast for the sea off the Aberdeen coast showed a maximum wave height of 6.5 metres over the majority of the UK North Sea as far as The Shetland Isles. One of us contacted the Met Office for clarification of the forecast wave height and was told the sea off the coast of Aberdeen would have waves in excess of 6 metres between 14:00Z and 15:00Z. There was a request made for the hourly forecast charts to be faxed to us so we would have the evidence at hand if management challenged us on our decision to stop flying, but they were not willing to send us the information, only give a verbal brief. Crews elected not to depart on flights that would require a return overseas greater than 6 meters. Management accepted crew's decision when briefed later.

Lessons Learned: Crews should not have to rely on verbal conversations with forecasters and hourly forecast should be made available on the Met Office website.

CHIRP Comment: The Met Office provides forecasts of Significant Wave Height on a briefing system used by offshore helicopter operators called OHWeb. Operators are required to base their planning and operating decisions on the Wave Height forecasts on OHWeb. Since the report to CHIRP was received, the time steps for the forecasts on OHWeb have been increased from 6-hourly to 3-hourly to improve the fidelity and availability of the forecasts. Although the Met Office generate the product in hourly time steps, it was decided that the provision of hourly reports would not be appropriate because they could represent a potential source of pressure on pilots. With hourly forecasts, it could be that some pilots would feel compelled to 'design' the flight route around areas of high sea state using successive short term sea state forecasts. Moreover, with high sea states some pilots could have a tendency to await the next forecast with the mission on hold instead of cancelling it, taking a 'rest' break, and replanning it thoroughly. Despite the introduction of 3-hourly forecasts there remains the potential for actual sea states to be higher than those forecast; when this occurs the N Sea operators confer over the source, number and reliability of the reports before making a collective decision to operate, postpone or cancel flights.

CABIN CREW REPORTS

INOPERATIVE FLIGHT ATTENDANT PANEL

Report Text: The aircraft had arrived into base from its previous sector with the Forward Attendant Panel (FAP) not working. This meant that the cabin crew had no access to information regarding toilets, door modes, temperature in the cabin or lighting. The test of the evacuation alarm; which would normally take place on the first flight of the day, could not take place due to the lack of FAP. The rear attendant panel of this aircraft has no command switch, and therefore it was not possible to initiate an evacuation from the cabin.

This was deemed as acceptable by the flight crew, but not by the cabin crew. We were unable to dim the forward entry for take-off or landing or send a cabin secure message in the standard format.

During the flight, the cabin became hot, and aware that we could not control the temperature ourselves, we contacted the flight crew. They admitted that they could not control it either, as the air-conditioning system was not working correctly. On the return sector, the cabin crew began to feel the effects [similar to those] of hypoxia, suffering with headaches and feeling light headed. The standard operating procedures could not be followed as a result of this fault, and the crew felt uneasy regarding the procedures used in this incident, as they were not laid down in company procedure.

Lessons Learned: I would suggest that less emphasis be placed on departure on time at any cost. As a crew we felt pressured into leaving on time even though we were unhappy at the number of faults with the aircraft, particularly the inability to initiate an evacuation from any part of the cabin.

CHIRP Comment: Where defects are identified prior to despatch or during flight operations, cabin crew should inform the SCCM and Captain immediately. The flight crew will be able to verify if the defect has been entered into the aircraft technical log and is awaiting maintenance action – often referred to as a deferred defect.

Dispatch and repair guidelines for aircraft equipment are usually detailed in what is called the aircraft Minimum Equipment List (MEL), a copy of which is carried in the flight deck in either paper or electronic format. Flight crew and maintenance staff will review the MEL to determine whether an aircraft can be dispatched and under what circumstances/provisions this is allowed.

This may require the establishment of alternative procedures, an example of this would be an alternative method for initiating an emergency evacuation similar to procedures established by operators that do not have evacuation alarms fitted to their fleet or required to be used in the event of aircraft system failure.

This report provides an example of a situation in which better communications between the cabin crew and the flight crew might have reassured the cabin crew. It seems likely that the cabin crew did not communicate their anxiety and the flight crew did not appreciate their level of concern. It is a theme that is regularly apparent in reports to CHIRP.

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Reports received by CHIRP are accepted in good faith. While every effort is made to ensure the accuracy of editorials, analyses and comments published in FEEDBACK, please remember that CHIRP does not possess any executive authority.

An Advertisement Carried for NATS – Pilots wanted.

Pilots are needed to support Emergency Training for Air Traffic Controllers at Swanwick.

Controllers undertake emergency training every year to maintain their licences. This training is split between **TRUCE** (Training for Unusual Circumstances and Emergencies) and **STAC** (Scenario Training for Aircrew and Controllers).

TRUCE sessions take place in the afternoon. For Swanwick controllers there are classroom discussions and time in the simulator, which is located at our corporate headquarters in Whiteley, Hampshire. STAC is a facilitated classroom session at Swanwick (0900 to 1600) run by an ATCO facilitator and pilot CRMI. A mixed group of pilots and controllers discuss how emergencies effect operations on the flight deck and control room and how a better understanding of each other's requirements can lead to better handling of these events.

Over past years we have hosted many commercial pilots and the vast majority have commented how useful their attendance has been. For our ATCOs, they get to hear how commercial pilots deal with emergency situations first hand, and pilots can gain a better understanding of what we do should they call PAN or MAYDAY. Expect to take part within the classroom discussions and the simulator exercises (you can even play the part of the emergency pilot during an exercise!). Pilots supporting TRUCE and STAC training are encouraged to visit the Operation Rooms at Swanwick.

Sensible expenses can be claimed for those travelling from the London area or equivalent distance. Lunch will normally be provided.

If you think you might have a spare day, please E mail us at TRUCE@nats.co.uk so that we can send you more details. Please include an email address, brief details about you, who you fly for and what you fly.

Contact Us

Ian Dugmore Chief Executive

Bruce Hunter Deputy Director (Engineering)

Flight Crew/ATC Reports

Maintenance/Engineer Reports

Stephanie Colbourne Administration Manager

Circulation/Administration

Cabin Crew Reports

FREEPOST RSKS-KSCA-SSAT, CHIRP, 26 Hercules Way, Farnborough GU14 6UU

Freephone (UK only): 0800 772 3243 or Telephone: +44 (0) 1252 378947

E-mail: mail@chirp.co.uk

Registered in England No: 3253764

Registered Charity: 1058262