

CHIRP

Air Transport FEEDBACK

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CONTENTS

Editorial

Aircraft Maintenance during Redundancy Consultation Period

Social Media

Inappropriate Use of Mobile Phones

When is an Engine Failure not an Engine Failure?

The Impact of Poor Passenger Behaviour

EASA FTLs –Acclimatisation and Rest Away from Base

Rostering

Life Jacket

EDITORIAL

We often receive flight crew reports about cabin crew reporting for work when unfit to carry out their duties. Encountering unwell cabin crew can put flight crew in a difficult position with regard to the degree of illness and the implications of deciding whether or not to allow the individual to continue to operate.

The reasons for cabin crew reporting for duty when they are unwell are many and varied but include fear of compromising the rules for probationary periods, renewal of fixed term contracts or opportunities for promotion. In addition, the cabin crew member may already have a record of repeated short term absence close to a threshold for administrative action, or they may fear an aggressive response during the process of reporting that they are unfit for duty.

All crew members have a responsibility to notify crewing of illness as early as possible if they are unwell. It is reasonable for crewing staff to ask whether the crew member, as a valuable company resource, can estimate when they will be fit for a return to duty. However, there is no excuse or justification for crewing staff to interrogate or intimidate cabin crew (or flight crew) members about the nature of the problem or to comment on the circumstances. The staff taking these calls are unlikely to be qualified to make judgements about health or medical conditions. Subsequently, it is a management responsibility to follow up the absence with the crew member in accordance with company policies and duty of care procedures. Of note, the illness absence policy for cabin crew may differ and be more restrictive than that for flight crew.

It is an unfortunate fact that although the vast majority of cabin crew are hard-working and reliable, a small minority are not; their behaviour increases the workload for their conscientious colleagues as well as requiring all absences to be scrutinised. However, the behaviour and absence profiles of this minority are sufficiently distinctive that line managers can distinguish between them and the majority who are assets to be valued. Therefore the message to cabin crew is that they should always be professional and call in as 'unwell' when appropriate.

Ian Dugmore - Chief Executive

[Back to the Top](#)

AIRCRAFT MAINTENANCE DURING REDUNDANCY CONSULTATION PERIOD

Report Text: During a notice period for redundancy of all staff, planning of scheduled work into the hangar during the 45 day consultation process both during the day and night, is still taking place.

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The current staff are not able to concentrate adequately on the required workload during this period of consultation, the main topic of conversation is not task related, more where are we going to work next, how am I going to pay the bills etc. My concern is of somebody missing a major problem with an aircraft and it being released back to service with the potential of an incident occurring. Or somebody being injured due to the lack of concentration.

Operator Comment: The event is correct we did as a company decide to close our [] facility, (not closed yet). When we announced the closure we contacted the customers and briefed them about what was happening, a decision was made to not carry out any maintenance for two days, to remove some of the human factor influences.

The decision was then taken to only put low maintenance man hour “A” checks into the facility going forward deferring other checks to our [other] facilities. We then increased the technicians per check from 6 to 9 and the mechanics from 7 to 9. The hangar manager was instructed to attend night shift handovers and personnel was based at the facility for the 45 days. The compliance engineer also worked with the staff reminding them about the importance of good practices.

Over the 45 days we had only one event that was the re-fitment of some fan blades out of sequence which caused a higher than normal fan blade vibration at High power.

The 45 days has now passed [Company] are still continuing to carry out overnight checks (P checks) and this will continue possibly to the end of July.

[Company] did understand what it was doing and reduced the risk to aircraft safety with the above steps, unfortunately no matter when you make some business decisions, you are forced by legal reasons and contracts to take certain actions, but it is how we manage these that reduces the risks, but those affected may see differently.

CHIRP Comment: Best practice for any SMS is to manage safety risks related to organisational change. The management of change should be a documented process to identify external and internal change that may have an adverse effect on safety. It is essential that organisations communicate effectively with their employees the outputs from these change management processes.

[Back to the Top](#)

SOCIAL MEDIA

Report Text: As a fellow pilot, the rise of pilots posing and taking photos on social media, whilst in flight is disturbing to say the least. See [a number of examples provided] - and there are hundreds more! It doesn't take much to work out who these culprits work for and indeed, their names I would guess. Even more disturbing, someone is making videos (up to 4 hours long) showing [name of operator] planes and procedures!! They are broadcasting actual [operator] procedures to the whole world. This is outrageous in my opinion and airlines need to do much more to train their pilots in social media handling. I think something needs to be done.

CHIRP Comment: Posting photographs and video clips on social media must not contravene company rules, compromise security or infringe other crew members' or passengers' right to privacy. Operators have a responsibility to ensure that the rules covering the use of social media are sensible and proportionate.

There are also risks associated with carrying and using unauthorised camera equipment on a flight deck as witnessed in the very serious [incident](#) involving an A330 Voyager aircraft on 9 February 2014.

[Back to the Top](#)

INAPPROPRIATE USE OF MOBILE PHONES

Report Text: For many years it has become apparent that crew are routinely abusing the rules concerning mobile devices, and phones in particular. There are ANO rules about this, in addition to company SOP's. Much of the time, the use of phones/PEDs is forbidden. At [], cabin crew are forbidden to use phones 'from briefing to briefing'; however, they get used on most turnarounds and almost always going off-duty, before the de-brief. It is at epidemic proportions, and seems to have become accepted practice.

My issue? We are supposed to be at work i.e. doing our jobs, and complying with the rules - whether we like them or not. From a CRM point of view, it is a disaster. We've all 'interacted' with people who are glued

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to their phones, or who walk down the street bumping into other people, for the reason they can't take their eyes off Facebook etc. for more than a few minutes. It's so unprofessional to see crew behaving like this at work. They even know what to say when caught out: "we are checking manuals" - as this is considered acceptable. They are not.

Pilots are not immune from this either. For similar excuses, I now regularly see FOs using mobiles IN FLIGHT. It has become shameless, and there is no need to explain how this is both unsafe, and a serious CRM issue.

This month, when landing at [], the FO reached to his phone and switched it on when vacating the runway. A few years ago, I clearly remember an FO switching his phone on at the "70 knots" call on landing at [].

The shame of the issue is that if you really need to explain to a professional person why it is not acceptable, the point must have been already lost.

Lessons Learned: Set an example by insisting on SOPs.

CHIRP Comment: The use of mobile phones and other electronic devices must not interfere with the operation of the aircraft. Their use should be covered by SOPs that are appropriate and sensible. If the rationale underpinning SOPs is clear and the restrictions minimised, as with those for a sterile cockpit for example, the professionalism of pilots and cabin crew will ensure their observance.

[Back to the Top](#)

WHEN IS AN ENGINE FAILURE NOT AN ENGINE FAILURE?

Report Text: My report is seeking Regulator clarification of whether in flight, an engine that is not capable of full thrust, can be taken to be an engine that has NOT failed.

It has been brought to my attention by a member of our training department, that the QRH for our twin engine aircraft, only demands we land at the nearest suitable airport in the event of a total engine failure, that is an engine that is not producing any thrust at all. He stated clearly and repeatedly, that an engine that is not producing sufficient thrust for safe flight on that one engine alone, can be used to enable continued flight to destination. So, if you have an uncontrolled rollback that no longer responds to thrust lever inputs, the QRH for a surging or stalled engine does not demand a landing at the nearest suitable airfield, even when the engine is at idle and does not respond to any thrust lever input at all. The same would be true for any running engine that is not able to produce full thrust for whatever reason. The instructor was quite adamant about this, and responded vigorously to my argument that this was not a correct interpretation of our procedures. He is right that such a rollback would require use of a checklist that does not require a landing as soon as possible, but airmanship demands that an aircraft that now has only one fully serviceable engine between it and an accident, is one that should be landed as soon as practicable.

Is it possible that the instructor is wrong? To me it sounded awfully like management hogwash, and that a crew that decided to continue normal flight to destination, passing any number of 'suitable airfields' en route with only one fully serviceable engine, would immediately be invited for tea, no biscuits, with the regulator to explain himself. However, this argument, that the QRH seems to allow such an operation needs clarification, because the level of pressure now being exerted on crews to toe the company line is so strong as to influence all but the bravest of the brave. I struggle to see how this can be a correct interpretation. Your input will be appreciated.

Lessons Learned - That it is possible that an airman's understanding of airmanship is no longer enough. We may now need a legal definition of airmanship, based on loopholes in the company manuals which have therefore been 'authorised' by the regulator. The unwritten will become the hole through which we are legally encouraged to jump, no matter how unsafe. The third crew member may yet reappear, but this time in the form of a legal advisor, rather like the old dog and a pilot in the cockpit joke. His role will be to monitor our decisions and tell us when we have no legal mandate to take action X, where less safe but legal action Y is available, and of course action Y will always be to the company's operational and financial advantage.

CHIRP Comment: It is both normal and correct that there should be a safety investigation following a serious incident in order to determine whether there are lessons to be learned. However, flight crew should

not be concerned about their vulnerability to disciplinary or legal action provided their decisions are made in a professional manner using all of the information available to them. If the checklist does not mandate a diversion, it is very much a decision for the Captain on the day, taking in to account the nature of the engine problem. If there is insufficient information to diagnose the nature of an engine problem in a twin-engine aircraft, a diversion would be appropriate. Similarly, if an engine is not doing what it should or is unable to keep the aircraft airborne on its own and a single-engine approach is appropriate, the aircraft should be diverted. The decision making skill of a Captain could be questioned if he/she continued the flight beyond an airfield at which a safe landing could be made, if an engine was malfunctioning but still running.

[Back to the Top](#)

THE IMPACT OF POOR PASSENGER BEHAVIOUR

Report Text: I have reported the increasing frequency of shockingly bad passenger behaviour many times over the years. It is getting worse and worse each season. The frequency and predictability is also getting worse. There is an obvious and clear endemic issue with bad, and criminal behaviour on UK flights.

In addition to the routes note for poor passenger behaviour over many years, there are now issues on many other routes i.e. the problem is becoming more and more common and widespread. This season it has been made known to me that []-based crew have recently been: attacked and held by the throat, thrown against the a/c galley; a sexual assault.

These incidents are predictable and largely preventable. We see the behaviour, we know the flights likely to be affected; the local police know this; the airline knows this. It is NOT being prevented. It is highly likely there will be a serious physical assault which will cause serious injury / hospitalisation / the ending of staff members' careers.

As a secondary point, our low cost flights are bringing the industry into serious disrepute. I feel so very sorry for the innocent, well behaved families, older passengers, children who have to sit near these yobs, and listen to vile, offensive language for 3 hours.

In my opinion, it is the biggest preventable safety risk we now face as pilots in the UK.

Lessons Learned - Protect your crew as much as is possible. Press for prosecutions.

CHIRP Comment: Members of the CHIRP Cabin Crew and Air Transport Advisory Boards have confirmed the severity and frequency of the problems reported above. Much of the bad behaviour appears to be alcohol-fuelled, although other substances, including illegal drugs, are likely to be involved. The availability of alcohol at airports is a difficult issue because of the revenue generated by sales and there is inconsistency among airlines about preventing drunken passengers from boarding; some operators ask handling agents to turn away passengers considered to be intoxicated while others require handling agents to contact the flight crew. The removal of passengers from aircraft by the police is not uncommon in the UK but in some countries the police may be less cooperative and/or national procedures may be more restrictive. However, more could be done to warn passengers about poor behaviour at the point of ticket sale; this would enable warnings to be targeted at those routes and airports known to be problematic.

Cabin crew and innocent passengers should not be required to put up with boorish behaviour, bad or sexist language, let alone the more extreme behaviour reported above. Nor should the safety implications of such behaviour be overlooked, including the distraction for flight crew and the dilemma of deciding whether to divert the aircraft. Miscreants should be prosecuted notwithstanding that it could take a year or more for cases to reach court and require crew members to give evidence. Supporting evidence is vital for a successful prosecution. Identifying the individuals involved and making notes about the incident as soon as possible can be helpful; if possible, identify other passengers who might be prepared to give evidence. Short of prosecution, "difficulty in controlling intoxicated, violent or unruly passengers" is a mandatory reportable occurrence under EU law. Conscientious reporting is essential and operators should encourage flight crew and cabin crew to report every instance of poor behaviour.

Poor passenger behaviour creates an intolerable working environment for the cabin crew, undermines the authority of the entire crew and affects the safety of everyone on board. The Authority and Industry are aware of the problem and it has been raised in the media recently. Nevertheless, CHIRP intends to draw this Report and the views of its Cabin Crew and Air Transport Advisory Boards to the CAA Av Sec and to the

(UK industry) Flight Operations Liaison Group ‘for information’, stating that CHIRP fully supports industry action that is being taken.

[Back to the Top](#)

EASA FTLs – ACCLIMATISATION AND REST AWAY FROM BASE

Report Text: I fear that the CAA have made an incorrect interpretation of an aspect of the new European rules and have published their version as guidance in CAP1265, resulting in its being accepted as gospel by operators who are including it in their ops manuals.

The process for calculating whether or not a crew member is acclimatised, at the point of starting a duty is more complex than we have previously been accustomed to, but is quite clear. Table 1 in ORO.FTL.105.

(1) (or the equivalent in your ops manual) is entered with:

- 1) The time difference between your current local time and,
- 2) The elapsed hours since you last reported at a place where you were acclimatised to the local time at that place (known as your ‘reference time’).

Out pops an answer and no other considerations are relevant.

However, in the relevant Certification Specifications (CS), is a table entitled ‘Minimum local nights of rest at home base to compensate for time zone differences’ (CS.FTL.1.235.(b).(3).(i)). No mention is made anywhere in the CS or the Regulation of this table having any relevance to the crew member’s state of acclimatisation. It claims only to mandate additional rest to compensate for time zone differences and is explicitly only applicable to rest at home base (as defined). Yet the CAA, on page 14 of CAP1265 (version 2 - Aug 15) say:

If a crew member’s rotation includes any additional duties that end in a different time zone to [sic - from] that of their first arrival destination’s time zone while they are in an unknown state of acclimatisation, then the crew member remains in an unknown state of acclimatisation until they have:

- taken the rest period in accordance with CS FTL.1.235 (b) (3) at home base;
- taken the rest period in accordance with CS FTL.1.235 (b) (3) at the new location; or
- been undertaking duties starting at and returning to the time zone of the new location until they becomes [sic - become] acclimatised in accordance with the values in the table in ORO.FTL.105 (1).

The Authority appears unilaterally to have decided that, when in ‘an unknown state of acclimatisation’, the sub-paragraph in the CS overrides the requirements of Table 1 in the actual Regulation, despite the CS Table referring specifically to rest at home base!

It is easy to construct example scenarios where the two rules conflict.

For example: start in the UK on UTC as your reference time, fly to the US east coast (UTC -5) and go off duty at 2200Z/1700 EST; take 48:30 rest, reporting again at 22:30Z/1730 EST on the third evening. Table 1 shows an ‘X’, meaning you are in an ‘unknown state’, but applying the CAP1265 guidance and the CS table shows that, having had 2 local nights’ rest, you are now acclimatised to Eastern Standard Time.

My concern is that the CAA guidance does not appear to abide by the EU Regulation or to EASA’s supporting CS and other documents and that no claim is made that EASA have approved any deviation from the rules in this case. My company’s Ops Manual includes a verbatim reproduction of the CAP1265 guidance and, having been approved by the National Aviation Authority is now the rule set to which my colleagues and I must adhere, even though I am concerned that, in this respect, the CAA appear to have got it wrong.

CHIRP Comment: This is a complicated area and the CAA has worked with individual operator’s crewing departments to ensure a correct understanding.

In the scenario postulated by the reporter, on the east coast of the US a crew member would not be considered acclimatised until they had been there in accordance with Table 1 of ORO.FTL.105.

The second paragraph of the CAP1265 guidance refers specifically to scenarios in which ‘a crew member’s rotation includes any additional duties that end in a different time zone to that of their first arrival

destination time zone while they are in an unknown state of acclimatisation'. For example: cabin crew based in Shanghai fly to Heathrow but do not acclimatise there. They depart London in an unknown state of acclimatisation and fly Heathrow to Hong Kong. Because Hong Kong is the same time zone as Shanghai (but not their home base) they could acclimatise in Hong Kong using the provisions of the second bullet referring to CS.FTL.1.235(b)(3).

[Back to the Top](#)

ROSTERING

Report Text: Please find attached a copy of the ASR/MOR I recently filed with regards to poor rostering practices. Specifically, this is with regards to changing from lates to earlies with a complete disregard for human factors.

Day 1: [UK Airport] SBY 13-19Z used for a [] 1530-2200Z.

Day 2: Home SBY 13-21Z used for a [] night stop 1755-2114Z.

Day 3: return to UK 1210-1539Z

Day 4. Home SBY 05-17Z

Called Ops at 1224Z on [Day 3] to express fatigue concerns being assigned a long early SBY following 3 days of finishing late [and resting for late duties]. Ops refused change. Called Duty Manager at 1228Z, could not get roster changed. Called Ops at 00:46L on Day 4 to report unfit for duty due to inability to sleep at that time.

Other Info: Ops agreed to put a note on roster to avoid being called before 0900L to allow me to have an 8-hour sleep. The Operations Manual states "when undertaking a period of Standby or Reserve, be sufficiently rested to undertake ANY Duty which could be assigned". Having gone to bed at midnight for the last 3 nights it's extremely hard to go to bed at 9/10pm in order to have the standard 8-hour sleep to be prepared to undertake a 12-hour SBY at 6am, making the roster legal but unachievable.

CHIRP Comment: A late finish is a duty that ends in the period between 0000-0200 local. The 'late' is based on the departure location (in this case UK local time) and the reported Day 2 duty finished at 2214 local UK time. Therefore this duty pattern doesn't contain a late duty.

Where there is a transition from late or night duties to early duties, crew members need a rest period including a local night before the early duty. This means that if they have operated a late duty (i.a.w the definition) then as long as the rest period includes a local night (8 hours between 2200 and 0800) their next report could be 0600 local. So even if the Day 2 duty had been a late they could still have completed a FDP (including a standby) starting at 0600.

[Back to the Top](#)

LIFE JACKET

Report Text: As a result of the various accidents and incidents with helicopters in the N. Sea in recent years, the CAA introduced several regulatory changes affecting operations. One of the changes was that from the 1st April 2016, the pilots on helicopters were to be provided with an aircrew life jacket which include a Short Term Air Supply (STAS) to assist the aircrew to escape from the helicopter underwater in the event of a ditching and capsizing.

My company selected a lifejacket supplied by [] as the solution to meet the requirement. It was immediately clear when it went into general use a few days before the 1st April deadline that it was very uncomfortable. In particular, the life jacket stole pressed forward on the back of the neck and whole jacket severely restricted movement of the head. The jacket also causes poor posture in individuals wearing it. There are other problems associated with it.

Since the life jacket was introduced, a significant number of aircrew have had severe neck/back problems such that they are medically unfit to fly. The number of air safety reports, medical reports related to the life jacket submitted by aircrew has exceeded one a day. (There is clearly something very wrong with this life jacket.)

There are quite number of individuals who are managing to fly with the new lifejacket, and appear to be suffering no immediate problems, but I suspect that they may well be incurring long term damage to the

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neck and back. The life jacket selected by the other operators from what I understand is not causing the same problems.

My company recognises this. For whatever reasons that they selected the [] life jacket it has turned out to be the wrong choice and needs to be replaced as soon as possible. The options that seem to be available are:

1. Try to modify the [jacket] - Tried with no significant improvement
2. Obtain a different life jacket from another supplier - The Company has approached the supplier to the other operators, but they do not have the capacity at the moment to provide life jackets to my company apparently.
3. Develop a brand new life jacket. - This is a long term solution and what is required is an immediate fix.
4. Allow a temporary suspension of the requirement to have STAS and therefore allow the company to use the Mk 44 lifejacket which has been used for years without any serious problems.

Unfortunately, the CAA are apparently adamant that there can be no relaxation of the rules and therefore this is not possible. (I have made enquiries within my company to various different individuals and believe that it is genuinely the regulator who is stopping the use the Mk 44 and not the company using the regulator as an excuse.)

Over the 25 years that I have been flying in the N. Sea, as far as I am aware there have been no survivable accidents where the aircrew did not escape from the aircraft. (Cormorant A the co-pilot escaped from the a/c but subsequently died.) Even in the L2 Sumburgh accident where the crew had difficulty with their escape exits still managed to escape. Therefore having a STAS life jacket must be of marginal benefit.

To me it seems that the risk/benefit of the current situation is totally wrong. The regulator should recognise this (Yes my company has got it wrong but we are where we are) and allow the use of Mk 44 life jackets immediately (albeit with conditions).

I am writing as I am sure you talk to the regulators and hope that in discussions with them, you end up making them re-think their position and allow a temporary relaxation or through you I obtain a clear reason as to why it cannot be done.

Lessons Learned - My Company has learnt many lessons from this debacle. As an individual, I am not sure there are much. The regulation was created with the best of intentions - the consequences have been for individuals not good.

Operator's Comment: After the initial introduction of the [] lifejacket (April 2016), it quickly became clear that the Life Saving Jacket (LSJ) was causing significant issues for a number of pilots. As well as problems with the LSJ waist band loosening off and Emergency Breathing System (EBS) mouth pieces coming out of their housing causing a distraction, the stole of the jackets were obstructing the pilots head and upper body movements. Moreover, the LSJ design appeared to be applying pressure to the neck /shoulder region which caused a large number of pilots to go sick due to back/neck pain.

We engaged with medical professionals to obtain independent advice and armed with this, together with feedback provided by our pilots, [the manufacturer] produced a modified LSJ which had a redesigned stole and EBS mouthpiece holder. The redesigned stole proved quite effective and the number of pilot issues significantly reduced as a consequence of the modified jackets introduction. As part of this discussion, [the manufacturer] stated they would investigate fitting an EBS to the legacy lifejacket (the Mk44) and that this system might be available June/July 2016.

More recently the Company has decided to undertake on-the-line flight trials using [an LSJ from a different manufacturer]. This product is already used by [other operators] and appears to be a more comfortable fit. At the same time, at our request [the manufacturer of the problematic LSJ] has continued to advance the design of their EBS jacket producing a ["b" version] which has a modified stole shape and improved waist band, and first indications are that it is an improvement over the original and modified version.

Thus, to summarise: We are undertaking an on-the-line flight trial on the developed "b" version of problematic LSJ and an alternative from a different manufacturer with a view to deciding which jacket

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provides the best solution for our flight crew to meet this mandatory requirement. It would appear that [our current supplier] is no longer pursuing the legacy Mk44 lifejacket with EBS.

As an aside, we are also investigating changing the zipper design on the immersion suits used by our pilots. Although still under consideration, it appears that for some individuals the use of an immersion suit with a cross-body zipper as opposed to a 'behind the head zip, with collar' might alleviate some of the problems encountered with the LSJ stole putting pressure on the neck region.

CHIRP Comment: Evidence from every industry shows the difficulty of completing projects on time and on specification first time. It is vital to begin as early as possible and include appropriate milestones and performance indicators along the way. Managing procurement projects when there are limited options for supply can be particularly problematic. Having found itself in a difficult position it is clear this operator has acted with commendable energy to resolve the situation and provide an optimum solution for the future.

[Back to the Top](#)

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Captain Karim Sachedina

It is with great sadness that we report the death of Captain Karim Sachedina in August 2016. Karim was a Captain with Monarch Airlines when he joined the CHIRP Cabin Crew Advisory Board (CCAB) in 2004 to contribute a flight crew perspective to the assessment of cabin crew reports. He became Vice-Chairman of the CCAB in 2010 and continued in this capacity until 2014. He also served on the Air Transport Advisory Board from 2011 to 2015.

Throughout his time on the Boards his expert contribution was invaluable and he was noted for the warmth, sense of humour and sympathy that were his natural characteristics. We are hugely grateful for the support he generously gave to CHIRP and wish all his family, friends and colleagues our heartfelt sympathy on his passing.



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