



CONFIDENTIAL HUMAN FACTORS  
INCIDENT REPORTING PROGRAMME

# FEEDBACK

Number 17

August 1988

**We** don't normally print reports on the front page of FEEDBACK, but we felt that this one so cogently expressed the views of many of you that we've made an exception.

*Summer at London Gatwick - slot times to be airborne within a 1 min tolerance, if missed 5 hour delay. Slot times for departure due "Palma Flow Control" found to be untrue as Palma is empty of a/c. Wide body a/c being told to expedite to 08 hold - a distance of 2 miles(?). Crews operating on minimum rest as a norm and extending hours to the maximum allowed. Runway closed at night for repair so operating to high weather minima result in diversions and then a repetition of the above. Clearances to "land after departing aircraft"! "Maintain 180kts to the outer marker". A reduction of say 40kts between outer marker and threshold is not good airmanship yet it happens on every approach regardless of windshear or cloudbase.*

*At the same time the CAA say that there is nothing wrong with West Drayton ATC. British Airport's spokesman states only 20 out of 390 a/c delayed during weekend of 11th + 12th June. Who is trying to fool who?*

*Surely there is someone "out there" who knows that a continuation of the above is a recipe for disaster. If he is there he is welcome to sample some of the frustrations from my flight deck. I would suggest Saturdays at 0800 or Sunday early pm. Or shall we continue until the inevitable happens? Never mind - it's bound to be "pilot error".*

**The AAIB** (used to be the AIB, and is now a lot more difficult to say) is located just down the road from us here in Farnborough. We have a good deal of contact with the inspectors since they fairly frequently ask us to see whether we have any reports that relate to an incident or accident that they are investigating. Sometimes it is the publicity that follows an incident which prompts reports from you (see p2), and we pass on disidentified versions of such reports to the AAIB. They usually help to show that the pilot who had the accident wasn't the first one to make the mistake.

Something that we haven't been able to help the AAIB with has been a concern they have for information on asymmetric thrust conditions in Cessna 441s. If you have experienced, or know of any occurrences of, asymmetric thrust conditions (steady state, transient, or oscillatory) in Garrett powered Cessna 441 aircraft, other than those deliberately introduced for training, do get in touch with; Air Accidents Investigations Branch, Dept of Transport, Royal Aerospace Establishment, Farnborough, Hants GU14 6TD. 0252 510300. Bet you thought it was the Royal Aircraft Establishment. Plus ça change, plus c'est la même chose.

**Thanks** to those who wrote pointing out the horlicks we made on p6 of the last FEEDBACK with regard to misset QNHs - entirely our mistake. You just can't get the staff, you know. Please remember that in this issue, everything in italics is, as nearly as possible, in the reporter's own words.

## PYO AT LGW

I was operating as pilot and Captain of a B737 returning to GATWICK at 0030Z. Having read notams apropos 08L ops. (for some weeks previously as well) my co-pilot and I discussed, then briefed for a 2NM SRA to 08L. SRA approaches are a rarity in my job, so I flew it in my mind a couple of times, before we started descent from just west of the Belgian coast. I could see LGW, across the cockpit, whilst at about 4000ft and about 6NM South. The greatest visual impact (apart from the terminal lights) was the flashing of a "million" yellow beacons, and sundry flood lights on the airfield. No other lights, neither runway nor taxiway, caught my attention. I remarked to the co-pilot that things looked busy down there. I was therefore fully notamed; briefed; and had seen the work in progress. Descent continued to 2000ft QNH and we were controlled onto a heading of around 085 degrees some "eight miles" from the field - mentally geared for the SRA. The controller said "call visual". Sure enough, there were the lights of two runways, and being relieved of having to fly an SRA, we called visual. The jet was settled in the approach configuration - slightly nose high but the lights were clearly visible. There was a set of very bright MAIN runway lights and to the left, a set of not so bright (and easier on the eye) runway lights. Which set do I go for? I verbalised my thoughts and almost immediately answered my own question, when I could just make out the flashing beacons (yellow) of the work in progress next to the right hand set of lights. I suppose the range to touchdown was about six and a half - five and a half NM. The co-pilot agreed that we were going to go for the right hand set, but did so in such a manner as to make me think that he had been unsure and was glad that our answers coincided. I requested ATC to dim the runway lights (which would also have confirmed the runway to us) as they were far too bright. They said that they were already at a minimum. At approximately 2NM I noticed some strobe lights somewhere in front of the runway and thought "fat lot of good they are except for annoyance". I was getting irritated by the brightness of the lights, as they were robbing me of my depth/height perception. The landing was a positive one but the game wasn't over - where's the end of the runway? The lights continued into more lights, hundreds of green ones in fact. Never mind the noise - I used the standard reverse thrust - until the runway end loomed up out

of the other lights.

So there you go! My co-pilot and I talked about the whole deal, afterwards. Neither of us could pin anything down as to why we both had doubts as to which runway to land on. We looked out of the crewroom window (in Concord House) and couldn't figure out why a centre line light taxiway could be attractive enough for us to consider it as another runway - but we did. There was a chance of my landing on that taxiway that night.

My analysis is this:- With the main runway "out", and confirmed as such by so many clues, I was not expecting a choice. My mental picture anticipated only one runway. Some would say there was only one runway - but at 8NM for myself and my co-pilot there were two; 08L must be the "left" of the two!?! Therefore the urge was to go left.

At this point I'm beginning to ramble a bit, so I'll stop. But it is annoying that at such a busy international airport, these things can happen. It wasn't the 1-11 Captain's fault - it was the fault of a lot of people saying that everything is fine and dandy, both BAA and CAA - ask the ATC "watch" at LGW who refuse to conduct take-off and taxiing operations simultaneously on 08L and taxiway 2.

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The CAA have approved the simultaneous use of the emergency runway and the taxiway 2 at Gatwick at night subject to certain wing span restrictions. I have yet to speak to a controller happy about this situation but due to the high levels of traffic scheduled for the summer GAL say they have little choice. Obviously financial considerations take priority over the safety of the public. I am an ATCO at Gatwick.

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Earlier this year, on returning from a long night flight, we were radar vectored for visual 26R, as anticipated. I was handling and this was my first "standby runway" landing for over a year. Viz was good and we went visual from 3000ft - the lights were clear from 10nms. I remarked to the Captain on the brightness of the lights - was it 26R? To satisfy my doubt he queried with the tower who altered the light intensity to identify the runway. On passing 1500ft it was obvious from knowledge of airport layout (esp. position of terminal) that we were correctly lined up. No one criticized me for doubting!

# MORE CLOSE SHAVES

## 1: PILOT ORGANISED

An inbound Dash 7 was on course to Ockham and descending to FL 90. An outbound B720 from Heathrow on a "BENDO" SID was instructed to climb and maintain FL80 because of the traffic above. Their respective tracks would cross. As the B720 approached the Dash 7 I again reminded him to maintain FL80 on reaching which was acknowledged. As the aircraft converged the B720 overshot FL80 by 3-400ft. I immediately confirmed that he was maintaining FL80 and the altitude readout rapidly reduced. The pilot offered the excuse that he was "avoiding cloud"! He was told that he nearly had more than cloud to avoid.

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F27, outbound SS, cleared 6000ft, spotted by SC approaching FL70 just before blip merged with Heathrow inbound descending FL80 and transferred to Heathrow APC for further descent. We do not know to what level F27 would have climbed and we did not listen to any R/T recordings to check the clearance to the F27, but Capt readily acknowledged his error. F27 descended quickly to 6000ft.

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I was working a Cessna 421 joining controlled airspace at level 70 from the North East of Daventry. The DTY W controller had his aircraft descending into Birmingham. As his aircraft approached FL80 he levelled it and told him he would pass traffic at Daventry and to expect descent after passing. We were both moderately busy. I then spotted his aircraft passing FL75 descending with about 4 miles to go to my mine. I pointed this out and issued emergency avoiding action. His aircraft saw mine and climbed to avoid it. My aircraft in the turn did not see the traffic which passed within a mile of him. The Sector Crew Chief had words with the pilot on the phone and no further action was taken. However two points are raised. 1) The pilot was very late on his schedule on an overnight parcels trip. Did he in fact doze off and allow the aircraft to descend? 2) Because of the violent 90 degree turn I gave the Cessna he could not see the traffic hidden behind his wing - would he have filed an airmisss had he seen the aircraft? This was the closest I have seen two aircraft on my sector in many years at LATCC and yet no airmisss statistic will record it. Indeed because the Chief spoke to the pilot no reporting action of any kind will exist.

## 2: CONTROLLER ORGANISED

FK27 en route Jersey-Stansted on track Woodley to Bovingdon at FL100 [agreed level from TMA (S)]. B757 en route Edinburgh to Heathrow radar released to Heathrow APC(N) at FL110 subject to the FK27. They marked their flight progress strips correctly and placed a "blocking" strip in the display at FL100 [this was observed by us via CCTV]. With the aircraft 3nms apart and closing we observed the B757 Mode C descend. CCTV indicated that Heathrow had cleared the aircraft to FL90. The aircraft passed within a mile of one another at the same level. Heathrow APC were very apologetic saying that they had "forgotten" about the overflight (FK27). Neither pilot said anything. This was an airmisss that the CAA says does not happen.

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... As I was dealing with the last of the flush into Gatwick, a BA 1-11 got airborne from Heathrow on a Samton SID and I climbed it straight to FL110 under a northbound FK27. The northbound FK27 passed a Gatwick inbound and, remembering a southbound FK27, I instructed it to descend to FL100. After I had completed another task I glanced back to the outbound BA 1-11 as it came within five miles and head-on and suddenly realised I had cleared the outbound to FL110 and descended the FK27 to FL100. Luckily the outbound BA 1-11 was only climbing at about 1000 feet per minute and was at FL84. I immediately instructed him to level off at FL90 and breathed a deep sigh of relief realising my error in time.

Although traffic levels are not overwhelming, they have increased such over the years that there is now a steady stream especially during the summer and we should consider making it mandatory for those on sectors to take a break at any time during the day after an hour and a half. I think that perhaps we are getting to the limits of our concentration.

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... The avoiding action which I initiated achieved a bare two miles. Neither pilot wanted to file an airmisss report. I am left with feelings of doubt, insecurity, and a knowledge that my professional ego has taken a severe blow. In addition I cannot put a number of "what if...?" questions out of my mind, and my colleagues' assurances that I am not alone (a fact!) are of little comfort at the moment.

# UNCLEARANCES

1 The Conditional Line-Up is a "sloppy" procedure which confers risk without any true benefit. At Aberdeen the procedure is used unnecessarily and to excess for helicopter departures, and in the end we will contrive an unnecessary and avoidable accident. The argument that ATC need the Conditional Line-Up because they are committed to X movements per hour is a fatuous statement. Now, Aberdeen ATC claim:-

**a** That the conditional line-up instructions are necessary in order to expedite the traffic flow.

**b** That by giving the instruction in two parts:- "After the departing/landing XXX", "Line-Up" that premature entry to the active runway will be avoided.

**c** That a conditional clearance given in advance frees the controller to carry out other tasks when the time comes for the helicopter to line-up.

2 These arguments are flawed for the following reasons:-

**a** The reaction time of a helicopter is very short and little or no time saving has been observed in relation to the conditional line-up clearance given in advance.

**b** Having given a conditional line-up clearance, the controller must still switch off the stop lights at the holding point before the helicopter can taxi onto the runway. The action of switching off the lights should be combined with the verbal instruction to line-up. There is an old maxim in aviation: "Vital Actions Require Conscious Thought".

**c** There is a read-over from railway practice, which has had the benefit of 150 years experience. A train is instructed to stop until the section ahead is clear, only then is it instructed to proceed. Those railway companies who thought that they could rely on the infallibility of the human element all reaped a bitter harvest in the end.

3 Aberdeen which has as many as 80 to 90 helicopter departures per day from the runway mid-point, is the most likely airport in the United Kingdom to have a runway collision. Helicopter pilots do not like the conditional line-up.

4 There are distinct parallels to be drawn between the situation unfolding at Aberdeen and the circumstance surrounding a famous military disaster:-

At the Battle of Balaclava in 1854, the British commander, located on a hilltop surveying the battle field, issued a seemingly straightforward instruction to a cavalry regiment. However, the troops in the valley below, without the benefit of his panoramic view, attacked the wrong target and suffered catastrophic losses; The Charge of the Light Brigade.

It seems to us that the big problem with any conditional clearance is that if you miss the conditional bit ('After the landing...'), then the rest of it still makes perfect sense as an immediate instruction ('Line up'); the system is fail-dangerous instead of fail-safe. We'll keep pursuing this one.

On the 3rd sector - all going well. Wx good and feeling well rested after a long weekend. Contacted EDIN, got the Wx as . . . and also cleared for the BEACON APP to R/W 07 but I was used to using 25 ILS or 07 ILS. A quick glance at the plate to confirm D/H etc. Beacon outbound in IMC and procedure turn "R". Something nagging me - couldn't place it - everything looks OK but decided to check ident again as needle/flag warning. Ident giving 25 ident. Check with approach (they must have forgotten to switch ILS's over) but no - I was cleared BEACON APP "NOT" ILS. First time anything like this had happened to me - I heard what I had expected - not what was said. A quick scramble for the NBD Procedures Plate and everything ended normally with no problems.

On departure from Manchester on Honiley 2S SID I climbed straight ahead to 2500ft, on ATC instructions, before turning right. ATC then cleared me direct to Honiley, no speed restriction, and FL70, which I acknowledged. I was acting P/2 to my FO's P1 sector. I then became involved in a very high workload. In addition to normal After T/O Checks, this was caused by:

**a** FO's aircraft handling (he was relatively new to type) was rough, e.g. A/C badly trimmed, throttle settings excessive etc.

**b** . . . . .

**c** Aircraft was empty, so climbing "like a rocket".

**d** Changing from QNH to Standard Setting at 4000ft involved a setting change of 25mbs on this occasion. In the midst of this I looked up at the mechanical assigned altitude reminder, saw 70 set, and noted we were climbing rapidly through FL75, grabbed the control column and called "Altitude". Just as I did so, Manchester ATC cleared us to FL150, informed us we were clear of traffic, and pointed out our height "bust". In addition to this fundamental error we had both missed our Company SOP "One to Go" call at FL60.

Two interesting points come out of this incident; Firstly, at the time of the incident both the FO and I

were convinced we had been cleared to FL130. Although I had noted down "FL130" I had not acknowledged any such clearance, and the FO had not set it on the altitude reminder. However, on subsequent playback of tapes, in the midst of this timescale an aircraft departing Leeds, on the same frequency, had been cleared to FL70 and then, before reaching, had been further cleared to FL130. As we were both familiar with Honiley SIDs out of Manchester I suspect that transmission, together with a subconscious expectation of FL130, had somehow preconditioned our thinking. The second point is that had an electronic altitude alert unit been fitted this "bust" would not have occurred. Even allowing for our mental confusion re FL130, I feel certain that an audio warning would have been more than enough to cause us to reduce the rate of climb and query the cleared level setting. In my opinion, with the presently crowded airspace in Europe in general, and over the UK in particular, these units should be a CAA mandatory requirement on all public transport A/C at the very least.

0500Z commenced standby. . [delays etc] . . .1615Z arr ABC. We planned for takeoff @ 1730Z and were given suitable "slot". 1715Z pax all boarded; baggage still being loaded and no load details available. 1725Z - a/c X on adjacent stand requests start clearance and is cleared to start @ 1733Z. 1731Z - our paperwork and loading at last completed, we call for start - given 1738Z. As a/c X is still surrounded by steps and service vehicles we ask if we can take his slot - X intervenes to say that he's now starting!! 1737Z X moves from stand. 1740Z we leave stand.

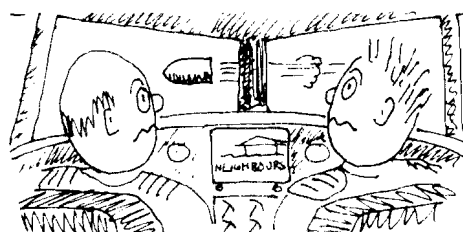
After delay in departure clearance Tower instructs us to "Line up and Takeoff" approx 1749Z. Just about to enter runway and Tower says "Hold Position" - we stop with aircraft's nose on runway edge line. Tower says X now returning with tech problem - instructs us to taxi down runway and return to stand (other aircraft are now behind us on taxiway). On reaching stand Tower instructs us to "re-enter runway and backtrack for takeoff No.1". During backtrack Tower instructs (or we THINK she does) "CLEARED takeoff: cleared FL now FL70". Despite read-back Tower twice repeats the revised FL at runway end, completing turn I call Tower "...966 rolling". After getting airborne tower says "966 airborne time 1801 - and by the way you took off without takeoff clearance". I apologise and say we understood we had received takeoff clearance whilst backtracking. Tower respond "That's OK" - after

discussion we believe Tower instruction during backtrack must have been "AFTER takeoff, cleared FL70". Three of us misheard or misinterpreted. If only she'd used the terminology "Departure" instead of "Takeoff"! - if only we hadn't been so frustrated - if only something had been obstructing the runway!!

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## TAKING FLAK

. . .Both the aircraft concerned were entering the UK UIR via SKESO on UA25. The first aircraft called South of SKESO and requested a direct route to POLE HILL. That track would take him through the Portland DANGER Areas DO12 & DO13. I checked the time but could not remember if we had access through this airspace at 2200 or 2000 - I decided to take a chance and instructed the a/c to route the boundary direct to POLE HILL. Some time later, my assistant wanted to know if we have an aircraft in the Portland Danger Area, Portland ranges being on the telephone - by this time we had two as the following a/c I had cleared direct to REXAM. The assistant reported that he overheard in the background shouts of "Cease fire, cease fire". I spoke to the Portland Range Officer and apologized for the mistake. My eagerness to provide the direct routing for the traffic blinded my doubt of the time that the Portland Ranges were inactive - I should have cleared the a/c BHD to POL, thus avoiding the ranges altogether - a basic error!



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### Who shortened the runway?

Information IS readily available on some aircraft, eg Tristar, through the INS system T/K G/S HOLD function to display acceleration. When I suggested this in BA my comments fell on stony ground.

In the last FEEDBACK, we called for blue Smarties and acceleration monitoring. Rowntrees have now introduced the blue Smarties. Amazing. Watch this space for acc monitoring, and thanks to BA for a very considered letter on the subject.

# SLEEP SLOT

Checked in at Man 06.55 GMT. 30 min delay at EMA due ATC. On arrival at destination was told indefinite delay due flow control at UK. I went to refile, came back, Captain looking at Ops Manual to determine max duty hours eleven and a half hours. Eventually I realised we would run out of hours so I called Ops on HF to inform them. Captain then asked me if I would mind saying I came on duty at 0700GMT (max duty hours twelve and a half). Foolishly I agreed. On return to MAN Radar asked if we wanted to go visual. Captain agreed and turned but lined up with Motorway instead of Rw 24. Tower Control informed us to "break left immediately". Landed without further incident.

LESSONS: 1 Captain had "Commercial Pressure" to return to UK. 2 I should not have allowed him to adjust my reporting time. 3 I should not have allowed him to go visual without me being visual.

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As a new F/O on type I was having to work hard to stay ahead of the a/c. In preparation for the flight I had 10 hours sleep ending at midday (local time, i.e. 1100Z). I reported at 1800Z for a 1930Z departure (the 60 mins allowed for planning was not and still isn't enough for me). We departed LGW at 1940Z, arriving E Med at 0020Z. Due to fog at LGW we did not depart for home until 0330Z. The Captain, a considerate and experienced man, asked all the crew whether we felt fit to operate as we would be extending the duty period. Being new to the game without much personal experience of staying awake for such a long time, I readily agreed, thinking "If he can do it so can I" - I AM 20+ years younger!

As we neared LGW I found it progressively harder to stay awake and took the occasional breath of oxygen.\* LGW was below limits so we diverted to ABC, which had 4KM VIZ in mist. On taking out the autopilot I was rather shocked to find that I needed nearly 100% of my capacity just to fly the a/c. My basic instrument scan needed great mental effort, and on trying to go visual at around 1000ft I began to weave slightly from side to side and so went back onto instruments down to DH, where I looked up again and made the transition without difficulty. The landing was fine, chocks at 0855Z. Whilst driving home (a 15 minute journey) from LGW at approx 1100Z, I went to sleep at the wheel for a few

seconds and woke up to find myself on the wrong side of the road with a car coming head on. Needless to say, I missed it.

As a result of this experience I now take care not to allow myself to be airborne more than about 20 hours after I have last slept. This has already led to a slight row with one Captain when I told him, at a delayed reporting time, that I would not be fit to operate beyond normal duty limits.

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Would you believe it - within 6 weeks of the notice to AOC holders, my company "cocked up" a planned night flight - 40 mins over max FDP - asked the CAA for a RELAXATION of the limit for that flight once per 2 weeks AND GOT IT! (Commercial dept. had sold the series so it could not be re-scheduled etc. Alternative - position crews at destination out of question as insufficient crews!)

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Bandeirante initiates missed approach to Rwy 10 following S/1 NDB/DME APP saying he had set the wrong DME. Then says unable to pick up NDB signals and homes in on QDMs. Single crew, end of NIGHT watch = big trouble - quite ridiculous - why do CAA allow this. TWO aircraft have been lost in recent times on Single Crew Cargo Ops.

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Reference the sleep study, don't forget the poor old night freight boys! 90% of my duty hours are between 1900 and 0700 hours - and in my experience the adjustment to allowable duty hours at night is long overdue i.e. I can come on SBY at 0900, be called at 1700 and still be legally completing a flight at 0500, probably with the company asking me to go into discretion!

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I suggest that CAP 371 be divided into sections. After all, a jack of all trades is master of none. So why not have a CAP 371 with sections for:-

1 Long Haul 2 Short Haul 3 Single pilot operation 4 Helicopters 5 Freight.

It might just then happen that each area of flying could be properly and effectively covered without leading to a compromise.

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\* Using oxygen doesn't really cure fatigue unless you're smoking at the time, and this is inadvisable.

# ROTARY ROUND UP

I was flying with a line training captain whose pedantic approach to life was a constant topic of conversation in the crewroom. This was my first flight with him so I was a little apprehensive and took care to make sure everything was as it should be. The day had started with a delay due to weather although the other operator at this A/F was already airborne and had flown two rotations and reported a cloudbase as 250ft (DH 350ft!). I was very impressed with everything about the day's flying until we approached the last rig. It was reporting cloudbase 500ft and vis 2NM. The rig approach was flown by the LTC in the LH seat. The NDB/Radar approach procedure was followed to the letter until we reached DH. We were IMC but contact the surface flying at 200ft (in accordance with the procedure) until we reached our limiting visibility of three quarters of an NM. With 2NM to run the LTC announced that he was descending to 100ft. I just sat meekly by and said nothing - why! What is the psychology of an incident like that? Why does a meticulous observer of the rules suddenly change in the course of one flight and why does an experienced offshore pilot like me let it happen! Note - the actual weather at this rig was 100 foot cloudbase and half an NM vis.

I was interested to read the item about "flare blindness" in Feedback 16. The a/c was on a helideck being refuelled and having the passengers embarked. We were on the deck for about 20 mins. Almost ahead of me about 10ft away was a yellow sodium deck-edge light shining right into my face. These alternate blue and yellow around the helideck. Being a small deck and the a/c landed on the "bum line" and the wind direction resulted in the front of the a/c being close to the deck edge. On departure I found I needed to have my instrument lights up full to adjust to the relative darkness of the instrument panel. When I turned the a/c in the hover to depart over a safe unobstructed area with the total blackness ahead, I had to strain hard to see my instruments for what is basically an IMC take off. SOLUTION: Variable intensity deck-edge lighting. The lighting needs to be bright initially to spot the deck amongst the myriad of lights on a platform, but could be reduced in intensity as the a/c approaches or once on deck.

The problem with SOME AS332Ls is that they were

not fitted with the factory fitted option of electrical screen demisting and a windscreenwasher and wiper for the main windscreen. Only the small side windows have an area which is electrically demisted - covering about a third of the area. The lack of main windscreen demisting is a problem on the ground; during an approach in IMC (when with the air bleeds off all windscreens mist up) and during precipitation (rain, sleet & snow) when there is no means of removing it from the main windscreen. The manufacturer's modification of electrically heated main windscreen, windscreen wiper and washer can be fitted - at a cost - but it would appear that we need to have a ground taxiing accident first to bring home the point.

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## THE POWER OF CHIRP

The 146 has a very comprehensive warning system. We have problems with spurious and unnecessary warnings, especially entering cloud after take-off, ie the worst time (!). One pilot normally mechanically keeps cancelling the alert. In this instance we had a genuine alert - ice detected - and neither of us reacted correctly until clear of cloud when we relaxed! As far as I know this problem has existed since the 146 entered service, but BAe don't seem to have got to grips with it.

We mentioned this to British Aerospace - who could not have been more helpful - and received the following from our original reporter;

... Obviously your words in high places are taken seriously - you'll be pleased to know that the initial problem has now been solved.

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## REPORTS IN THE LAST FOUR MONTHS . . . .

Flight deck	
Fatigue, comm pressure, CAP371	29
Own errors	13
ATC related	10
Misc	7
Tech problems	6
	Total 65
ATC	
Separation erosion	10
Management	3
Staffing, workload	3
R/T	3
Own errors	2
Misc	2
	Total 24

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DATE OF RECEIPT AT THE R.A.F. INSTITUTE OF AVIATION MEDICINE

WE ASK THAT YOU GIVE YOUR IDENTITY ONLY TO  
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IN ANY EVENT THIS PART OF THE FORM WILL BE  
 RETURNED TO YOU, AS SOON AS POSSIBLE, TO  
 CONFIRM THAT WE HAVE RECEIVED YOUR REPORT.

YOURSELF	THE FLIGHT	THE INCIDENT
CREW POSITION	DATE	TIME (PLEASE STATE LOCAL/GMT)
TOTAL FLYING HOURS	FROM :-	DAY/NIGHT
HOURS ON TYPE	TO :-	LOCATION
	IFR/VFR	PHASE OF FLIGHT
	TYPE OF OPERATION	WEATHER (IMC/VMC)

PLEASE USE THIS SPACE TO WRITE YOUR ACCOUNT, USING EXTRA PAPER IF YOU NEED TO

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