



Confidential Human Factors Incident Reporting Programme

# FEEDBACK

MAY 1995

NUMBER 35

It has long been the case that crews and other witnesses at accident investigations refer to previous incidents, which were not common knowledge, of the same or similar type as that leading to the accident in question. Most of the incidents described are human errors - about the same proportion as found in full-scale accidents.

For this sort of information to be known and used to prevent accidents, potential reporters have to be convinced they can report errors without fear of ridicule, retribution or jeopardising their job. This can be achieved only by protecting the identity of reporters. Anonymous reporting is open to abuse and can be vindictive. Reports submitted in confidence have to be validated, and this requires the reporter to identify himself initially. The good intentions of the author may need to be established and the details discussed. Once the report is closed all personal details of the reporter are removed from all records. We not only send back the name and address at the top of the report form, but also any signatures or headed paper.

Reports are further disidentified by removing unnecessary descriptions of places, times or experiences which might lead to the identity of a reporter being discovered. This is true both for all reports submitted to the CAA MOR database and also that subset we publish - the latter always has the approval of the reporters. This disidentification is particularly difficult with ATC reports, so for them especially it is helpful to have several reports on similar or related topics, which we can then present to the appropriate body with our recommendations.

Effective action from CHIRP almost invariably means that some existing SOP, check list, regulation or technical standard has been found inadequate. When CHIRP identifies such problems it is often viewed as an irritant by those who originally framed the offending documentation. In such a situation they have to be convinced that the CHIRP action is supportive of their aims to operate safely and efficiently.

The data has been used to identify areas of hazard and concern where scientific research has been directed. Further proof of the viability of CHIRP is that in the past some recommendations made have been ignored with subsequent accidents occurring, and some changes made that have almost certainly prevented accidents. Definitive proof of the prevention of any specific occurrence is not feasible. However, even where we appear to take no positive action, FEEDBACK has raised the awareness of the aviation community many times over. Now read on for the latest sample of reports!

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## THE FRENCH POSITION

### TO INTERCEPT - OR NOT?!

At many airports, the normal method for feed onto the ILS is by radar vectors. I have often wondered what one should do, if a radio failure, or simple traffic congestion prevents the controller from specifically clearing me to intercept the ILS, when on a suitable, but perhaps not ideal, heading. Last month I had two instances which highlighted the ambiguity - and danger - of this situation.

Case 1: Inbound to a European airfield from the North for a Westerly runway; much traffic, much weather, continuous conversation on the radar frequency, mostly in another language. We were given a heading of 180 degrees which was effectively, base leg; no further information, continuous chatter. We watched the localiser come and go, deciding on balance that we were not intended to intercept, hoping we were correct. Large red returns on the radar rapidly racing closer. At last managed to get a word in to ask for early turn away from weather and hopefully back towards the airfield but receive a terse negative. We are eventually given a 180 degree turn to the North and later an intercept heading for the ILS. I assume that the Southerly heading through the localiser was to achieve separation, but it would have been so nice to have been told.

Case 2: A few weeks later, Southbound to land on the northerly of two parallel Westerly runways using parallel landings. I have just arrived on the Final Director's frequency to hear the controller tell a Northbound aircraft that he has gone through the localiser for the southernmost runway and is approaching the most northern of the parallel runways.

The somewhat aggrieved reply was that no

instruction to intercept the localiser was given (apparently true). Controller angry (and very busy) gives correcting heading to the SW and declares that "It is the law. If you are on an intercept heading you must intercept!"

Now there is room for common sense here of course. In Case 1, I saw no danger in continuing South (we had plenty of fuel!), but I would see much danger in Case 2 of continuing North towards a second parallel landing runway. But the ambiguity is still there. When you have received no specific instruction to intercept the Localiser but heading is satisfactory, but have no idea what is happening around you since all the instructions are in Dutch (or might as well be), do you, or don't you?

My guess is that you usually do (but in Case 1 my heading was at almost 90 degrees, so no). It would be a very great help however if Controllers always told the pilot "I am taking you through for separation" (or similar). I know the Controllers can get impossibly busy, but a phrase like this is a real gem for us because we are then in the picture and R/T will be reduced since we will not need to call to query our course. At LHR we will always be given information such as this; the Controllers here really do set a world-beating standard.

Incidentally, what does the law in France say about intercepting the Localiser?'

*CHIRP has made extensive enquiries about this problem and the advice is as follows: When a French Radar Controller puts you on a heading 45° or less to the inbound heading you can expect to intercept and establish. Additionally, the controller should request that you call "Established" when settled on the inbound track, normally on the ILS. If you are approaching the extended centreline at >45° and he has not*

*asked you to call "Established" then you can expect to be taken through for spacing. For those of a persuasion to read it for themselves, in French, the relevant document is RCA 3, paragraphs 10.7.3.2 and 10.7.3.3.*

\* \* \* \*

## **SOP TO THE CHECKLIST**

.... It seems to me that there is a severe risk that as pilots we are deluding ourselves that all we have to do is blindly follow the SOPs and checklists and everything will be all right. ....

I have grave doubts that airlines really encourage their crews to think for themselves. Training conforms to a formalised routine to cover a syllabus of known failures all carefully briefed and discussed in advance. The required actions are known in advance.

LOFT training has helped to an extent, but this is not perfect either. I recall an exercise where once things started to go wrong in a way not foreseen by the instructor, the exercise was halted on the basis that the sim was not behaving properly. Eventually, having talked it through it was discovered that the checklist drill was inappropriate for the failure in question. Had the exercise not been halted, I believe the crew would have lost control of the "aircraft". .....

We swish round in glass cockpits on autopilot yet most flightcrew recognise the need to practise handflown raw data approaches from time to time, in order to maintain basic flying skills. How many of us, however, recognise the need to keep our brains from atrophy, by really thinking hard about failures, and not blindly following the

checklist drill without full consideration of the implications.

Is there a solution?

*It is often the case that when things go wrong there is no appropriate checklist to deal directly with the combination of problems in that particular situation. It requires thoughtful use of extracted bits of several checklists, or several complete checklists in a specific order to deal with the problems successfully. That is when a more detailed knowledge of the aircraft systems, computers and their interactions is invaluable. The changes being made in the recurrent training programmes and the newer applications of LOFT are useful but no substitute for an enquiring mind.*

\* \* \* \*

## **SOP TIP**

.... if the sequence of reading the checklist is broken for any reason (ATC calls, Cabin Supervisor messages etc) then after the disturbance the checklist is resumed at the last check that was completed and started from there again. It goes without saying that if you are not absolutely certain in your mind for whatever reason that the particular check has been completed, then go back once more, or even start again if necessary. I have never seen this written down as a Company SOP but I have no doubt it has saved numerous potential embarrassments over the years from all the people who practise it.

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## **SOP TRAP**

Line training on glass 737 after 5 years on clockwork similar twin jet. Line Trainer is inclined to rush each push back and not follow SOPs. These require Cpt to read

ZFW from load sheet, F/O enters it into FMC/CDU and reads back TOW. If this checks F/O then enters VOL. 4 supplement to extract temperature correction and V.Speeds. Cpt checks these and enters into FMC/CDU. F/O then calls for push and start.

On each sector Cpt was giving load sheet to F/O to deal with and enter figures while he called for and initiated push and start at a rush.

On this sector jump seat was occupied by a company pilot who further distracted the Cpt by discussing mutual acquaintances with him. During Climb-out, (F/O handling) climb page on CDU gave no figures. Cpt said "it does that" and re-entered V.Speeds on take-off page.

I realized that in the rush and distraction on turnaround I had failed to enter the ZFW to obtain a GTOW check, I had obtained V.Speeds using the ZFW INSTEAD of a GTOW and entered these without a temperature correction. Thus we had taken off using incorrect TOW/speeds, all the info had "fallen out" shortly after T/OFF and NONE of this was checked or spotted by the line trainer due to complete lack of SOPs.

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## FUME FURORE

DOES INHALATION OF TURBINE EXHAUST FUMES CAUSE TIREDNESS OR ANY OTHER KNOWN LONG TERM HEALTH RISK.

I have never been able to satisfactorily explain why I am so tired after a duty period. Most of us have to take to our beds to recover. I sleep well, exercise regularly am experienced in the job which is not too

demanding.

We fly many sectors in a shift. Average sector 15 mins average number of sectors 20. Each time we land and disembark passengers we get exhaust fumes in the cockpit. We try to minimise this because of the discomfort to eyes and breathing but it is always there. Is there any health risk?

*Extensive enquiries by CHIRP produced very little information! Although no definitive trials seem to have been done expert opinion was that the exhaust air is mostly cooling airflow with few combustion products concluding that discomfort was the main problem with negligible health risk. But, if you know better let us know!*

*Fumes were a topic of report in the early days of CHIRP:*

Had driven to the airfield arriving just after 0700, to carry out a site inspection, have meetings and after lunch left at 1230 for local city where arrived at 1300 and had another site check and meeting. Then rendezvous with other crew member and walkout to aircraft at 1430 for flights to EMA, thence to XXX and finally YYY, a fairly full working day was well in progress by the time we flew, and this may have some relevance to what follows. Our aircraft was parked 20m at most behind right wing of a Viscount. During external check we were asked to move our a/c so that Viscount could briefly run his No.4 engine, and were assured that only idle power would be used. Aircraft moved directly to rear of Viscount whose ground staff made it imperative that we lean on our right wing as the only possible precaution. During the 2-3 minutes of running we both must have breathed in a good few lungfuls of kerosene fumes even though we tried to face "down-blast" for some of the time. Eventually airborne at 1450 During take-off I recall an unfamiliar

and uncharacteristic lightheaded feeling, as though all was not real. My map reading was lax to say the least - we were way east of track over the western edge of ZZZ which was blithely identified yet no action taken to correct heading. The fact that the ADF needle was correctly pointing left whereas it should have been to the right was also noted yet ignored. The aerodrome appeared ahead and descent commenced after a "field in sight" call. Our position was requested and we were then told that we were about to make an approach to an old disused RAF aerodrome. Descent was checked, the supplied QDM steered and we landed at dest. without further incident. During this final phase I attempted to excuse myself by blaming the compass. There was of course no error here of any significance because aircraft has slaved gyro and standby magnetic both of which subsequently proved faultless. I have flown in that area on similar work many years and there was just no explanation or excuse for this mess - until I thought about those lungfuls of fumes half an hour or so earlier. On landing I felt vaguely odd, and my other crewmember had headache, dry throat and slight nausea, all of which took some time to clear. This insidious hazard associated with a crowded apron may be worth wider publicity.

*And whilst we're on the subject of fumes it has been brought to our attention and we hope, already, to yours that a particular brand of rain repellent, namely "Rainboe", is very noxious and fumes emanating from faulty canisters within the cockpit are extremely hazardous. We thought that you should BEWARE. The repellent has been given a citrus scent to make detection easier.*

\* \* \* \*

*Did you hear the one about the aircraft asked to "pull up a bit" by ATC?*

## RNAV TRAP

I was called in whilst on standby to take an ad hoc flight to the northern North Sea. By the time I arrived at work the flight was closed with a full load. With the co-pilot I planned fuel minimums based on a refuel at an airfield both ways to give the max payloads. As I was taking a full load out and the Wx at Base required holding fuel I did not anticipate returning direct.

Whilst outbound I checked the RNAV TAS computation and it was correct. Having refuelled and called the sig log they requested we offer a return payload without a refuelling stop - a rather unusual request - I calculated the fuel requirement based on the RNAV then the co-pilot calculated the payload. We both watched each other in our tasks. The return time was one and a half hours. The alarm bells should have rung instantly but we were both pleased to be on a one stop back to Base on a Friday night.

Luckily the load given allowed us oodles of extra fuel - it was only when in the cruise returning to Base that I realised that a GPS of 176kts were needed to make Base in an hour and a half. Check RNAV TAS should have been 130kts - showed 159kts! - I feel a little silly as I am always trying to instill the need to cross check for gross error and never to rely on fuel planning based only on the RNAV which always tells porky pies!

\* \* \* \*

## EJECTED SEAT

I was engaged on aerial filming work. The aircraft was fitted both with a "Nose and a Side mount" for camera attachment. In order to ensure maximum manoeuvrability, the aircraft only had pilot plus cameraman, in addition the port rear door had been

removed.

The cameraman had some helicopter experience, and therefore when changing from wing Nose mount to the Side mount, I would land, shut down to idle, and allow the cameraman to move positions. Prior to taking off again I would verbally quiz him, to check he had secured eqpt. etc. All straps and cables were either tie-wrapped or secured with "gaffer tape".

During the phase of flight in question, we had just finished filming down a mountain gorge with the side mount, located in the rear cabin. We then landed, and the cameraman moved from the rear cabin to the co-pilot's seat located in the front cabin to operate the nose mount.

Having secured himself and arranged his equipment, I verbally checked with him that he had secured all equipment in the rear cabin. I then made a visual check over my shoulder. Everything was OK, including a foam rubber cushion which he was using to sit on. This was secured under a seat belt, located furthest from the open door.

We took off, and after 20-30 mins flight we landed for the cameraman to re-position in the rear cabin. Whilst the seat belt was still fastened the cushion was missing.

At no stage during this flight was any tail or main rotor strike felt, and post flight inspection revealed no signs of strike damage, fabric tatters etc.

I suppose the lesson has to be that all items/loose articles, unless physically secured to the airframe, have to be placed in the luggage compartment, or placed in a bag which can have the seat belts placed through the handles. I was lucky. This incident could easily have led to catastrophic failure.

## INVISIBLE PROBLEM

On a number of occasions we have come close to taxiing into the back of the a/c ahead.

Conditions - night, good visibility, lights everywhere.

PROBLEM - Many a/c have rear facing white navigation lights on the wing tips. These "get lost" at busy airports with vast quantity of other lights making a/c ahead very difficult to see. No taxiway centreline lights.

SOLUTION - At least one tail nav light near centre line of a/c. Taxiway centreline lights.

*CHIRP has been making enquiries about this problem and in the general view of the Regulators the problem just doesn't exist. There are rearward facing lights on aircraft and they do meet the requirements of the ANO, Section III's various rules. However, it would be unfortunate if there was a taxiing accident because of this situation. There is also the interesting fact that Rule 11, (3) suggests, if the red or green wing nav. light is more than 2 metres from the tip, an additional light of the same colour be fitted at the wing tip. So there is a precedent for lighting to show the physical extremities of the aircraft. Anybody else out there experienced the reported situation?*

\* \* \* \* \*

## BACKING UP

Operating a 737 out of XXXXX at nighttime. Three persons in cockpit - "Just Promoted" Captain was in the LHS for the first time ever - also in cockpit, a covering F/O for the Captain. Taxiing out to the holding point, in the dark, following another

737. (Believe this a/c was operated by some Nordic Airline.) This a/c ahead was given a conditional line-up clearance "after the next landing a/c line up ready for immediate departure".

The landing a/c landed and subject a/c commenced lining up, (obeying instructions) which involved a 90 degree turn. He pulled forward up to the runway line and commenced his 90 degree turn onto runway. (All the while reporter in a/c behind him at the holding point.) Then over the radio came a clearance from Tower which was "after departure maintain r/w heading until passing approx 4000ft.". Following this ATC said "stand by for release" (this is a non-standard phrase). The cleared a/c stopped - Capt (or whoever) must have been confused and he still had 45 degrees to go to complete the turn. He then opened REVERSE on his engine and commenced reversing towards us. FRANTIC transmit by us to Tower "a/c in front is reversing!" - subject a/c must have heard this transmit and stopped. There were further frantic calls, he then went quickly.

ATC gave us exactly the same line up clearance, using the same non-standard phraseology.

This same non-standard clearance was given on the next visit to the airfield and caused the same resultant hesitation.

*This problem has now been resolved by bringing the confusion to the attention of the controllers and having them use standard phraseology.*

\* \* \* \*

## **OVERLOOKED!**

Pushed back off stand, started engines and

did after start checks as normal.

We then asked for taxi clearance and proceeded to taxi to the runway, only to hear over the headset that the ground crew member was still attached! Just as he made his presence known, the tug driver went into full reverse and the vehicle was seen in front of us. We put the brakes on, and thankfully no damage or hurt was done!

So what went wrong? We made a mistake - both of us! More importantly how would it be avoided again? Several thoughts spring to mind. The most pertinent perhaps would be for all handling agents to be advised that after pushback and park brake is "set", for the tug to pull back far enough so that the driver can see the pilot CLEARLY. This would mean that WE can also see HIM and there would be less likelihood of US moving off with a tug in the way!!

I suggest that the tugs have a very noticeable flashing light on top of the cab so that it is easily seen at night as well.

\* \* \* \*

## **WHAT LOCK?**

I fly freight around the UK and Europe where long night duties are the norm.

The duty period in question consisted of two sectors followed by a split duty and then a final leg. As the weather at destination was forecast to be below limits the company decided to put us in a hotel for the split duty to have the flexibility of either calling us to continue the flight if the weather was good or allow us to have a minimum rest period, to continue the flight later in the day, and therefore not affect that night's operation. As it turned out the weather was good so we were called to continue the flight after

having had approximately four hours sleep, arriving at destination nearly three hours late, at 09:00. Pressure was put on us to reduce rest to ten hours at the hotel after a fourteen hour duty, no crew available to replace us we were told. Having considered that both the FO and I had had about four hours sleep we agreed that with some more sleep during the day we would feel well rested that evening. Neither of us had what could be called quality sleep during those ten hours, bits of sleep, here and there during the preceding two days had disrupted our pattern.

After selecting gear up on the first takeoff the nose gear would not come up. Drills were actioned but it remained down and locked. A while later I knew what had happened, I'd left the locks in.

Was this an oversight due to both of us being tired because of the lack of sleep? I did the preflight and removed three other locks, as well as answer "On Board" to the locks item on the checklist. You can't put your finger on it, but today it's a lock left in place, tomorrow? Something more ominous?

I believe this use of the split duty should be banned.

*That report probably sounds familiar to a number of our readers! The onset of fatigue almost invariably produces symptoms of disorganisation and peripheral administrative failures in use of charts and documentation. This is a typical example. These situations are not helped by a plea of "nobody else available" or the opportunity for a "bonus payment".*

\* \* \* \*

**TCAS** keep sending the reports for **FEEDBACK 36** - no space this time.....

## MORE CREEPING UP ON YOU

1. This is a Flight Time Limitations report.
2. The enclosures, A & B.
3. Normal max FDP for 3 sectors twelve and a half hours based on 0800 RPT.

Enclosure A is new addition to OPS manual. Scheduled turn-arounds at MEDITERRANEAN DESTINATIONS 50 min not realistic. In effect before the amendment the planned duty would have been in excess of the max allowed. Even with the extra hour we were still 20 min into discretion. At top of descent London gave me "descend at your discretion to FL240 to expect to be level at FL180; 35 miles west of Otringham". I simply did not assimilate this at first and had to have it read back. Pilot flying had missed part of xmission too. We were very tired. Days off prior to or after a duty period are immaterial if the actual FDP is too long. Is this creative rostering and will CAP371 be further breached? Enclosure B shows crew duty hours, which have been corrected by me. At both DESTINATIONS IN THE MED there was intense thunderstorm activity requiring avoidance.

*This airline subsequently went into liquidation.*

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## APU WITH FTL

The company operates intensive short-haul services, with some aircraft programmed for eight short sectors per day. This has recently been split 2/6 for the crew instead of 4/4 apparently to save mid-day positioning movements, so we report mid-morning and work for over 12 hours.

On my first such rostered day, having had

good pre-flight rest, we took off on sector 6 and as PNF I was pleased to find that I wasn't "half as tired as I thought I'd be" - and then proceeded to select "battery off" instead of APU. PF didn't notice (past monitoring?) until the a/c shouted at us with warnings and then we REALLY woke up!

Fortunately a relatively trivial mistake, but a lesson in the insidious nature of fatigue; by the time you've actually reached the stage of FEELING fatigued, it's PAST the time to stop flying!

\* \* \* \*

## ROLLING

Delayed reporting.

My Co uses the system to effectively put you on standby by using a "rolling delay".

A delay is given, usually accompanied by the words "call before leaving home". When doing so a further delay is then given, this can occur up to 2 or 3 times or 4 hours of delay is reached.

Planning food or sleep is not possible as the delay at any one time is 1 -> 1.5 hours.

Crewing's reaction at 22.30 local to "call me please I'm going to bed" before the 2nd delayed flight of the weekend was "No - we might forget". So to protect themselves they increase my fatigue level.

Total time on delayed report in the last 4 flights has been 8:40 - 1 day's work yet no credit for this appears in the duty time total. The additional figure certainly feels like an extra day.

\* \* \* \*

## ATC TOO TIRED TOO?

ATC early shift ends early afternoon so I put the following incident down to fatigue on the part of the controller.

At the hold for Main Rwy and the power checks completed; a turboprop on short finals and a lot of chatter on tower frequency. "Delta Charlie ready for departure." The turboprop has touched down for a full stop landing after circuit training; controller, "Delta Charlie line up Rwy (main)" a/c "Line up (main) Delta Charlie". The turboprop has passed the intersection, which links the main apron with the runway, where at an intersection holding point another propjet calls "ready for departure". The low winter sun shining through an industrial haze layer makes identification difficult. The turboprop just landed is turning to backtrack and vacate at the intersection. Controller tells the a/c calling for departure to enter and backtrack (main) which the a/c does with great rapidity to get out of the way of the aircraft now backtracking to the intersection.

Lined up between the numbers on the Main Rwy I realise that a mistake has been made and an aircraft is coming quite fast down the runway and a collision is imminent. A/c "Delta Charlie we can depart from intersection on Short Rwy". The controller wakes up "Delta Charlie clear takeoff (short)". The runway intersection is just ahead of me and I quickly cleared the Main Runway and departed on the Short Rwy.

It was not pleasant having an a/c bear down on one with such rapidity. I must stress that the crew of the backtracking a/c appeared to be unaware of our presence despite strobes and a landing light blazing away.

A combination of controller workload,

controller fatigue, backtracking a/c poor lookout and familiarity, probably having backtracked the same runway many many times without incident, lead to complacency and what could have been a nasty collision.

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## FINALS CALL

You made a remark that ATCOs are perhaps being made to "fit more aircraft in" [FEEDBACK 33, Page11] and I can unequivocally say that at my unit we ARE.

In order to achieve the movements NATS have agreed with the BAA the deactivation of the Separation Monitoring Function on final approach, published a joint NATS/BAA/IATA pamphlet encouraging pilots of landing aircraft to nominate and adhere to specific runway exit points and the turning of a "blind eye" where lateral separation is reduced to below two-and-a-half miles when sequencing aircraft onto the ILS (when the minimum vortex wake separation required is three miles).

If this is what it's like in a non commercial environment, heaven help us all when we become privatised.

*The NATS response is that there never has been a regulatory requirement for SMF and it was an addition made by them. The "pamphlet" asking pilots to consider nominating turn-off points was only ever part of the pilot education programme to promote existing best practice. There has always been the option to clear pilots to make their own separation, with the preceding aircraft in sight, on final approach.*

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## RAF RETURN FIRE

*Several reporters took up the cudgels on behalf of the RAF ATC and the text below says it all most succinctly:*

"CARELESS TALK COSTS LIVES"

Reference: Feedback No 34, Jan 95.

I would like to make the following comments on the points raised by the above article;

1. "Who departs IFR on QFE". All RAF aircraft arriving or departing a MATZ, IFR or VFR, operate on QFE.
2. "Taxy RW12 QFE XXX". At an RAF airfield this call means that the aircraft is clear to taxi and that the runway in use for this aircraft is RW12 which has a QFE of XXXX. It does not give the aircraft clearance to cross either an active runway or the main instrument runway for the airfield (if not in use by this aircraft).
3. "Check gear". Standard RAF R/T requires a pilot on finals to call "gear down". If he does not ATC are obliged to call "check gear". This is primarily an extra prompt to aid pilots in high workload single seat aircraft.
4. "What type of approach do you require". Pilots are asked this question as the ILS is not the standard first choice approach for all RAF aircraft. Not all RAF aircraft are equipped with ILS (eg Harrier) and so the PAR is usually permanently available. It is the pilot's responsibility to specify the type of approach required.

Whilst I might agree with the author's comment that "excess R/T is potentially dangerous" I feel that all the examples given show a lack of understanding of RAF

procedures rather than "excess R/T chatter".

Perhaps a timely reminder to operators that not understanding local procedures is potentially dangerous might be appropriate.

\* \* \* \*

## ¿QUE?

I recently overheard an exchange between London ATC and a VIVA flight which underlined the need to speak slowly and use standard phraseology.

The London controller speaking VERY fast "VIVA XXX, turn right 230 degrees climb level 260 good rate". Long pause, followed by incorrect read back of heading and flight level. ATC repeated clearance using the same wording - at the same rapid fire speed. Another long pause, but this time heading correct in read back. After a third exchange and a total elapsed time 50 seconds the Spanish pilot understood ATC instructions.

This was a classic case of two similar numbers being easy to confuse, with the addition of the non-standard phrase "Good Rate" which clearly meant nothing to the Spanish pilot. However his phrase book would have included "Expedite Climb".

*Easy to say; difficult to do!*

\* \* \* \*

## DON'T BANK ON IT!

*The current interest in unexplained bank applications and strange autothrottle behaviour lead us to print the following:*

.... levelling after climbing to about 20 grand only one throttle retarded in response to the autothrottle command. Of course at

that height there is plenty of surplus power so the throttle moved right back to idle in an attempt to hold the speed. The autopilot could not hold the attitude and we were about 30 degrees of bank before the crew grabbed it. I heard of one other case (levelling after descent and only one throttle opening) and fortunately both times were day VMC - night and a busy crew things could have developed. And just for a simple failure.

*and*

During a right turn as part of a departure with both autopilot and autothrottle engaged the autothrottle drove power lever 2 to idle whilst giving full power on engine No. 1. A/C rolled through 40 degrees before being manually corrected. Autothrottle disconnected and reinstated at altitude. Bite check revealed no recorded failure, system satisfactory!! Handling pilot reported having experienced something similar previously.

*When telephoned this latter reporter was surprised to be able to report a second incident of a similar nature, again no record on the BITE check. This time it was levelling off and decreasing speed after a descent. The autothrottle went from closed to No. 1 fully open and the aircraft rolled through about 40 degrees, ( a good job he did not have 30 degrees of bank on already).*

\* \* \* \*

## WHY NOT THEM TOO??

I was on duty with a U/T.

Although my U/T was cautious we had to file an APHAZ and were withdrawn from duty (suspended by any other name). However the pilot whose fault it was continued to land and to the best of our

knowledge flew at least 3 more sectors if not more. Why when it is considered appropriate for the controllers to be withdrawn doesn't the same rule apply to the pilots? They can get just as shaken up about this sort of incident as we do. Maybe the CAA should look into this or do they consider pilots to be less likely to be affected, if an incident/airmiss/APHAZ occurs.

*CAA advise that companies make their own arrangements under such circumstances!!*

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## QUOTE - UNQUOTE

"There is a continuing need for a confidential reporting system independent of the CAA and airline management"

*GAPAN review, Sept '94*

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*Caveat on Statistical Use of Aviation Safety Reporting System Information, from Battelle, March'95*

"All ASRS reports are voluntarily submitted, and thus cannot be considered a measured random sample of the full population of like events. ...Moreover, not all pilots, controllers, air carriers, or other participants in the aviation system, are equally aware of the ASRS or equally willing to report to us. Thus, the data reflect **reporting biases**. These biases... ... distort ASRS statistics.

Only one thing can be known for sure from ASRS statistics - they represent the **lower measure** of the true number of events which are occurring. Because of these statistical limitations the **real power** of ASRS lies in the **report narratives**. Here pilots, controllers, and others, tell us about aviation safety incidents and situations in detail. They explain what happened, and more importantly, **why** it happened. **Using report narratives effectively requires an extra measure of study, the knowledge derived is well worth the added effort.**"

*CHIRP concurs!*

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"EUCARE ... development, as a German system, began in 1992 with the design objectives established by

ASRS and CHIRP"

*EUCARE draft final report, Jan '95*

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" .... your experiences in incident reporting would be of inestimable value .... for the synthesis of a sound conception for a maritime incident reporting system"  
*Maritime Studies, Wismar Polytechnic, in preparation for a 4th Framework bid.*

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I shall be retiring at the end of this month and would like to wish you continued success in the development of FEEDBACK. It has an important role to play in maintaining and improving aviation safety and I wish you success in maintaining the high standards of reporting and comment which have been set in the past.

Tom Murphy CBE, Managing Director, CAA.

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The report on the future of CHIRP prepared by the Master and Immediate Past Master of the Guild of Air Pilots and Air Navigators was given to the CHIRP Liaison Group on 13 November 1994. The Chairman was the Chairman of the Liaison Group and the Members were the Chief Inspector, Air Accident Investigation Branch, the Master and I.P.M. of GAPAN, and nominees of BALPA, the CAA, and FODs. Essentially it was widely accepted that CHIRP should continue, and the CAA with the support of the air carriers agreed to finance the programme through the charging scheme as long as it was correctly focused and costs contained.

The Working Group met on several occasions, and concluded that an appointment of a Director was the key to the future success of CHIRP. The Director must be widely respected in the world of aviation and acceptable to all interests concerned with flight safety. The Director CHIRP must be well supported in his work, and the way in which this will be met is being pursued. This could be a government agency, a university department or a professional society, and several prestigious organisations are known to be interested in providing the infrastructure.

The recommendations of the Working Group were endorsed by the CHIRP Liaison Group at their meeting on 14th March 1995. An advertisement for Director CHIRP will appear shortly, and then the organisation will be set up.

Air Commodore Tony Nicholson,  
Commandant RAF School of Aviation Medicine  
Chairman, CHIRP Liaison Group