

FEEDBACK

Issue No: 71

Summer 2004

EDITORIAL

CHIRP SURVEY

First, our thanks to those of you who took the time to return the CHIRP Survey forms which were distributed with the last issue of FEEDBACK. It is pleasing to record that the vast majority of the responses received to date have been positive. Your responses and your detailed comments were an important element in the information presented to the Independent Review Board which met in the last week of July to conduct a Five-Year Review of the Programme. All of the comments received were made available to the Board, which is currently considering its recommendations.

We plan to publish a summary of the survey results, together with the Review Board findings and recommendations in the next issue of FEEDBACK, however, in the meantime, I would like to clarify several points arising from the survey responses/comments.

A significant number of respondents have requested more follow-up information on the reports published in FEEDBACK. In cases where we are able to give details of any action taken, without placing the identity of the reporter at risk, we do publish what action has been taken in response to a particular report. However, it is important to realise that when representing a reporter's concern, where it is possible for the matter to be reviewed and/or addressed without using the detailed information in the report, we specify only the general area of concern to the organisation. If subsequently we publish the report with a detailed summary of the action taken, there is often an increased risk that the incident/reporter might be identifiable. As a reminder, we always seek the consent of the reporter before releasing information to a third party, and we always advise a reporter of the action that we have taken when closing a report. As we don't retain reporters' details, we are not able to contact a reporter subsequently to establish whether there has been an improvement, where this is relevant. If you have reported an incident and you have noticed changes as a result of your report, please let

us know and we will publish a follow-up. Notwithstanding these points, we will endeavour to provide you with this information whenever possible.

A second point raised by a number of respondents is CHIRP's ability to effect change. The fact is that we have no regulatory or executive authority, nor would it be appropriate, but act as a conduit to pass safety related information received from reporters, that often would not otherwise be available, to the relevant agency to permit the matter to be assessed and, when it is deemed to be appropriate, to be acted upon. I am conscious that some areas of concern seemingly continue to be reported, without any change being apparent; FTLs is often quoted as such an example. However, it is worth reflecting that reports submitted over several years relating to the definition of a 'week' in calculating cumulative duty hours, use of the hotel alleviation to extend a sequence of early starts, the effects of a mix of early/late FDPs within a roster sequence, and a lack of awareness of flight crew members to additional FTL related guidance contained in Notices to AOC Holders have contributed to some action being taken. In 2000 CAA (SRG) commenced a consultation process that has eventually led to the publication of CAP 371 Edition 4, a copy of which is now available on the CAA website. The deadline for implementing these changes (1 April 2006) to permit operators, where necessary, to adjust their schedules, is disappointing to many of us who have represented these concerns over more than six years. Will these changes address all of the FTL issues? The simple answer is no, and we will continue to highlight to CAA (SRG) examples where problems continue to be reported.

Two final points, although we seek reporters' consent to publish their contribution, cost constraints permit us to publish only a selection of the reports that we receive, therefore if we don't subsequently publish your report this is the reason; all reports, after disidentification, are retained on our database. Also, you will always receive a response from CHIRP to a report you submit. If you hear nothing from us please don't assume we have ignored your report - we just haven't received it!

Peter Tait – Director

An Air Transport Safety Newsletter

from the Confidential Human Factors Incident Reporting Programme

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If you receive FEEDBACK as a licensed pilot/ATCO/maintenance engineer you will need to notify the department that issues your licence of your change of address and not CHIRP, please write to (including your licence number) to Personnel Licensing, CAA (SRG), Aviation House, Gatwick Airport South, West Sussex RH6 0YR:

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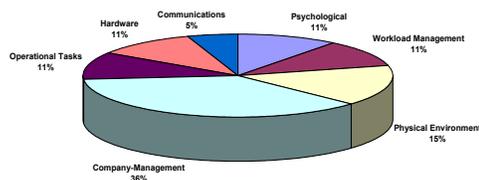
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ATC REPORTS

ATC Reports received in Period: 7

Key Areas:



APPROVED TO TOW?

Recently the Airport Authority has adopted the Airport Operators Association guidelines and official CAA policy regarding the requirement for drivers of all vehicles on the aprons and manoeuvring area, to undergo a specific training course (provided by the Airport Authority). Subsequently, an AOA driving permit for apron or manoeuvring area - or both - is issued to individuals who successfully pass the course.

The facilities of an aircraft maintenance and engineering organisation are located such that they are required to tow aircraft (anything up to large twinjets) across instrument and visual runways.

One ground running area is on the threshold of a runway, and often after ground runs, there is a requirement to tow back to the parking area.

Initially the Airport Authority insisted that any towing on the manoeuvring area had to be escorted by a qualified member of the airport staff, but after pressure from ### (the engineering organisation), they relented, and devised a scheme whereby ### could tow unescorted to some parts of the airfield, but not others.

We now have a situation where ### are allowed to tow large aircraft unescorted across an instrument runway, but they must have an escort to cross a non-instrument runway.

In my opinion, the engineers are either qualified to tow on the manoeuvring area or they are not, and it is not my job to query their qualifications, but the Airport Authority considers otherwise.

The situation as it stands, leads to a lot of unnecessary work for us, and the ATSAs, especially when we are busy executing our primary ATC tasks, but moreover, I am concerned that there is a significant possibility of an unintentional runway incursion because of unqualified staff towing aircraft.

The reporter's concerns about towing were raised with the engineering organisation. The company confirmed that all the drivers engaged in towing and other driving activities on the airfield would undergo the approved course and, on passing, would be awarded the new certificate of competency. All drivers held an appropriate certificate of competency issued prior to the introduction of the AOA guidelines.

WEATHER AVOIDANCE

The incidence of weather avoidance appears to be on the increase and this is highlighting a concern that many of us working in the London TMA have started to see.

The "problem" is occurring AFTER aircraft are clear of weather. Many flight crews are now taking it as their right to return to whatever heading or navigation route they were on before they requested a turn for weather avoidance. Quite often this occurs without telling ATC of the change of course.

It is the considered view of the controller that any heading given for weather avoidance is a radar heading i.e. an instruction to turn.

In many cases there are two or more aircraft in close proximity turning towards the same piece of "blue" sky, hence any unexpected turn by an aircraft could have serious separation consequences.

I wonder whether the higher authorities should clarify this to the flying community - weather avoidance is an extreme situation for BOTH ATC and crew and uncertainty like this needs to be removed.

There appears to be no 'best practice' guidance to either pilots or ATCOs for the communication of weather avoidance manoeuvres and, given the multiplicity of circumstances faced by flight crews when in the vicinity of adverse weather, simple guidelines might not be possible.

Notwithstanding this, the matter has been referred to CAA (SRG) for consideration, as the reporter suggests.

In the absence of formal advice, the following might be of assistance in addressing the reporter's concern.

- 1. Pilots to notify ATC as early as possible of the need to turn and to request a heading, rather than "Request turn left/right twenty degrees" to assist the ATCO's tactical planning.*
- 2. ATCOs to consider including the phrase "Report when clear" when issuing the subsequent clearance to change heading.*
- 3. Pilots to report "Clear" and maintain heading until further cleared by ATC.*

AN UNNECESSARY DISTRACTION

Anticipating a traumatic day due to a planned changeover of support equipment during our shift. Visual Control Room very messy with extra and unfamiliar "electronic equipment" all over the limited workspace.

Carried out the normal quick handover on taking over the aerodrome controller position but my mind was on the perceived chaos to come later on when the new equipment was made live. I was concerned that the event had been planned to take place during the day, on a potentially busy week day, with no restrictions on the traffic being allowed to operate whilst we ATCOs tried to cope with an untried and unfamiliar system which would instantly replace the old kit. The manufacturer later admitted that they had never done a daytime changeover anywhere before.

Despite being told there was a jet aircraft backtracking the westerly runway for departure into the circuit, I had not appreciated that my colleague had actually cleared it for take-off prior to my taking over. A light aircraft then reported ready so I looked out at the runway, saw no traffic on it due to the tails of parked aircraft obstructing the view of the runway threshold, missed the contact on the Surface Monitoring Radar due to bright sunlight on the display, and cleared the light aircraft to cross immediate, believing the jet to be still backtracking. Fortunately, my colleague was still in the VCR and shouted a warning to me. I was able to stop the light aircraft just past the stop bar on the taxiway, and confirm that the jet was clear for take off when he immediately queried it, having commenced his take-off roll.

A near runway incursion with potentially disastrous consequences for which I am still not very proud and still recovering from the shock of what might have happened due to my inattention.

The situation described in this report is one that a Safety Management System (SMS) is designed to identify in advance and to specify rules/mitigating procedures to avoid a situation such as that reported.

Similarly, an SMS should specify 'best practice' for conducting handovers between ATCOs; this should include a full handover briefing in non-normal circumstances to protect against an oversight such as that which occurred.

ATC COMMENTS

MORE ON FREQUENCY CONGESTION

With reference to the letter about "Frequency Congestion" in Issue 69 as I am a little perturbed about the first paragraph of your response. I believe that the TMA sector being talked about is "####". Well in March

2003 NATS decided to take away the "Southwest Departures" position which could be used to split the "###" sector when busy.

Therefore if it had not been taken away, the sector could have been split in mid-July when this report occurred and maybe there would have been no frequency problems. I know NATS are bringing "SW Deps" back in July 2004 but it should never have been taken away in the first place. The first paragraph of your response in my opinion implies that NATS have responded to a busy and awkward sector and devised a split. The truth is they already had one!!

It would be nice to think the pilot in question could be told this but I am not holding my breath.

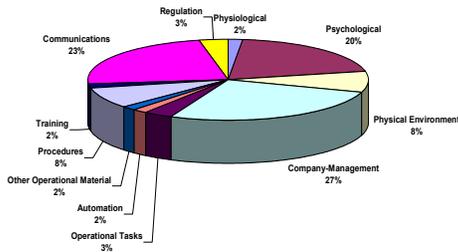
This comment correctly identified the Sector in the original report and the matter was raised again with NATS. The reason for withdrawing the position had been that the procedure had been used so infrequently that it would have been necessary to schedule simulator time to ensure that controllers remained current in the procedure.

With the benefit of hindsight retaining the capability would seem to have been a better option.

FLIGHT CREW REPORTS

Flight Crew Reports received in Period: 41

Key Areas:



FREQUENCY CONGESTION

On the above flight, we experienced considerable difficulty 'getting a word in edgeways' when checking in with Daventry Sector frequency ###.#.

During the times stated the ATC controller coped magnificently with what was obviously 100% workload. The frequency was continuously occupied with transmissions which resulted in several missed calls/instructions, thereby increasing the controller workload.

In my experience, this type of situation is becoming more common in the UK, probably as a result of structural under-resourcing. (LHR ground frequency is

another good example). It seems that certain sectors/frequencies that should be 'split' are being left to become overloaded. Thirty three years of aviation experience worldwide have impressed upon me that there are, without doubt, no better ATC controllers anywhere in the world than in the UK. It seems, however, that the current obsession with 'the bottom line' is leaving them under-resourced and unsupported.

In spite of anecdotal evidence that suggests that frequency congestion is an increasing problem, NATS advises that the number of actual overload reports submitted has decreased significantly in 2004. NATS also commented that frequency congestion does not necessarily relate directly to a controller's workload.

Consequently, from a pilot's perspective, if you experience difficulties such as that detailed above, it is strongly recommended that you file an MOR to permit the matter to be investigated.

RUNWAY CHANGES

(1)

Destination was LBG, Runway 27 briefed and Nav systems set up. As the descent was initiated from FL 380 the ATIS began to come in giving RW 07.

The next 17,000 feet of the descent both pilots spent reprogramming the GPS and looking for the new charts, I monitored the descent and initiated the height calls. Fortunately we had a third Captain on the Flight Deck who found the new approach plates and updated the PIC as to our whereabouts. Another complication was that the ATC transmissions were not clear and the approach instructions/STAR code had to be repeated twice, thus causing further delay. The Flight Deck crew and ATC were four different nationalities (and languages)

With hindsight if we had asked Paris ATC on first contact "which runway can we expect at LBG?" we would have not fallen into the trap, perhaps?

Subsequently we all felt we could have done better, as the PIC said later, "one big hole in the cheese".

(2)

FRA was using R07L and R07R for landing. R07L ILS was U/S, so a VOR/DME approach. R07R was ILS. We were on a radar heading from Redli still with no idea of which runway we were landing on. The procedures for these approaches are very different from a pilot's point of view and require different briefs and radio aid set-ups. We had planned for ILS R07R as we normally land furthest from the terminal while R07L also used for

departing traffic. One mile from the centreline we were given a heading for interception of R07L. We had been kept high and fast and had trouble achieving a stable approach.

I don't know why FRA allocate runways so late, but they seem unaware that it takes more than a couple of seconds to set ourselves up. Also they seem unaware that non-precision approaches take more planning and are difficult (and can be dangerous) to recover from getting high.

I went back yesterday and was only informed of landing runway when turning base for R25. Less of a problem as VFR, both ILSs were working and we hadn't been kept high, but it would have been nice to know earlier!!

Late notification/change of the runway in use for landing has been recognised by pilots as being a particular problem for many years at some European airports. In the case reported, a late change from a precision approach to a non-precision approach can have safety implications. We would be interested in other similar experiences to those reported above.

The first reporter's suggestion to request the runway-in-use on first contact is worth considering, if only to highlight to ATC the unreliability of the ATIS information.

NON-PRECISION APPROACHES

I regret not writing in on the first occasion that this incident occurred.

Incident One:

Many months ago, the ILS to the Northeasterly runway at AAA (Major UK airport) was functioning without a glidepath. This was a long-term problem and NOTAMed, but most approaches are flown to the Southwesterly runway.

On the flight in question there was a low cloud base (Bkn 600'ish) for a localizer only approach to the Northeasterly runway. AAA controllers never set you up at the platform height (the height prior to commencing the final approach descent published in the approach procedure) for any approach on to this runway; they always put you below the published profile.

Not to worry, when carrying out an ILS you just intercept the glidepath and down you go. But for a localizer only approach the pilots must initiate the descent at the correct distance for the height and check at regular intervals to confirm that they are maintaining the correct glidepath. We set up for the approach, commenced descent at the "correct" distance and at the first check of altitude versus range we found that we were below the 'glidepath'. The warm fuzzy feeling is replaced

by the "what has gone wrong" feeling. Was the altimeter mis-set? Had we, the pilots, made an error? The radar altimeter confirmed that we were clear of the terrain. Had the cloud base been near minima I would have ordered a go around but just as we levelled off we saw the ground and continued the approach to land. We had commenced descent at the published DME but from the wrong platform height.

Last night, we landed at BBB after a flight from CCC. The METAR was 16020G30 8000 Few 800 Bkn 1800 - RN. CCC was operating on the Easterly Rwy with the glidepath switched off, presumably because the flight checker had found a problem earlier in the day. The approach was commenced in cloud, it was dark. The approach was flown with a strong crosswind, severe turbulence from the wind passing over the cliffs to the south and the windscreen wipers operating. The approach was nearly abandoned because of the severe turbulence at low level. In addition to all this, we needed to calculate the point required to commence our descent because we were radar directed on to the final approach and descended below the platform altitude by ATC. Fortunately we had our wits about us and had foreseen the problem, but we could have done without this extra workload.

I would like it if controllers could stick to the published heights or the published procedures are changed to what reflect what happens in practice.

ATCOs are probably aware that in the case of an ILS approach, flight crews can generally accept a different height above aerodrome elevation to intercept the ILS glide path from that published. However, for a non-precision approach, and for the reasons cited above, it is preferable that flight crews are not given the last-minute task of recalculating the point for intercepting the notional glide path based on a lower altitude than that published. Any error resulting from this additional workload at a busy stage of flight could result in the aircraft failing to achieve/maintain the notional glide path, leading to an unstable approach or unanticipated proximity with terrain

From a flight crew perspective, if you are instructed to descend to an altitude below that published for initiating the final descent for a straight-in non-precision approach, and you would prefer to commence descent at the published height, you should request permission to do so.

COMMERCIAL RIVALRY

Our aircraft pushed back simultaneously with a competitor airline's aircraft, both inbound to ### (A UK Regional Airport). ABC123 called for taxi (to ensure that they took off before us) whilst the ground engineer

was in front of the nosewheel, in the nosegear bay, removing the undercarriage pin. Fortunately, taxi clearance was not issued until the engineer was clear of the aircraft.

ABC123 pulled onto stand 2 minutes ahead of us, both sets of pax disembarked simultaneously and both crews caught the same bus to the car park. The ground engineer's life was compromised, and for what?

SOPs exist to safeguard the aircraft, its crew and passengers, and other persons, vehicles etc. When a Captain starts to flaunt SOPs, especially when he is in a rush, in-built safety measures designed to minimise danger start to be eroded, increasing the inherent risk to life. If a Captain is prepared to flaunt one SOP does it not follow that he is likely to flaunt other SOPs thus further reducing safety margins?

The crew in this incident were flaunting SOPs and they were rushing, a recipe for disaster. I am not aware of any management pressure at ### on Captains that may have had influenced this particular Captain to act as he did on that day. I know for a fact that management pressure of this sort does not exist in my airline. I believe that a cockpit culture of dangerous rivalry is developing. A minority of Captains are to blame and need to be more disciplined and professional before serious harm is done. I wonder how many other airlines suffer from this?

I have been told of crews from the same company disobeying conditional push-back clearances, ie not pushing as far as ATC have instructed them to, so blocking in other operator's aircraft also fully ready for push back. When challenged by ATC as to why they had not obeyed the clearance, they simply laughed over the RT.

We are supposed to be mature, disciplined and professional as flight deck crew. Let us all behave accordingly and help each other, whoever we work for, before it's too late.

Fortunately, practices such as those described in this report are rare but are typical of the commercial rivalry that can develop between some pilots/operators.

However, the effects of what are perceived by the recipients to be unprofessional or unfair practices can last for the rest of a Duty Period and thus be quite detrimental to flight safety.

Worth thinking about the next time you try to sneak in front of 'the opposition'?

NO SUBSTITUTE FOR VIGILANCE

On the UB600 from ABJ to ROB climbing through FL120 for our cleared level of FL310 and estimating BUSOT at 1428. ABJ comes on air to warn of an

aircraft (a Yak 40, callsign ###) estimating BUSOT at 1425 at FL230, not yet in contact with Abidjan 121.1.

We immediately call the traffic on 126.9 and get no response and since ABJ not in contact we decide to level off at FL220. ABJ releases us for FL220. We maintain FL220 constantly calling the Yak on 126.9 with no response. We also keep a vigilant watch for a TCAS response and the supernumerary pilot looks outside to try and see.

At BUSOT we call position and later hear the Yak calling ABJ. After a check on the DME distances by ABJ we are given clearance to climb to FL310.

My concerns:

- a) No monitoring on 126.9 by Yak.
- b) No show on TCAS. So at best he was not on the UB600 or at worst was and didn't have a working transponder.

Given the number of near misses, more vigilance on people's position by ABJ is required and also more checks for a working transponder and standard IATA broadcast techniques.

The reporter's vigilance was fully justified by this incident, and is worthy of consideration if you operate in this area.

FREQUENCY CONFUSION

There has been a recent discussion in your pages about confusion of radio frequencies allocated. This occurs much more frequently in Europe than in North America, because correct R/T convention requires you to say the full frequency number e.g 132.15MHz becomes "One Three Two Decimal One Five". It is quite easy to mishear this as perhaps 133.15 or 132.25 and hence end up talking to the wrong agency.

In the USA and Canada this frequency will usually be passed as "Thirty Two Fifteen". Now there is no confusion as to the frequency. In the age of not only trying to reduce mistakes but also the length of R/T transmissions, is there really a need to include the "ONE" at the beginning. After all, we don't say VHF at the end as this would be more correct.

Just because it's always been done that way doesn't make it correct!

As mentioned previously NATS in conjunction with CAA (SRG) is investigating ways of reducing RTF congestion, two of the principal causes of which are mishearing/incorrect readbacks of ATC instructions.

The reporter's suggestion was passed to NATS and was evaluated as part of this initiative. Unfortunately, the US phraseology is not fool-proof, "Thirty Two Fifteen"

vs "Thirty Two Fifty" for example, and this phraseology will not easily accommodate the addition of 8.33kHz spaced frequencies as they are introduced in the UK. Moreover, as with the proposal to drop the first digit 'one' from RTF instructions, the suggestion does not comply with the current ICAO Standards and Recommended Practices.

The discovery of a 'silver bullet' solution to this problem appears to be unlikely, however, informal studies suggest that a very significant proportion of RTF messages are either incorrect or incomplete. Improved adherence to the recommended phraseology/readback requirements might bring about a measurable improvement.

When was the last time that you reviewed your RTF phraseology in relation to CAP 413 - The Radiotelephony Manual?

FLIGHT CREW COMMENTS

MORE ON FREQUENCY CONFUSION FC2975

Subject: Issue 69; Frequency confusion

When the "new" complex frequencies were introduced a few years ago, some were to be prefixed with the word "Channel" to prevent such confusion. The word never really caught on, except for a few ATC Units (notably over France - would you believe!). Perhaps now is the time to "re-introduce" the prefix "Channel" before all frequencies that potentially cause problems ie 129.22.

Although NATS is not yet using 8.33 kHz frequencies in UK airspace, several other European ATC providers, notably France do and thus an instruction to change to an 8.33 kHz frequency is issued occasionally.

Currently, NATS does not mandate the use of the term 'Channel'; but as these frequencies become used more frequently in the UK FIR, the use of the term 'Channel' will be considered in relation to the ICAO guidelines.

MORE ON OFFSETS (FB69)

In FEEDBACK Issue 69 (Page6), we summarised the current ICAO guidelines on the use of lateral offsets, which currently precludes their use in parallel route systems, when the route spacing is less than 50nm. Also use of an offset (always to the right of the centreline relative to the direction of flight) must be approved by the appropriate ATS Authority.

Subsequently, we received the following comment:

I would urge the ICAO Separation and Airspace Safety Panel to approve 1nm offsets in all airspace where RNP > 1nm.

It is a positive, simple and effective contribution to safety. With my ANP in the order of my wingspan and no precision ground radar it seems madness for any party to sit on the fence. Modern Flight Management Computers warn if ANP > RNP so they could be programmed to warn if, for example,

ANP + OFFSET > RNP/4 by a "reduce offset" command

And so allow a practical solution.

ANP = Actual Navigation Performance

RNP = Required Navigation Performance

There is anecdotal evidence that some pilots are already applying lateral offsets in some geographical locations, where there is perceived to be a risk in maintaining the centre line.

The risks of the ad hoc use of lateral offsets are obvious; as the reporter suggests, given the accuracy of modern navigation systems, the development of more widely applicable formal guidelines for the use of lateral offsets should be considered as a matter of urgency.

The matter has been represented to ICAO.

REPORTING TIMES (FB69&70)

(1)

I was very disappointed with your response to "Reporting Times - Legal or Professional?" (FB69). Especially the particular words: "...and, on particular occasions, it might be preferable to report a little earlier than the scheduled report time to avoid rushing"!!!

A Report Time is a Report Time. If it is inadequate 'on particular occasions' then the only option left 'to avoid rushing' is for the flight to depart late. Full Stop!! To sanction bad rostering in the way that you have done will have all unscrupulous airlines jumping to their copies of 'Chirp' and saying that "see, it says.....

(2)

Ref page 5 FB70, the boxed item following the piece REPORT TIMES - LEGAL OR PROFESSIONAL? I notice that 'report times are based on the average time needed to complete the necessary pre-flight duties...' An average implies that on some occasions more time is required and on other occasions less time is needed.

Do any of the FEEDBACK readers have experience of less time being adequate?

The CAA could be advised of the answer to this question.

(3)

It does trouble me to feel that I need to write regarding comments by the CAA (SRG) in FEEDBACK No. 70 - you have comments from them including the words:

"Where a pilot, because of his professional attitude to his position, decides to report to work earlier than the stated report time ... "

This choice of words by the CAA is very unfortunate because, using simple logic, it implies that a pilot who does not 'report to work earlier than the stated report time' does not have a 'professional attitude to his position'! I am not the only one who sees it this way as colleagues of mine have interpreted it in exactly the same way.

We have probably the absolute minimum report time: 40 minutes before departure. Because of the way that our company has matters arranged it is quite easy for an average crew to report at exactly the report time, complete all necessary tasks, have about five minutes of relaxed 'gossip' time and still go 'off chocks' ahead of STD.

I know that in other airlines there are managers who will pounce on crews for not being in significantly before report times. The CAA's comments in FEEDBACK will be taken by them as vindication of their 'bully boy' tactics, which will naturally be counter-productive for airline safety.

A 'professional attitude' to the position of an airline pilot will be to ensure the safety of his passengers and crew by avoiding fatigue. The best way to ensure this will be to avoid 'busting' the limits set down by the very well researched UK FTLs. The UK has world leading standards here and nothing should be done or said by people in regulatory authority that could be used by anyone to chip away at these standards!

The above comments reflect the vast majority received on this topic.

In my role as editor of FEEDBACK, I apologise for permitting the third-party comment to be published in the last issue without correction/further clarification. With the benefit of hindsight, it is clear that the wording of the last paragraph of the CAA (SRG) comment, albeit as submitted, did not reflect accurately the Authority's position or those of the Advisory Board, which reviews each issue of FEEDBACK before publication.

The Advisory Board reviewed the comments received and concluded that additional clarification should be

published. Subsequently, CAA (SRG) provided the following additional statement on the issue of report times:

The (CAA (SRG)) comment published in the last FEEDBACK was certainly not intended to imply that those pilots who do not report for a duty earlier than the stated report time are unprofessional. The significant sentence in the response was that it is not considered acceptable for operators to put pressure on crews to report early unless the additional time is counted towards the FDP. It should be remembered, however, that the report time is an average time and it is perfectly reasonable, if crew members wish to do so, to report early to enable pre-flight preparation to be completed in slower time.

RULE 5 AND SVFR CLEARANCES (FB70)

(1)

It is perhaps worth reminding pilots that a large park or recreation field within an otherwise built up area is not (legally) suitable for a forced landing as such an area comes itself within the definition of a congested area - see the Air Navigation Order.

Thus it would be no defence to say that you "hopped" from being within gliding distance of one park to another park on your way across the city!

(2)

"Rule 5 and SVFR clearances". What about helicopters?

The inclusion of the words "fixed wing aircraft" at the beginning of the reply implies, incorrectly, that the rule is different for rotary wing. Whilst the rule is written slightly differently for helicopters, the tenet is the same, i.e. you must be able to alight clear if the engine stops, but this is not brought out in the reply.

Both comments are correct, except that the requirement for a helicopter is to be able to "alight without danger to persons or property on the surface"

TAKE-OFF MINIMA (FB 69)

You published an item in FB 69 on the absurd mismatch between aerodrome operating minima (AOM) of the crew/operator and the rules for licensing of Aerodromes. For many years I have been involved in discussions on All Weather Operations with the CAA, ICAO, JAA, ECAC et al. One recurring theme is the mismatch between Aerodrome Standards and (Flight) Operational Standards. The Aerodrome Standards departments of

many authorities (the UK is not alone in this) are evidently quite capable of reading Annex 14 and translating it into national rules. For some odd reason, none of them seem to have read (or maybe understood) the opening of this august work of reference. I am delighted to be able to help them.

From Chapter 1, Page 1, 'Verse 1':

Introductory Note.- This Annex contains Standards and Recommended Practices (specifications) that prescribe the physical characteristics and obstacle limitation surfaces to be provided for at aerodromes, and certain facilities and technical services normally provided at an aerodrome. It is not intended that these specifications limit or regulate the operation of an aircraft.

The last sentence says it all.

CAA (SRG) Aerodrome Standards Department has been invited to comment on the reporter's observations.

CABIN CREW REPORT

This report was published in the most recent issue of CABIN CREW FEEDBACK and, as the matter has flight deck implications, it is reproduced here for information.

TURBULENCE ENCOUNTERS

After take-off, the cabin crew were released by flight crew to commence duties and to start setting up the cabin service. Passengers were seated with seat belt signs on

As turbulence was becoming increasingly more serious, In Charge advised the crew and helped to secure the galleys (only unsecured area) as passenger seatbelt signs were still illuminated.

The aircraft dropped unexpectedly resulting in the cabin crew being thrown to the ceiling and subsequently on to the floor, seatbacks or passengers depending on cabin crew location in the cabin. I managed to secure myself in the crew seat though I felt dizzy and gasping for air.

Cabin crew checked themselves first and then passengers. Passengers were concerned about the structural soundness of the plane. A cabin report was passed to flight deck by In Charge. Cabin crew dealt with pax, calmed and reassured others.

The ongoing severe turbulence lasted 10 minutes.

At the debrief after the flight I asked the flight crew why we were not told to get strapped in and pilot replied that he was too busy keeping the aircraft under control.

Comments about what I learnt about this experience:

When In Charge advised crew to suspend cabin service duties because of turbulence becoming severe, cabin crew engaged themselves in securing the aircraft leaving

them little time to look to their own safety and security. Moreover, the operations manual does not state anything about how quickly turbulence can become severe or about the aircraft dropping in altitude following severe turbulence.

As a suggestion, a code of best practice should be drafted in this case scenario and maybe in the case of other related adverse weather conditions.

Since, in spite of all of the aids/information available to flight crews, unforeseen encounters with moderate/severe turbulence can and do occur, even in clear air, it would be hard to draft a code of best practice taking such extremes into account, as the reporter suggests. Fortunately, occurrences such as that described above are relatively rare.

The Cabin Crew Advisory Board reviewed this report and noted that there are occasions when the effects of turbulence are more pronounced at the rear of the aircraft than at the front and thus the flight crew might be unaware of it.

In such a situation, the Board recommended that the In Charge cabin crew member should assess the level of turbulence being experienced in the cabin and when necessary, inform the flight crew and request the fasten seat belt signs to be switched on, if they are not already illuminated. If the level of turbulence warrants it, the In Charge should discontinue non-safety related duties; the passenger cabin and other applicable areas should then be secured.

Having released the cabin crew, notwithstanding the nature of the encounter and the subsequent high flight crew workload, a quick call from the flight deck as the turbulence increased, instructing the cabin crew to strap-in, would have been helpful.

ENGINEERING EDITORIAL

The lead Editorial refers to the CHIRP Survey forms recently distributed. Thank you to all who have submitted Engineer responses - those who still have it in mind to comment please do so, the Survey has not yet closed.

As has already been said, we will publish the results of the Survey in the next issue of FEEDBACK; however, it is worth making some preliminary remarks from comments already received.

Firstly, there have been requests for more Engineering reports to be published; this is really in your hands. Although we do not publish all the reports we receive, some are too sensitive, others raise the same points as those selected for publication, it is still a fact that Engineers submit fewer reports than, say, pilots, particularly in relation to mistakes/errors/near misses.

We can only print reports from those received, so if you believe you have something worth reporting please do not hesitate to do so.

Reflecting pilot reports to an extent, one of the more frequently reported topics concerns fatigue, excessive working hours, manning and shift patterns. These issues have been consistently reported since the start of the Engineering programme. An Industry-sponsored Safety Management Systems Working Group has done some work on drafting an 'Engineers Working Hours' guidance document. CHIRP has been involved in this work. As and when this work comes to fruition, we will summarise the results in FEEDBACK.

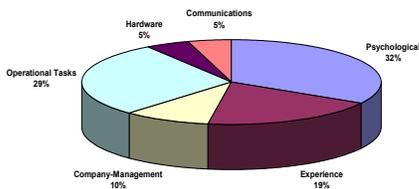
Security is an ever-present fact of life both at work and in our private lives these days. In this issue of FEEDBACK we publish two comments about the visibility of airside passes, together with the DfT's response. However irksome it may be, we all have to do our bit and help to keep ourselves, our colleagues and above all our customers, the passengers, safe and secure. Please observe the need to display your passes and obviously take precautions to secure the passes and holders from becoming yet more FOD items: Engineers are known for their ingenuity, see what you can do on this one!

David Johnson - Deputy Director (Engineering)

ENGINEERING REPORTS

Engineering Reports received in Period: 6

Key Areas:



A STICKY PROBLEM (E288)

On attempting to remove all of the emergency egress windows, they were found immovable. At least two broke, such was the force required to move them.

They had all been sealed in with silicone sealant, rather than with silicone grease. I thought it best that I reported (this incident) so that emergency exits on this aircraft (twin piston-engined, unpressurised) and many other similar aeroplanes types are not compromised.

*This is not the first reported incident of using silicone sealant instead of silicone grease.
A real HF 'gotcha'!*

TESTS - INTEGRITY & AIR

I am a licensed engineer working under contract abroad and was involved in planning a maintenance input to a particular aircraft, one of the work orders (WO) for which related to a problem with a flight control system.

After the aircraft had been in the hangar for a couple of days, one of the licensed mechanics working on it informed me that he felt the aircraft should have a test flight before being released to service. I agreed with him and arranged to open a test flight WO.

On later checking the ops computer I was horrified to find the aircraft was planned to fly in a revenue service the following morning. Assuming there had been an error in communications I called ops and was told that "No, the aircraft does not need a test flight, a tech pilot will fly with it on the revenue flight in the morning".

I immediately called the manager of the planning dept and informed him that I strongly believed the aircraft should be test flown before going into service. His response was that it was an Engineering decision and therefore none of my concern. I told him that I had requested the test flight and therefore was involved, but he insisted the matter was "none of your business".

Next I called a more senior manager, explained the situation and asked him to intervene. His response was much the same as the planning manager's.

There followed a series of conversations between various individuals, including myself, with the managers attempting to get the WO withdrawn. To no avail, no one would do so without written authority. I also informed the senior manager that if they went ahead and released the aircraft without a test flight I would leave the company immediately.

Thankfully, the chief pilot was informed about the situation, and decided that the aircraft should indeed undergo a test flight. I do not know who called him. The test flight eventually took place the following afternoon. The feedback received indicated that the control system was still unacceptable and needed further work and another test flight.

This incident is by far the most serious I have ever experienced in that in my opinion, management wilfully tried to endanger an aircraft and it's occupants due to commercial pressure and for economic reasons.

I strongly urge all qualified engineering staff, when working in a new and unfamiliar environment to acquaint themselves with the local authorities and practises before commencing employment, and in any case as soon as possible thereafter. To this day I could not tell you the phone number of our local Regulator's office, whereas if this had happened in the UK I would certainly have had the opportunity to go directly to the CAA for backup to prevent such a dangerous situation

from developing. Never assume that you will always be around to monitor the situation. Even when still employed nobody can be at a company 24 hours a day. The safety culture required must be universal and not dependent on individuals, and has to come from the top down.

AIRSIDE PASSES

The reasons for the introduction of more stringent checks for the issue of airside passes are obvious; however, the new procedures have had an adverse effect on some individuals as this report illustrates, and continue to influence the ability of engineers to rectify defective aircraft away from base in a timely manner.

I wonder if you have heard from any other aircraft engineers trying to get airside passes. One year ago I applied to a UK airport for an airside pass. I had recently held one with a company based there. I now had to reapply giving full details of my movements for the last five years with addresses of the people who could vouch for me. Even a two-week visit to hospital would have to be covered unless you got the company to fib a bit and say your employment had been without a break.

I had worked abroad during that five-year period and proof would have been difficult to obtain. As it turned out I decided not to take the job in question but it was obvious to me at that time that it would be very difficult for me to get a pass if I told the truth about my movements because it would involve maybe seven or eight different references, any one of which I may not have been able to produce or the company may not have provided. Human Resources departments will go for the easier option, so because I have moved around a bit I am discriminated against.

Recently a friend, also a licensed engineer, lost a job because it took too long to go through this process.

This limits our right to work. Even though I have the Scottish Disclosure certificate, companies have to check back five years and if it proves difficult they will turn me down for employment.

While this report focuses on the employment aspect, it is important to recognise that there are underlying safety issues associated with some aspects of the new security arrangements; these are the frustration and time pressures that result from seemingly avoidable delays in obtaining an appropriate airside clearance, transporting spares/tools airside and the manner in which personal searches are conducted at some locations.

These factors can adversely affect the subsequent human performance of individuals, who are often already under pressure to complete an unscheduled

maintenance task in as short a time as possible and, thus might be deemed to be detrimental to safety.

ENGINEERING COMMENTS

VISIBILITY OF IDS

(1)

As anticipated, we received several responses to the item on visibility of IDs; here are two of them:

Visibility of ID's both as a certifying engineer and as a manager"

I totally disagree that ID's must be worn at all times, when an engineer is actively engaged in maintenance, having a loose bit of plastic is a positive hazard. ID's fall off frequently, if not noticed it can produce a hazardous FOD. I, like many line engineers, remove my ID and place it inside a locked (buttoned down) pocket whilst working. I was under the impression that this was in compliance with DfT rules.

Your report and actions I believe has produced the opposite to intentions and will increase the likelihood of more incidents - not reduce them.

(2)

This is in pure contradiction to Health and Safety and Engineering practices! Working on aircraft can be hazard enough without introducing another potential item of FOD.

A member of security has challenged me at my aerodrome where my ID was on my person (in a secure pocket) but not displayed. After inspection I was asked (no - told) to display my ID, which I politely refused as I was in the middle of a maintenance action. I quoted Health and Safety and the Safety of the Aircraft to which he took my details and threatened to report me to his supervisor.

Even in these times of increased security, surely common sense should play an important part in aviation security.

Following the comment above to the effect that the DfT had given a dispensation for Engineers not to display their passes when working on aircraft airside, the DfT was invited to comment. The reply was as follows:

DfT do not offer any exemptions from our requirements for Restricted Zone passes to be displayed. We cannot regulate to take account of clumsiness but there are legitimate health and safety considerations. Fortunately there are viable options on the market such as the so called 'ski pass', where the pass is displayed in the pocket

of a clear arm band worn around the upper arm. This carries no danger of being caught in conveyor belts, moving engine parts etc.

ASRS - 'CALLBACK' REPORTS

These reports were taken from Issue 297 - June 2004

CAP IT!

Judging from the number of reports submitted to ASRS, the problem of missing or improperly secured engine oil caps is still a concern. Let's get the word out and put a cap on this problem.

- After removing and replacing the oil filters I am required to have another mechanic run both engines to perform a leak check on the filter assemblies. After performing the leak check, the left engine required servicing. At this time I noticed a ramp employee waiting for access to service the lavatories. I serviced the oil to full and then moved the lift truck, closed the cowl, and moved to the next engine. After completing the work on the right engine and noticing that the ramp employee was finished servicing the lavatories, I returned to latch the cowl closed. I left the oil cap removed.
- Excessive oil was discovered on the engine cowl of the #2 engine. Upon further inspection it was found that the oil tank cap was unsecured. The engine was serviced with six quarts of oil and continued in service. I had serviced the engine oil the previous night and may have left the oil tank cap for the #2 engine unsecured, causing the loss of oil. I have a good system for ensuring that the oil tank caps are secure, but it is possible that I may have erred on this occasion.... It was night, with good weather conditions and no distractions....

CAA (SRG) ATS INFORMATION NOTICES (ATSINS)

The following CAA (SRG) ATS Standards Department ATSINS have been issued since April 2004:

CAA (SRG) ATS Information Notices are published on the CAA (SRG) website -

www.caa.co.uk/publications/publications.asp?action=sercat&id=2

Number 42 - Issued 21 May 2004

Changes to Procedures for the Notification of Air Traffic Control Incidents to the ATS Standards Department

Number 43 - Issued 18 June 2004

Report of the Investigation into the Mid-air Collision Over Uberlingen

Number 44 - Issued 26 July 2004

Area Navigation (RNAV) Procedure Applications

Number 45 - Issued 26 July 2004

Availability of Documents at Operational Positions

Number 46 -- Issued 26 July 2004

Single European Sky

Number 47 - Issued 26 July 2004

Arrangements for the Regulation of ATC Units that are Required to Operate a Safety Management System

CAA (SRG) FLIGHT OPERATIONS DEPARTMENT COMMUNICATIONS (FODCOMS)

The following CAA (SRG) FODCOMS have been issued since April 2004:

CAA (SRG) Flight Operations Department Communications are published on the CAA (SRG) website - www.srg.caa.co.uk

7/2004

1. Reduced Vertical Separation Minimum (RVSM) Airspace Flight Procedures

8/2004

1. JAA Operational Multi-crew Limitation (OML)

9/2004

1. MMEL Alleviation for Non-required Equipment
2. Amendment to the Air Navigation Order 2000

10/2004

1. Pressurised Cabins - Use of Exits

11/2004

1. The Wearing of Protective Helmets by Crew Members Engaged in Underslung Load Operations

12/2004

1. Mode "S" - Aircraft Identification Reporting

13/2004

1. CRM Accreditation - All AOC Operators
2. Training Symposium
3. Safety Restraints
4. CAP 731 - Approval, Operational Serviceability and Readout of Flight Data Recorder Systems

14/2004

1. Additional Caution for Pilots Making ILS Approaches to United States Airfields
2. Land and Hold Short Operations (LAHSO)
3. Visual Approaches to UK and USA Airfields

15/2004

1. Letter of Intent: Proposal to Amend Articles 50, 51 and 129 of the Air Navigation Order 2000 to Reflect Current International Practice in Relation to Area Navigation, Required Navigation Performance and Operational Approval.