

CHIRP FEEDBACK

Issue No: 84

Autumn 2007

SECURITY REPORTS

CHIRP Narrative: Over the past nine months or so we have formally represented concerns expressed through this Programme about inconsistencies/problems with UK airport security procedures reported by flight crew, engineers and ATCOs, and the potentially deleterious effect that these are perceived to have on flight safety, to both the Civil Aviation Authority and the Department for Transport. Our most recent submission was to the Permanent Secretary DfT.

The response from the Permanent Secretary stated that the concerns reported to us had not been raised by any of the stakeholders attending the National Aviation Security Committee and the Operational Subcommittee that meet regularly to consider such matters; these committees include representatives from the CAA, UK operators, BALPA and other transport unions. Moreover, whereas more than 70 reports on this topic have been submitted to CHIRP, the Department's response also stated that the CAA, having reviewed inputs received from a variety of sources, including the CAA Mandatory Occurrence Reporting (MOR) system, was not persuaded that the problems reported through this Programme translated into a real flight safety risk.

CHIRP's role in the UK safety reporting system is to supplement the other reporting methods that are available. Thus, if the above situation is correct, it is perplexing as to why concerns similar to those received by **CHIRP** have not been reported directly to companies or to the CAA through their respective reporting systems; as an example it is understood that the CAA MOR database contains only one recent MOR on this topic. Equally perplexing is the perception of senior DfT officials that BALPA has expressed no concerns about the current situation, as this contrasts with recent assertions by representatives of the BALPA Security Committee that the matter has been raised with the DfT on more than one occasion.

From the foregoing it is clear that, in the absence of additional evidence to support reports submitted to this Programme, neither the DfT nor the CAA is likely to be persuaded that there is an ongoing human factors safety-related issue that needs to be addressed. It is possible that individuals, whose professions are underpinned by clear regulatory and professional accountabilities, have elected to use **CHIRP** rather than use the CAA MOR scheme, believing that the latter should be reserved for incidents of a mainly technical

nature. This is not the case, and any incidents involving security checks that individuals feel have a consequent effect on flight safety can and should be reported to the CAA using the MOR scheme. As a reminder, the scheme includes the facility to report confidentially directly to the Authority (See CAP 382 for details). We will continue to represent those concerns reported to us, as far as we are able.

If the **CHIRP** reports are indicative of a wider problem, as the anecdotal evidence continues to suggest, and the situation is not addressed there is a possibility that the flight safety risk will remain and that at some UK airports the enemy will be perceived by some professionals as being the security system and not the terrorist.

The following reports are among those received since the last issue of FEEDBACK on this topic:

A NON-UK FLIGHT CREW VIEW

Report Text: The new security standards at British airports seem way out of line and quite an overkill. They are using a security standard designed for the general public to harass working flight crew. As crew members, we have passed numerous government and company background checks, fingerprinting and prying into our personal lives.

Now, only in Britain, we too have to display liquid containers in clear plastic bags and surrender any containers exceeding the 3.4 oz limit intended for the general public. Why are we exempt from this ridiculous rule in all countries including the US, but the almighty British feel they need to take my 4 oz tub of toothpaste?

When is good common sense going to prevail, real security threats addressed and proper efforts employed to really foil the bad guys?

LOCKED IN - NOT OUT!

Report Text: I would like to inform you of the quite ludicrous situation which I found myself in, with my FO, at ### Airport recently. I had operated a positioning flight from my UK base arriving at ### around 01:00 local time. On arrival, there was no one to meet us from our handling agent; however, after a radio call and short wait, some steps were brought to the rear of the aircraft. After briefing the Engineer on outstanding defects on the aircraft, we disembarked and attempted to leave the airport.

We walked across the apron to the staff exit. The control post was manned by two security operatives who advised us that we would have to "swipe" through the door in order to exit from airside. We tried to swipe our

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An Air Transport Safety Newsletter

from **CHIRP** the Confidential Human Factors Incident Reporting Programme

cards but both produced the message "Not in System" and the door steadfastly refused to open! We asked the security personnel to open the door for us but he assured us that it was against the rules and summoned his supervisor, who explained that if we couldn't swipe out, then we couldn't leave! She told us that we would need an escort from our handling agency or we could exit via the arrivals hall.

We returned to the apron and tried to gain access to the terminal building by use of our swipe cards, again to no avail. Giving up, we returned to the aircraft and called our handling agent once again to request an escort to see us through security. The handling agent's reply was that there was only one person on duty and she was too busy dispatching aircraft so we would have to wait. At this point I rang our own Operations and explained the problem; Ops offered to call the handling agent's office at ### Airport to see what they could do. Eventually, the engineer on our aircraft offered to come with us to the Control Point to see if he could swipe us out. When we got there we found that the handling agent's rep had come up with the same idea and had requested another engineer to attend the Control Point to offer the same assistance. The engineers swiped the door and we walked to freedom at last.

My observations from this absurd episode are as follows: At no stage did anyone bother to check our ID, even after their own system alerted them to the fact that we were not valid ### pass holders. There is no visual check made on exiting the restricted zone at ###, if you can swipe out, you can leave, even if you have found a card on the floor or stolen it; nobody checks. ### Airport Security would rather have us airside than landside, even though we didn't have a "valid" ID in their eyes! As a result, two engineers and a dispatcher were diverted from safety critical tasks in the middle of the night to assist with a security issue which was nothing to do with them.

At other UK airports, if you use your ID to allow someone else access through a swipe door you risk having your ID removed with attendant loss of job etc. At ### it is positively encouraged or even required! It is apparently more secure to find someone on the apron, who I have never met before and ask them to swipe open a door for me, rather than have a trained security operative check my ID and then allow me passage.

Earlier in the day I was unable to exit the airbridge at my base airport to carry out a pre-flight inspection of the aircraft due to my ID not swiping there either.

If this intolerable level of idiocy continues, sooner or later it will form a link in a chain, which leads to an aircraft accident.

AN ENGINEER'S TALE

Report Text: I was despatched along with the company's power-plant manager and a line liaison engineer to CCC Airport to diagnose and subsequently recover one of our aircraft which had a reported defect outside Minimum Equipment List limitations and had been grounded.

Upon arrival at CCC we elected to make our point of entry the apron security gate adjacent to the Terminal but were refused entry on the grounds that they had not received notification of our impending arrival from our head office. Producing my Passport, CAA Licence, Company type approval certificate, Airport AAA ID pass and Driving permit along with my current Disclosure Scotland, Driving Licence (with photograph) and National Insurance number card made no difference.

Impressing upon the security agent that we had an standing arrangement with an operator based at CCC to escort us at all times and that the liaison engineer we had with us had in fact gained entry the previous night without these formalities had no beneficial effect and we were told to go to the ID centre in one of the office units. This involved a significant further delay as a large number of people were trying to access the public car park; we then had to undertake an enforced walk around the airport until we located the building we required.

Having accessed the required office we were faced with similar problems to those encountered at the apron gate until one of the senior security officers on duty recognised me (Oh yes, I forgot to say I held a pass for apron, terminal, hangers and manoeuvring areas at CCC Airport for over 30years). Now our problems were being dealt with promptly and efficiently but whilst filling in the required paperwork two other people arrived in the office; a female in normal clothing (no hi-vis or company

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Number of Reports Received Since the Last Issue and Report Topics:

ATC - 2

Comments on CAP413 Supplement
ATCO Shift Patterns/Workload

Flight Crew - 64

Airport Security Procedures
Rostering - 18/30 hour Rest Periods
Rostering - Planned Use of Discretion
Electronic information - Operations Manuals
Passenger Boarding/Refuelling
Alleged Reduction in Safety Standards
More on Smoke Hood Training
Fleet differences - Training
Flight Deck Door SOPs
Helicopter Advisory Routes

Engineer - 4

Airport Security Procedures
Access to EADS AD Information - Light Aircraft
Aircraft Security
Authority to Sign CRS Release

logo) and a male in standard working uniform complete with hi-vis jacket. Their problem, the female explained, was that the male had lost his CCC pass and they had come to report the fact. Upon giving his name the female was informed that the security office had the pass and they had in fact had it in a drawer for approximately 4 months. This information was relayed to the male, who with some unease admitted he had in fact lost his CCC ID some 4 months earlier.

Now forgive me for a mild outburst here, but we were trying to recover an aircraft and could prove our life histories and were struggling to obtain a day pass only to see at first-hand that this person could have been entering CCC for 4 months without a current CCC ID on display at entry or during his normal daily routine.

Having at last secured a "day pass" covering us for 2 days we were sent back to the apron security gate where we were required to show all our credentials again, empty our pockets and to take off our footwear then be subjected to a physical search which was fairly rigorous to say the least, whilst our van was searched directly outside the gatehouse by another security operative who barely even looked inside the rear of the vehicle, where in error I had left my packed lunch (including 2 litres of orange soft drink) which all went unnoticed.

Finally we were handed over to our escort and just about to move off when the very abrupt, non-uniformed senior security officer stopped us once again and was less than courteous about the fact that our yellow hi-vis jackets were not to be worn, as we must be clothed in orange hi-vis jackets with 'ESCORTED' upon our backs. Another delay while the correct clothing was found for us.

In all the saga of our entry to CCC on that day took approximately one and a half hours and tempers were a little frayed by the time the escort finally managed to

position us at our aircraft, which by the way was fixed within 30 minutes.

Everyone talks about the war on terror; this feels more like a war on engineers.

A SECURITY TARGET?

Report Text: The security at AAA (major UK airport) is OK on quiet occasions but when it gets busy there never seems to be any staff available to carry out the ridiculous checks required. AAA Security has now delayed me two days on the trot getting to the aircraft.

On Day 1 I had been called off STBY to operate to BBB which has a normal report of 09:45Z I arrived in the crew room at 10:00Z. On arrival at Security there were approximately 12 crew members in front of me to whom I explained my situation; they all gracefully let me through. The security staff were all privy to my situation, but after my bag had gone through the X-ray machine they decided that they wanted to pull it apart! On no other occasion have they ever done this and on this occasion I had taken items out of the bag as I was positioning back with another airline and did not want to run into carry-on weight problems.

I can only presume that they were having their bit of fun by deliberately delaying me, as they knew I was running late.

On Day 2 the queue at Security was out of the door with at least four crews trying to get through. Again, only one X-ray machine in use with the same old excuse of no staff, so it took us 25 mins to get through. I took the supervisor to task over this situation; he offered only a pathetic excuse about shortages of staff and empty apologies, followed by an unnecessary body search of my colleague who had not set off any alarms. This caused a 5min delay off stand as we were still carrying out the final checks. (I will not allow these fools to make me rush)

It is about time the powers that be resolved this ludicrous situation before it is directly attributable to an accident, or at least throw resources at it as have the Americans so that it is no longer a chore or a flight safety hazard going through Security.

ANOTHER INTRUSIVE SEARCH

Report Text: I was very interested to read Peter Tait's appraisal of security-screening events and their undoubted effect on flight safety in a recent CHIRP leaflet. I myself had a particularly bad experience whilst proceeding to my aircraft at ### recently and submit the following report which has also been filed with the Company for investigation.

Crew screening point: I presented myself for routine screening. Having removed my jacket and hat for x-ray examination I walked through the body-scanning device which sounded the audible alert. This is a frequent occurrence for me as I have a certain amount of orthopaedic metalwork in my right leg. Thus, I am au-fait with the usual physical search routine.

During the course of his subsequent physical check the security operative touched my genital area with the back of his hand. This was NOT an accident but a deliberate

action starting at my belt line and moving downwards. The action was not sexual and the touch - though positive enough to be felt quite distinctly - would NOT have identified any anomalous object in my opinion. I immediately voiced my displeasure. Mr. ##### said he was acting in accordance with DfT guidelines. I again voiced my opinion and said that I would report the matter through Company channels.

Mr. ##### then made a telephone call to the Security supervisor (I believe) at a different location and said that I was to go there and speak to the supervisor. I replied that I would not as I had 180 passengers waiting for me and reiterated that I would report the matter through the Company. Mr. ##### attempted to engage me in dialogue. He even suggested that the genital area would be an obvious place to conceal prohibited matter and again said he was acting i.a.w. DfT guidelines. Not wishing to inflame the situation, I refused to be drawn and informed him that our conversation was over. The offending search was not witnessed by any other security staff or the First Officer. Having boarded my aircraft I telephoned a Company manager at home to both report the incident and seek guidance. Recognising the flight safety implications the manager, to his great credit, asked if I would like to be replaced for my duty. I declined his invitation and operated the flight; though it did play on my mind throughout. I and flight crew in general, I suspect, are unaware of the physical search techniques that are allowed under current DfT guidelines. I find it extraordinary that such an intimate touch should be permitted.

CONTACT LENS FLUID - STILL A PROBLEM

Report Text: I would like to report another issue with security staff at AAA (major UK airport). Last month, I was refused access to airside due to having a bottle of contact lens solution with me. The standard size for these bottles is 120ml. As I wear contact lenses, I require the solution with me at all times. Due to the sterility of the solution, I do not deem it reasonable to pour the solution into a smaller container. Any infection subsequently caused would not enable me to carry out my job as a pilot, and in an extreme case, could cause long lasting damage to my eyesight.

After a previous incident with security at the same airport, I had queried the carrying of lens solutions with BALPA, who advised me that although the solution should be free of infection if decanted into 100ml containers, it was recommended that the 100ml bottle was regularly sterilised either by boiling or by microwave heating to avoid certain acanthamoeba bugs, which may be partially resistant to the hydrogen peroxide that forms the bactericidal element of the lens solution. I was advised that as an alternative - if I (not security) deemed the fluid to be 'Essential to my duty' in a quantity over 100ml, then I was able to take it through search - but the security staff were then bound to 'test' it as being authentic before allowing it (or any other such liquid) to pass airside.

During the most recent incident, I explained that I was entitled to carry my contact lens solutions with me, as I

required them for my job. I was told that I couldn't take them with me as the bottle was 120ml in size. I then asked to speak to a supervisor; the woman to whom I was talking told me that she was the supervisor. I informed her that she should know Transec's rules, and that I needed the solutions with me or I wouldn't be able to fly. She was very rude and waved a copy of the security regulations in my face and said that she did know the rules. I felt that the way that she behaved, did not portray any professionalism with respect to her position. She then went to phone someone who I assumed was her supervisor. It turned out to be the crew desk, so she did not even refer this to a higher authority. At this point I was extremely angry, as my First Officer and I were on the verge of operating the flight into discretion, and we were being delayed even further.

I was not allowed through security, so had to return to the briefing area. I informed crewing that I was not allowed through security so couldn't operate the flight. At this point, even if I would have been allowed to my aircraft, I was not going to operate as I was extremely angry, and felt that I couldn't operate safely. It has finally come to this - being refused access to my aircraft for the sake of 20ml of contact lens solutions.

The impracticalities of this situation, and also the rude and arrogant way that crews are treated, is becoming more of a safety issue. Angry, frustrated, and distracted are not the ideal way that Flight Crew should be operating aircraft after these incidents with security staff.

ENGINEERING EDITORIAL

LICENCE EXAMINATIONS - WAITING TIMES

Earlier this year we published reports concerning the long waiting times associated with booking appointments with the CAA for Engineer Licence examinations; some of these followed closure of the Silsoe examination centre .

In recognition of the difficulties experienced by engineers the CAA has increased examination capacity at Aviation House, Gatwick and has opened a new examination centre at Shuttleworth College, Old Warden Park, nr Biggleswade, Bedfordshire, SG18 9EA.

The web address to check for examination availability is: http://www.caa.co.uk/docs/177/srg_eld_examdatesandvenues.pdf

MORE ON CHIRP - MEMS

As the saying goes "To err is human". Trying to prevent errors from happening repeatedly is human factors!

There are very few surprises for those who have been in the industry long enough to gain sufficient experience and to make the odd mistake; it's all part of the continuous 'learning curve'. However, the real benefit to be gained is in trying to impart the lessons learned from individual errors to as wide an audience as possible for the common good.

In the last issue, I summarised the results of an analysis conducted on 525 of the more than 750 reports that

are currently held on the MEMS database, which **CHIRP** manages on behalf of the MEMS group of airlines/maintenance providers. As a reminder, the CHIRP-MEMS group was established in 2003 with the aim of providing a focal point for gathering information on maintenance error incidents investigated by member companies and sharing best practice solutions that are applicable more widely across the industry. The current membership, including new members who are in the process of joining, totals 16 and includes both the CAA and the AAIB.

As some of you will be aware, many companies have adopted a tool based on the Boeing/Goodrich MEDA format for providing a consistent approach to investigating errors; MEDA not only provides a methodical approach to identifying the causes of errors, but just as importantly provides an insight to the probable solutions to reduce the risk of recurrence; this tool is used as the standard for the MEMS database.

As safety conscious engineers we seek to learn from our own mistakes and those of others; it's part of our culture. However; from information to date as to the reasons for the basic errors that we make, the problem appears to be that we seem to be equally quick in forgetting earlier lessons that we learned. With very few young engineers being trained currently, the population of certifying engineers is developing a more mature demographic profile, and yet the errors continue to occur.

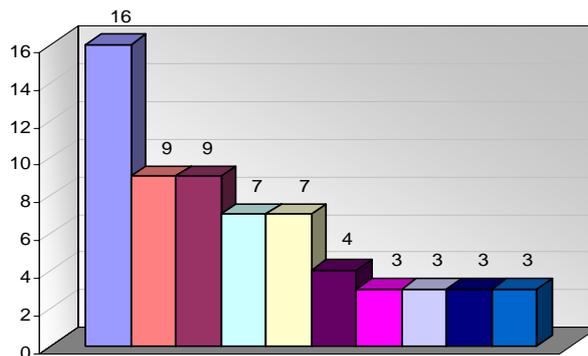
The MEMS group is seeking to identify both the contributory and circumstantial factors in human error incidents and to understand why some of these are perhaps taken for granted or overlooked. It is important to understand that MEDA investigations take place after an incident has occurred. Frequently, a similar set of factors/circumstances lead to a 'near miss', which is only known to those involved; it is most important that we also collect data on these incidents, which can be reported, in confidence, using the normal CHIRP process; these reports, after being appropriately disidentified and with the reporter's consent, will be added to the MEMS database. The benefit to all of us will come from analysing maintenance error incidents and openly discussing preventative measures with engineers willing to participate in the debate.

The CHIRP-MEMS website at www.chirp-mems.co.uk has been recently updated and provides further information; the website will be regularly updated to provide useful feedback on past events and errors as a general learning opportunity, and will also allow engineers to comment and provide a valuable insight to maintenance safety standards.

Mick Skinner

ENGINEER REPORTS

Most Frequent Engineering Issues Received:
12 Months to September 2007



WORKLOAD/MANNING (1)

Report Text: Currently two UK employment agencies list vacancies for a licensed mechanic to work a 12-hour night shift, seven days on, seven days off on a Public Transport aircraft at a UK regional airport.

Have we suddenly forgotten all we have learned about Human Factors?

CHIRP Comment: The content of the advertisements was brought to the attention of the CAA, who agreed to discuss the matter with the respective agencies.

In 2002 the CAA commissioned a study into engineers' working practices. The report 'Work Hours of Aircraft Maintenance Personnel' was published in March 2003. The report's recommendations include the following:

Para. 5.4 (g) Total work including overtime should not exceed 60 hours or seven successive work days before a period of rest days.

Para. 5.4 (j) A span of successive night shifts should be limited to 6 for shifts of up to 8 hours long, 4 for shifts of 8.1 to 10 hours long and 2 for shifts of 10.1 hours or longer. These limits should not be exceeded by overtime.

The document can be viewed via the CAA website http://www.caa.co.uk/docs/33/PAPER2002_6.PDF.

WORKLOAD/MANNING (2)

Report Text: I am employed on line maintenance tasks. Following a recent merger, my colleagues and I have been working a rather confusing shift pattern of rotating twelve-hour days and nights, with a mixture of 5 days

on; 5 off; 4 nights on; 5 off; 5 days on; 4 off; 5 nights on; 5 off.

The maintenance task covers several types; however, it is the manpower levels and the workload that is of concern to me.

Since transition to the new arrangement several months ago, on my shift, a colleague and I are required regularly to maintain up to ten night stop aircraft. This includes daily inspections and out-of-phase checks, to this end fault diagnosis and rectification gets very little attention and invariably defects end up in the Aircraft Deferred Defect (ADD) logs to be rectified at a later date; this is a typical night shift.

Also, I have just finished a five-day, day-shift during which, for the first two days, I was the only cover for one aircraft type on the whole station. During this period I was required to sign off work that had been carried out by hangar staff and also to carry out a serious defect investigation on an engine that has a history of high ITT whilst working at height in a different hangar, on my own. If there had been an accident and I was rendered unconscious there would have been nobody to raise the alarm.

During this work period I am also expected to attend tech aircraft on the line from our own fleet and third parties as they rotate through during the day. We are also hindered by the lack of equipment and resources to carry out some of these maintenance tasks because there is so little of it. For instance, data down-loaders; apparently there are only three of these pieces of equipment available so they are constantly being ferried around the network, getting broken or lost.

There are also gaps in the approved maintenance data that is available at this station, whilst I appreciate the ease of use of computers for storage of Maintenance Manuals I don't have access to the Fault Isolation Manual, so fault diagnosis is done from memory or via the telephone with Maintenance Control. Consequently we are unable to carry out the task required, so the task is transferred to an ADD.

During attendance to one tech aircraft a few days ago, the captain asked me how I was coping; I asked him why did he ask? He replied, "You always seem to be here". This prompted a thought; are the crews losing faith in our ability to maintain the aircraft to the required standards? I would like to think that my standards are not slipping and I work hard to maintain them. To this end I feel that it is time for action and report the situation to the Authorities, because we cannot go on like this.

CHIRP Comment: The reporter's concerns were raised with a senior engineering quality manager and were subsequently the subject of a detailed investigation by the company.

In relation to staff numbers, it was acknowledged that a number of significant logistical challenges had been initially encountered in determining the correct level of support for the various fleets and in the case of one aircraft type, particular difficulties had arisen. As a result, the number of engineers qualified on the type was being increased; this would significantly reduce

the workload on other staff. The increased staffing would also address the reported certifying concerns.

A review of open Aircraft Deferred Defects showed the fleet average to be well within industry levels; this was a good indicator that the standard of serviceability was being maintained.

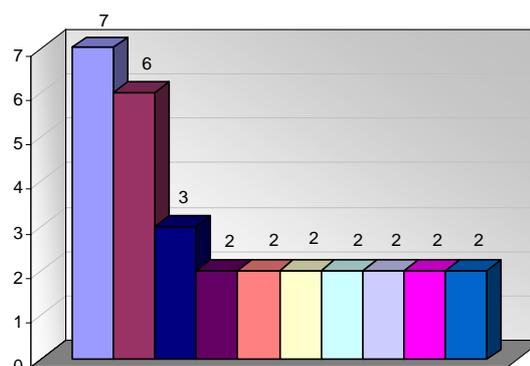
With reference to the availability of data down loaders, several were confirmed not to be available, being under repair; additional down loaders were due to be delivered imminently.

The company investigation into the availability of approved data had identified a problem with accessing one particular Fault Isolation Manual; this had been rectified.

The manager emphasised the availability of the company reporting systems, including an internal confidential scheme, and encouraged staff to use these.

ATC REPORTS

**Most Frequent ATC Issues Received
12 Months to September 2007**



- Communications - External**
(Pilots)
- Air Traffic Management**
(Separation)
- Pressures**
(Commercial, Domestic, Management)
- Company Policies**
(Operational, Safety Reporting)
- Duty**
(Length, Rest)
- Handling/Operation**
(Operation of Equipment, Airmanship)
- Procedures**
(Use by Others, Adequacy, Use By Reporter, Lack of)
- Regulation/Law**
(Compliance with)
- Resources**
(Compliance, Knowledge, Absence)
- Security**
(Ground, In-Flight)

MORE THOUGHTS ON 'HEADINGS'

Report Text: A few observations on your report "RTF Phraseology - Headings" in Issue 83, if I may.

Your reporter is incorrect in his assertion that ATCO is wrong to add the word "degrees" to heading values other than those ending in a zero. The MATS Part 1 currently states:

"For all transmissions, with the exception of those used for surveillance or precision radar approaches, the word 'degrees' shall be appended to heading figures where the heading ends in zero, or in cases where confusion or ambiguity may result."

This leaves it entirely open to the individual ATCO's judgement on the spur of the moment as to whether confusion or ambiguity might result - therefore, the effect is a variation in technique and phraseology; another well thought-out procedure from CAA.

CHIRP Comment: Further to the comment in the last issue, it is understood that NATS has elected to adopt the addition of the word 'degrees' to all heading instructions as 'Unit best practice'. This decision is based on the significant reduction in certain types of level bust incidents that followed the introduction of the word and the HF benefit of maintaining commonality in the phraseology used by ATCOs for heading instructions.

However, it is understood that not all UK ATS providers have adopted this practice and the matter is to be discussed further at the next meeting of the CAA RTF Phraseology Working Group.

THE STRAW THAT.....

Report Text: I am an experienced ATCO at ###, where I have been working for more than ten years.

For a significant period of time we have experienced a shortage of fully trained ATCOs due to long term sickness problems. This led to a decision to change the shift pattern to accommodate the training of part-validated controllers on the watch list. There was little discussion with the operational ATCOs; the new pattern seeming to have been agreed between the management and the watch supervisors.

Although the unit is not a 24-hour hour one, we do have frequent extensions to our operating hours due to late running flights and occasional out-of-hours commitments agreed with local users. One of the effects of the new shift arrangement was the necessity to close radar down and operate a combined APP/TWR to facilitate ATCO breaks; also, the new pattern left us with the minimum recommended 12 hours off between several of the shifts. We were also asked to be 'flexible' and not feel we had to close radar just because we were rostered again 12 hours later or to insist on a break 'just because we had worked two hours'.

I anticipated that the new pattern would be fatiguing; however, working it was not as bad as I had expected, although by the latter part of the day shift I felt tired. If I had just been working as an ATCO I would probably have coped OK. However, as one of few On-the-Job Training Instructor (OJTI) rated ATCOs available, I found that I was almost constantly mentoring one of the trainees. I've enjoyed training in the past, but started to notice that my concentration was drifting at times,

particularly in cases where the trainees were fairly advanced and doing well with often little input required.

The situation was fairly relentless, as on taking a fatigue break you felt obliged to de-brief the previous training session, thus the trainee would almost always be in the rest room with you - before you went back for another operational session. Even when I insisted on doing a 'solo' session, the trainee would almost inevitably (and reasonably from a training point of view) want to 'plug in and listen'. I was also finding a problem with some of the new 'just out of college' students, as it has been many years since I had any formal OJTI training and I started to feel that my teaching methods were probably way out of date, when compared to the Unit Training Plan that new students are trained towards at college.

I don't think I realised how tired I was becoming until a fairly unimportant disagreement arose, which I would normally have shrugged off with a joke to colleagues, resulted in me taking the following day off sick. A subsequent visit to my GP resulted in my being prescribed 'Beta Blockers' and, on consulting with the CAA Medical Branch, they then withdrew my medical certificate temporarily due to the medication and cause.

To conclude, I think my main problems were a combination of the watch pattern, too much OJTI duty and a manager seemingly unsympathetic to problems brought to him. However, I thought that my case might be of interest to others, in that I really didn't see the problem coming until a minor disagreement just 'pushed me over the edge'.

CHIRP Comment: This report details an interesting chain of events in which the reporter, although aware of the various pressures to which he was being subjected, was unable to prevent the situation developing to a point where medical intervention was necessary.

Two general points are worthy of consideration. The first is the use of fatigue breaks for other management/training commitments. Whereas some individuals are able to use this time for other tasks without any detriment to their operational performance, others require the 'clean break' from their primary duties that the fatigue break is designed to provide. The second point is that if you feel unduly stressed for whatever reason, let someone know; don't press on until an incident occurs or you reach the point that you are medically unfit to continue working.

CAA (SRG) ATSINS

The following CAA (SRG) ATS Standards Department ATSINS have been issued since July 2007:

Number 110 - Issued 25 July 2007

Departure Speed Restrictions - RTF Phraseology

Number 111 - Issued 27 July 2007

Use of Obsolete RTF Phraseology and Multiple Level Instructions in Departure Clearances

Number 112 - Issued 13 September 2007

1. "Student" Prefix and Considerations for ATS Personnel
2. Instructions to Aircraft on Final Approach

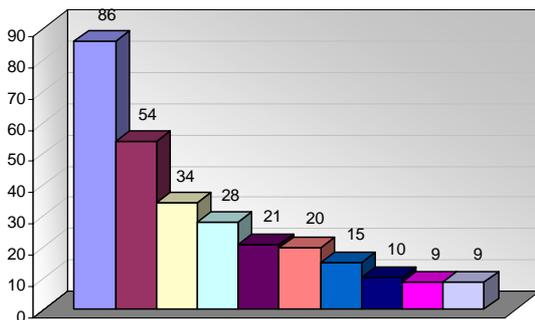
Number 113 - Issued 14 September 2007

Letter of Consultation - Proposal to Amend the UK's Air Traffic Services Outside Controlled Airspace

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FLIGHT CREW REPORTS

Most Frequent Flight Crew Issues Received:
12 Months to September 2007



- Duty**
(Rosters/Rostering, Rest, Length, Crewing, Disruption)
- Security**
(Ground)
- Communications - External**
(ATC, Regulators/Government)
- Procedures**
(Use by Others, Adequacy, Use by Reporter)
- Company Policies**
(Absence, Operational, Safety Reporting)
- Air Traffic Management**
(Separation)
- Handling/Operation**
(Aircraft Handling by Crew, Airmanship)
- Aircraft Technical**
(Systems, Propulsion)
- Pressures**
(From Management/Supervision, Commercial, Time)
- Training**
(Technique, Relevance, Design)

RTF PHRASEOLOGY

Report Text: I was Pilot Flying and was in the hold at AAAAA. After a few descent instructions in the hold, we received the following instruction from ATC: "Hold cancelled at AAAAA make a right turn all the way round onto 270 degrees."

At this time we were three miles away from and inbound to AAAAA. I heard no pause between any of the words, so what exactly does this instruction mean?

1. My hold at AAAAA is cancelled. Now turn right to 270; or
2. My hold is cancelled. At AAAAA, make a right turn to 270.

I think this instruction could be interpreted either way, and it involved some discussion on the flight deck at a busy time. I interpreted it to mean turn immediately, and did so through the autopilot. However my colleague and the relief pilot thought I had to go to AAAAA first and then turn. I ended up disconnecting the autopilot to stop the right turn until reaching AAAAA, all the time with an ongoing flight deck discussion about this ambiguous instruction.

With hindsight, we should have simply queried it with ATC, but the frequency was quite busy. Please provide some clarification regarding this instruction and suggest some better phraseology to remove ambiguity.

CHIRP Comment: This matter was referred to the Communication Error specialist in the ATS Unit concerned, who confirmed that the phraseology used had been ambiguous and an example of poor rushed R/T. The Unit has addressed the specific concern.

As the reporter reflected, if you have any doubt as to the intent of an ATC instruction, query it as soon as you can get a word in.

MORE ON EMERGENCY DESCENTS

CHIRP Narrative: In the report on this topic published in the last issue of FEEDBACK (Page 7), the reporter sought information on ATCOs' preferences for the emergency descent procedure and associated transponder settings. The comment accompanying the report sought to answer the reporter's questions and to explain the basis for the significant difference between the expectations of UK En Route/Terminal air traffic control officers and the emergency descent SOPs based on the current ICAO recommended practice.

As was noted, the matter was referred to the CAA for two reasons; the stated variation in guidance offered by instructors and the possible ramifications of an emergency descent being performed in UK Controlled Airspace, much of which may not have been designed to tolerate a significant unplanned lateral deviation. .

The following comment provides a different perspective on the issue:

Report Text: The report in Issue 83 of FEEDBACK page 7 titled 'Emergency Descent' stated that its author had received contradictory advice concerning the correct procedure for the pilot to follow in the event of an Emergency Descent and sought clarification from CHIRP.

Throughout their training and operational life, pilots will receive from their peers written instructions and well-intentioned advice gleaned over a significant period of time - much of which is inaccurate, sometimes conflicting and sometimes completely out of date. Where the advice is conflicting, they should be sufficiently disciplined to identify the correct source document and ask where it is written or at least attempt to resolve it themselves by looking at the regulations which are increasingly freely available on the 'Web'.

I fear your 'CHIRP Comment' to the report, although stated as advice in the last sentence, only served to muddy the waters further for, in my opinion, it was wrong since it reflects what NATS controllers think pilots

should do in the UK and not what the published rules state for the whole world.

I believe the applicable recommended practices governing flights which suffer decompression have been fully promulgated by ICAO at PANS ATM - Doc 4444 Para 8.8.1.2 (which says it's complementary to the basic ICAO Annex 2 and 11 Standards and Recommended Practices). These recommended practices may be modified by any contracting State by publishing their reservation in any of the following documents: ICAO Regional Supplementary Procedures (Doc 7030/4); their own AIP; NOTAM/AIC.

If we assume that the author of the report meant procedures in UK, the downloadable version of the UK AIP says, interestingly, at AIP GEN 1.7 ' UK differences against the current version of Doc 4444 are under review and will be published in due course'. I could find no applicable NOTAM/AIC. Thus the basic EUR Region rule is applicable to the UK and is covered at Doc 7030/4 EUR/RAC-7 Para 6.1.1.1 - Action by the Pilot-in-Command, which includes the following statements:

When an aircraft operated as a controlled flight experiences sudden decompression or a similar malfunction requiring an emergency descent the aircraft shall, if able:

Initiate a turn away from the assigned route or track before commencing the emergency descent;

If UK NATS wants to formulate and publish any special procedures, they should be mindful of the fact that most professional pilots flying overhead the British Isles will not be British nor even native English speakers and cannot all be expected to be up-to-date on another minor variation of the rules used only in the UK, even if it is actually published!

I'm only a British Instructor/Check Pilot and doubtless a professional, full-time CAA regulator could add some finer points to this. As I tell those who suffer under the weight of my own well-intentioned advice, 'if you find that what I've told you is wrong or conflicts with what you've been told earlier then don't just stay quiet, tell me so that we can research it, find the up-to-date answer and then spare others from more rubbish'.

I hope this proves helpful. Perhaps after the CAA has had time to comment, you'll consider publishing some of this as a correction in your next edition.

CHIRP Comment: The reporter correctly highlights the current ICAO recommended practice for an emergency descent procedure, but it should be noted that some SOPs might be more specific.

The CAA, which has the responsibility for mandating UK airspace policy/procedures, has formed a flight operations/ATC working group to review this matter; it is anticipated that the outcome of the review will be promulgated by the CAA in due course.

ELECTRONIC INFORMATION - AN IMPROVEMENT?

Report Text: I am writing through sheer frustration with my company's attitude to change. I am a reasonably young, computer literate pilot who is not averse to change, but change in this company is leading to a reduction in flight safety. Our documents are moving

online, and we have no access to the online documents on the aircraft.

Today I was reading the briefing for my flight and in the brief the following text was displayed....

Page 1 of 15 ***** NUBRF FOR ABC123/date* PRINTED AT time/date EG## --All ATC instructions to enter or cross a RWY will include the RWY entry point designator at which the aircraft is to cross the RWY. ALL such clearances are to be read back to ATC in FULL. If a FULL readback is not received ATC will instruct crews to do so. //New and revised Pre-Departure Clearance procedures available in electronic briefing section on intranet. Paper manuals will be amended at next revision.

Now the item that concerns me is that the Pre-Departure Clearance procedure has changed - we use the procedure on each departure and so it's fairly important to know about any new procedure.

So, having read this briefing, we have to go to a computer down the corridor, log in, click on 5 links, download and view this new procedure, all within the very limited briefing time. [20 minutes to swipe in, print all the regular flight documentation (50 pages), staple them, read them, review them, order the fuel, and make our way to the bus].

Until recently when we entered the briefing area we could have a look at a notice board and thumb through any new notices. One copy of these notices could be read by all pilots. Now they have introduced a new system of self briefing - and removed the notice board....the result, during your briefing you have to click on a link wait 30 seconds while a computer program loads to then print out your own personal copy to read. If you have been away for two weeks you may have 5-10 notices to read, all this again must be completed within the specified briefing time.

Some time ago the company had a rewrite of some of the useful "supplementary information" and created an electronic document. Up until a year ago all this information was contained in the Crew Orders and a set of these could always be found on the aircraft, as well as each pilot having their own copy. Now this information is available only on the intranet.

One particularly useful example is on the subject of pilot incapacitation, so instead of being able to have a look at this document when someone most needs it (@ 37,000'), the information is now only available on a computer connected to the Intranet. (Admittedly there is some procedural information available in the QRH which is on the aircraft).

The company is very quick to save money by embracing some modern technology, but they have unrealistic expectations of how much a pilot can remember. They keep taking the tools of the job away from us, and expect us to become a computer wiz overnight. Training? - You are on your own! (The company does not and are not interested in issuing us with computers, unlike some other UK carriers) I pity some of the less computer literate pilots within the company, because the next step is to remove the flight planners from the building - shortly you will be on your own.

I know there are probably more pressing flight safety issues. At least I have told someone, and someone listened for once!

CHIRP Comment: Whereas the introduction of electronic flight bags for retrieval of flight information is subject to a detailed review by the CAA prior to implementation by an operator, there is no similar prior review associated with changes in the dissemination of pre-flight information; however, the CAA does conduct routine audits of an operator's ability to disseminate pertinent pre-flight information, both in terms of the method of delivery and time taken.

When introducing a significant change in the method by which flight crew/engineers can access information, the effectiveness of the new procedures should be assessed through the company's quality and safety system and any shortcomings addressed. Notwithstanding this, there is anecdotal evidence that some airlines' hardware and IT back-up capability are not as effective or reliable as they should be for an essential service, leading to delays in the retrieval of pre-flight information.

The introduction of electronic information systems can provide significant commercial benefits; however, a wider use of IT does not automatically mean that the system is more efficient. Where there is evidence that access to and availability of information has not been enhanced, the company should assess whether the report time continues to be appropriate for the new method. In a case where the briefing time routinely exceeds that available within the report time, if the company elects not to act, the CAA should require that the report time be adjusted accordingly.

PASSENGER BOARDING POLICY

Report Text: The First Officer and I arrived at our aircraft very late, due to extensive delays to our previous flight inbound to LHR. In this fleet, the flight crew and cabin crew frequently work to different rosters, and our cabin crew were already on the aircraft.

The passengers were also already on the aircraft; our company permits, and on occasion encourages, boarding with no flight crew present, in the interests of punctuality. In fact, the time required to board a medium twin-jet (20 minutes) is always less than the time planned for proper flight crew checks (35 minutes). My belief is that the policy is intended to put not very subtle pressure on the flight crew to curtail their pre-flight checks and depart as soon as possible.

An engineer is supposed to arm the cabin emergency lights and switch on the no smoking signs before leaving the aircraft with the cabin crew. In this case, the no smoking signs had been left switched off whilst the aircraft had been refuelled with passengers on board. Some airports do not allow refuelling with passengers on board at all, or require the fire services to be in attendance. In contrast, our company permits refuelling with passengers on board at this airport with no flight crew on the aircraft.

I believe this procedure to be fundamentally unsafe. If an emergency were to occur, the cabin crew are not

trained to operate flight deck controls or switches. They are not trained to use the radio to summon fire cover, and frequently the jetty telephones at ### are unserviceable. Also, whilst all flight crew receive repeated training in emergency situations in the simulator, there is no equivalent training or assessment on high pressure emergencies for the cabin crew.

I have raised my concerns with the company on several occasions, both verbally with management and in writing. As captain of the aircraft, I have a responsibility for the welfare of both the passengers and crew. The only reassurance I have received from the company is a verbal statement to the effect that "If a problem occurred before you reached the aircraft, obviously you could not be held responsible."

I think that this is unsatisfactory. The company has a duty of care to the passengers which cannot be properly provided on the aircraft in the absence of the flight crew. I believe that the practice of boarding the aircraft, and especially refuelling with passengers on board, with no flight crew present, should be discontinued in the interests of flight safety.

CHIRP Comment: JAR-OPS 1 Sub-part D requires an operator to have a procedure for de/refuelling when passengers are on board. This includes the requirement for at least one qualified person to remain at a specified location, who is capable of handling emergency procedures concerning fire protection and fire fighting, handling communications and initiating and directing an emergency evacuation. The key issue in this requirement is that the nominated individual(s) is(are) appropriately trained and competent to carry out all of the required tasks.

JAA operators are required to promulgate a procedure covering these responsibilities in the Operations Manual and comply with it. This particular matter has been referred to the CAA.

REFUELLING ON THE RAMP

Report Text: While on stand at a major UK airport, just prior to closing doors, I noticed a small fuel bowser stop behind our pushback tug, which was attached to our aircraft. The driver climbed out of the bowser and began to refuel the tug. I was about to leave the aircraft and ask the driver if he could avoid attempting to refuel the tug while it was attached to the aircraft, when he finished and drove off.

I have always believed that risk management was about minimising the actual risk, and refuelling ground equipment while attached to aircraft wasn't actually minimising risk. I filed an ASR and spoke to our station manager, she admitted that she didn't know the correct procedures which should be followed regarding ground equipment and that I should simply file the ASR and wait for a response.

I would be interested to learn what the correct procedure is regarding refuelling of ground equipment.

CHIRP Comment: Some Aerodrome Manuals specify locations where refuelling of ground equipment is to be undertaken. Notwithstanding this, the practice observed was unacceptable and raises serious concerns about

the apparent lack of control in the ground handling organisation concerned.

It is worth reporting any potentially unsafe ramp practices to permit the matter to be taken up with the ground handling organisation/airport authority.

DIFFERENCES IN APPROACH PROCEDURES

Report Text: At one major French Airport, they are now clearing us to land while there is still another aircraft in front of us on final approach. Does this not devalue the landing clearance to a point of irrelevance? They might as well clear us to land on departure from Manchester!

Also at Paris and in Spain, they are now assuming that we will capture the glide before we have captured the localiser. If you ask for further descent (because you are going above the glide), they say 'you have been cleared for approach' as if you are an idiot. How can we take the glide (which may be false, as it is at Liverpool), while way off the localiser?

In the UK, just to be different, we still have this absurd procedure whereby they will only clear you for the localiser rather than the approach. This invariably results in not being able to contact ATC to tell them you are established, because the frequency is busy. You then have two choices - either capture the glide anyway, and risk the wrath of the controller or you go high on the glide and proceed with a highly unstable approach while desperately trying to capture the glide from above. Why cannot the CAA adopt the European method?

CHIRP Comment: When ATC issues a clearance to land, this effectively transfers the responsibility for maintaining safe separation from ATC to the pilot. A number of ICAO States issue this type of landing clearance. In the UK, the phrase "Land after the (aircraft type)" is used to permit an aircraft to land before a preceding aircraft is clear of the same runway, provided the ATCO is satisfied that the criteria detailed in CAP 413 Chapter 4, Para 1.9.3 are met. When such a clearance has been issued, the responsibility for ensuring adequate separation rests with the pilot of the following aircraft.

Regarding the phraseology associated with descending on the glidepath, the reporter's viewpoint that the UK should revert to the standard ICAO phraseology at all UK airports is shared by pilot groups and some ATC providers, but has been deemed not to be acceptable by the CAA. Following a further review, the CAA RTF Phraseology Working Group has agreed the use of the phrase "When established on localiser, descend on ILS" when this is possible; this phrase addresses the reporter's second point. This change is expected shortly and will be promulgated by AIC, FODCOM and AT SIN.

TRAINING IN NEW SOPS

Report Text: Recently the company introduced new Standard Operating Procedures without giving any training or guidance. As a result of this, the SOPs are now less standard than I have ever experienced in my

flying career with everyone doing things differently because no-one knows what they are supposed to be doing or how it should be done.

This is particularly apparent as a First Officer with Captains doing things 'their way'. The operation now can only be described as a 'shambles'.

CHIRP Comment: Organisational changes arising from a restructuring or a merger presents management with many challenges and can also be unsettling for some individuals who are used to a particular way of operating. However, the introduction of new SOPs without adequate training is highly undesirable from a CRM perspective and the potential safety implications should be the subject of a risk assessment.

The CAA has been apprised of the reported concerns.

DE-ICING PROCEDURES

Report Text: On boarding, I noted that the aircraft, which had only recently arrived, was building some patchy hoar frost on the upper surface of the stabiliser and wings. I requested the engineers to arrange a de-ice team to come and to inspect the aircraft after completion of fuelling.

(Refuelling often clears ice. However, this is difficult to confirm due to the size of the aircraft and light colour of wing surface).

The de-icing team had not arrived on completion of boarding; however, the engineers advised me that no ice was present on the wing.

Our engineers are normally excellent and very trustworthy; however, I went into the now crowded passenger cabin and saw a few small patches of frost.

The de-icing team called and confirmed several patches of frost on both wings plus frost on the left horizontal stabiliser (in shadow of tail fin).

I will speak to the two engineers, who I respect a great deal, next time I see them so that they are aware.

As commander, it is ultimately my responsibility to ensure that the wings are clean but I do feel that, on another day, with another crew the aircraft might have departed on the word of the engineers.

CHIRP Comment: As the reporter notes, it is the aircraft commander's responsibility to check the condition of the aircraft. Several fatal accidents have resulted from assumptions that the aircraft was clear of ice when this was not the case. Adherence to the correct procedures is vital, particularly with all the additional pressures that can accompany winter operations.

Perhaps a review of your company's winter SOPs and/or CAA FODCOM 19 (2006) is worth considering?

CABIN CREW REPORTS

DE-ICING PROCEDURES

Report Text: On turnaround I noticed ice on the left wing, which I passed on to the rest of the crew. I noticed the ice while standing on the steps at Door #L.

The Captain advised me he was going to de-ice the wings himself, by transferring fuel as it would save on de-icing costs.

During the boarding process I noticed 3 more walk-arounds being done by the flight crew, obviously keen to inspect the wings. This also involved them both sitting in overwing seats immediately prior to boarding to observe the upper wing surfaces.

Once all pax were boarded, the First Officer commented he had observed ice ridges on the underside of the right wing, so de-icing was requested, and a delay incurred.

CHIRP Comment: This is a good example of excellent vigilance and appropriate action by cabin crew.

Although transferring fuel can in some circumstances clear lightly contaminated surfaces, the operator confirmed that the company SOPs stated that an aircraft must be clear of all forms of frost, ice, slush and snow before take-off, and that there was no other de-icing procedure in their SOPs other than using an approved de-icing fluid.

A FINAL THOUGHT ON WINTER OPERATIONS



This photograph was taken very shortly before take off - the pink coloured areas are patches of snow and/or ice

CAA (SRG) FODCOMS

The following CAA (SRG) FODCOMS have been issued since July 2007:

- 17/2007**
Implementation of EU-OPS - Exemptions and Derogations
- 18/2007**
Regulation (EC) No. 1107/2006 - Concerning the Rights of Disabled Persons and Persons of Reduced Mobility When Travelling by Air
- 19/2007**
Departure Speed Restrictions - Radiotelephony (RTF) Phraseology
- 20/2007**
Area Navigation (RNAV) - CAA Guidance Material
- 21/2007**
Letter of Consultation: Proposal to Amend the Air Navigation (Dangerous Goods) Regulations 2002.

Regulatory Impact Assessment for the Amendment of the Air Navigation (Dangerous Goods) Regulations 2002 to Reflect the Coming into Force of Provisions of the European Commission Regulation No. 3922/91 Annex III (EU-OPS)

22/2007
Consultation by the CAA on a Proposal to Amend the UK's Air Traffic Services Outside Controlled Airspace

23/2007
Child Restraint Devices

24/2007
AOC Suspension and Revocation of Suspended AOCs

25/2007
Letter of Consultation: Proposal to Amend the Air Navigation Order 2005 For The Purpose Of Introducing An Additional Responsibility For Operators Of Helicopters Operating In Support Oil And Gas Exploitation Within The United Kingdom Continental Shelf Airspace, New Definitions And An Additional Requirement To Be Included In The Operations Manual

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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 (including your licence number) to Personnel Licensing, CAA (SRG), Aviation House, Gatwick Airport South, West Sussex RH6 0YR:

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