

CHIRP CC FEEDBACK

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EDITORIAL

When I was invited to take over responsibility for confidential reporting in 1995 the Programme was available only to professional flight crew and air traffic control officers. After reorganising the Programme, it was progressively extended to include engineering staff, general aviation pilots and in 2001, the Cabin Crew Programme was introduced.

In the twelve years since this Programme started, with the assistance of Kirsty Arnold and more recently Stephanie Colbourne, we have responded to more than 1,700 cabin crew reports and have published 48 issues of Cabin Crew FEEDBACK.

This will be my last issue as, after more than seventeen years, I will be handing over the role of Chief Executive in September to Air Commodore Ian Dugmore RAF (Rtd), who was selected for the post from more than 50 applications. Ian held a number of senior safety related posts prior to his retirement including Director of Aviation Regulation and Safety Ministry of Defence and is the current Director of the UK Airprox Board (UKAB).

We have dealt with a wide range of safety issues over the years but one of the more significant enduring issues has been the relationship between flight crew and cabin crew members. The introduction of the locked flight deck door changed several aspects of Crew Resource Management and the relative responsibilities, many of which have been debated in FEEDBACK.

During my career in aviation the reliability of commercial aircraft has increased to a point where in-flight emergencies are now extremely rare. However, as a former test pilot, I am very aware that should a serious emergency situation occur a successful outcome will depend on the professionalism and teamwork of each and every member of the crew on both sides of the flight deck door. Knowledge and understanding of each other's roles and responsibilities, and mutual respect are important factors in a successful team.

My very best wishes to you all.

Peter Tait

NITS BRIEFINGS AND ALERT CALLS

Report Text: We arrived at the aircraft and were told that there was a problem with it. We did not know what the nature of the problem was; as a result we were delayed with passengers onboard for approximately 30 minutes. Finally the Captain spoke to the passengers; the problem, we still didn't know what exactly, had been fixed and we were ready to go. A short time after take-

off in the climb, the Captain made the ALERT call. I looked at my colleague, who decided to take the NITS briefing and was ready with pen and paper. After about 3 more minutes, the SCCM arrived in the galley and said: 'It's OK, it's not an emergency landing, we're OK, but here is the NITS brief anyway - NATURE = the gear doesn't retract, INTENTIONS= getting clearance from air traffic and go back to base, TIME = as soon as we get clearance to land, SPECIFIC INSTRUCTIONS = none'.

The SCCM returned to the front galley, and a few minutes later the Captain announced we were going back to base because 'there was still a problem with the aircraft and the engineers needed to look at it'.

The Captain then made the landing call to the cabin crew. We finally landed, disembarked the passengers, and gathered at the front of the aircraft. We expected some kind of a debrief. The Captain said that it wasn't a real emergency, when I asked him why the ALERT call was used; he replied that it was to ensure all the trolleys were secured and that we were sitting down. We hadn't left our seats, as the seatbelt sign was still on and there is a camera in the flight deck for them to check this. I told him that the passengers were asking us what the problem was and that he should have informed them, to which he replied they didn't need to know. The SCCM made a phone call to management, advising that we would operate to the original destination once a new aircraft had been organised and that all cabin crew were okay. So, we operated the flight, we were not debriefed, we were not asked how we were and most of all I am still unclear about whether the correct procedure was used.

Is it correct practice to use an emergency code/procedure for a non-emergency situation or just to make sure we are seated with trolleys secured? Doesn't this bring confusion and uncertainty to the current safety procedure and cause unnecessary stress and worry to the people onboard; the crew and passengers? After a situation like this, shouldn't some kind of official debrief take place? Surely we can all learn from non-emergency situations as well. Shouldn't management make sure that this didn't affect any of the crew on board (duty of care)?

Clarification on emergency procedures is needed. Both the cabin crew and the passengers should have been informed what the problem was. A proper debrief should take place for situations like this.

CHIRP Comment: The use of NITS briefings and ALERT calls is covered during cabin crew training.

The ALERT call is used to trigger a series of actions for the cabin crew members to undertake during a non-

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normal situation, such as a return to the departure airfield; however, its use in such circumstances would depend on what is stipulated in the company Operations Manual. Sometimes the Captain will make the decision not to inform the passengers of the situation so as to not cause any unnecessary distress.

The purpose of the NITS [NATURE-INTENTION(S)-TIME-SPECIAL INSTRUCTIONS] briefing is to inform cabin crew of any emergency or non-emergency situation and of the Captain's intentions in a structured manner. Similarly a NITS briefing is used to ensure that Air Traffic Control and the emergency services receive the most important information. It is wise to remember that the flight crew's primary task in any situation is to fly the aircraft and deal with the situation; therefore, it might not be always be possible to issue a NITS briefing to the SCCM immediately after an ALERT call. In the circumstances described, the Captain acted correctly in briefing the SCCM; this allowed the flight crew to plan the unscheduled return to the airfield.

After any situation in which an ALERT call/NITS briefing is issued, a post-flight debrief should be held to assist the cabin crew and flight crew to understand what happened and discuss any difficulties experienced.

EVACUATION SLIDE INJURIES

Report Text: On a recent training course with my company during evacuation slide training, I fell at the end of the slide and hurt my knees and the back of my hands as I came down at a very high speed.

There were no Velcro strips at the end of the slide to break my fall or two people at the end of the slide to assist as I have experienced with other airline training. The mat you land on was very thin and hard and made the impact on your knees even worse.

I have since found out that three other crew members on different courses have also had accidents on these slides and ended up having knee operations.

I wonder what perspective the CAA has on this.

CHIRP Comment: The reporter's query was referred to the CAA Cabin Safety Department for clarification on the regulations for slide descents during initial and conversion training.

The CAA advised that it is an operator's responsibility to ensure that each cabin crew member descends an evacuation slide representative of the aircraft type's main deck sill height. The slide can be fitted to an aeroplane or a representative training device. A further descent should be made when a cabin crew member qualifies on an aircraft type on which the exit sill height differs significantly from any other aeroplane type previously operated.

Ensuring that evacuation slide descents are conducted in a safe and controlled environment is the responsibility of each operator and is regulated by the Health and Safety Executive and not the CAA. This would normally require the operator to conduct a risk assessment on each of the representative training devices prior to any practice emergency slide descents being undertaken on training courses; the risk assessment should be reviewed regularly. Velcro strips or deceleration strips are designed to slow down the

descent of passengers and cabin crew and not to break falls.

When any incidents occur similar to that detailed in this report, they should be reported to the company and, where required, the Health and Safety Executive to enable the correct investigations to take place.

CABIN AIRFLOW

Report Text: The cabin air was stuffy especially towards the middle of the aircraft, some increased breathing and heart rates were noticed by the cabin crew. On checking the airflow was set to 'low', presumably to save fuel, the air quality was noticeably poor, and breathing had accelerated to compensate. This is a very common occurrence with this particular type of aircraft. Cabin crew often ask to adjust the air conditioning to make the air quality better but rarely the airflow is adjusted to normal. We are not only worried about our own air quality and health issues, but surely this can put strain on passenger's hearts and lungs. 'Normal' airflow setting needs to be mandated.

CHIRP Comment: The flight crew Standard Operating Procedures will always ensure that there is sufficient airflow through the main passenger cabin to maintain a safe level of ventilation for both passengers and cabin crew.

In some aircraft types, different airflow rates can be selected; the circumstances in which different settings may be used, such as the number of passengers onboard, are detailed in the flight crew Operations Manual and are normally based on the advice of the aircraft manufacturer.

In most aircraft the cabin airflow is comprised of air supplied directly from the engines but on occasions this may be mixed with cabin air that is recirculated through the airconditioning packs.

If the cabin conditions are as described in this report, the correct course of action is to report the matter to the SCCM and the Captain. If the problems should persist on a particular aircraft a report should be entered in the Technical Log to permit the matter to be investigated.

PUSHBACK PROBLEMS

Report Text: The amount of hand baggage on this flight was extreme, not only in quantity, but also the size of individual bags. With this in mind and having crew engaged in various duties it was impossible to communicate this to the ground staff. With passengers still standing and hand baggage not yet stowed; the aircraft pushed-back as soon as the boarding door was closed. This meant the crew had no choice but to stow the passenger baggage themselves, as we are not allowed to request passengers move around the aircraft whilst taxiing.

During this time I noticed that two seats had been allocated to two adults and two infants. The other free seats in the row had been allocated to other adults. This meant that four seats were allocated to six people. My concern over this was the quantity of emergency oxygen masks fitted at these seats. I have since confirmed there are only five. I contacted the SCCM who requested that I contact the Captain directly. The Captain stated that, in the event of a decompression, he

was happy for the passengers without masks to be provided with portable oxygen. This goes against our SEP training procedures, and endangers the safety of the customers and crew. I voiced my concerns, and reiterated that I move the passengers before take-off, unless we could confirm the allocation of emergency oxygen outlets was sufficient. The Captain told me he thought there were six, so it would be fine. I was extremely unhappy with this and stated so to the Captain and SCCM.

We were given no time to challenge the decision or to re-seat the passengers. As soon as the seat-belt signs had been extinguished after take-off, I swapped people around to ensure there was no danger caused by the lack of emergency oxygen outlets.

I take our passengers' safety extremely seriously, as I do that of the crew. We should not have been placed in this predicament by the allocation of seats in this way, but we should have been able to overcome it. If our flight crew colleagues understood the work load for the cabin crew, in each aspect of the flight, then perhaps these situations wouldn't occur. It should be clearly stated that punctuality MUST take second place to safety and security. As for pushing back the aircraft whilst passengers are still standing and baggage not stowed; this can only be resolved by a change in procedure. A call MUST be made by the flight crew, to ensure passengers and crew are ready for push-back.

CHIRP Comment: The aircraft door should not be closed if there are any outstanding issues with handbaggage which cannot be safely stowed in the cabin, and the aircraft is not ready for push-back/engine start with passengers standing in the aisle.

Cabin crew must be assertive and raise any such concerns with the operating SCCM, who should also inform the flight crew that the aircraft is not yet ready for pushback.

Operators' Cabin Crew Manuals should include the number and location of masks located throughout the cabin and where extra masks are available, the seating of all passengers must ensure that these are accessible.

In the event that incorrect seating is identified either during boarding or during the securing of the cabin, then this must be resolved before passing the 'Cabin Secure' check to the flight crew.

LOW DOOR PRESSURE WARNING

Report Text: During take-off phase the caution light on the door panel lit up. I checked the error message on the display which read "DOOR PRESSURE LOW".

Having had a previous incident of this nature which required returning to stand after push-back to allow the engineers to fix the problem, I called the flight crew to report the problem. The First Officer answered and I explained the problem. He replied saying it was to do with the slide pressure and would come back to me after they had completed the departure. Mid-flight the Captain came out to the fwd galley and asked what the message had read. I explained that the reason I had called immediately was that I'd previously had such an incident that required returning to stand, and as far as I was aware, a slide pressure issue would come up on the

display as just that. This was referring to the power assist function of the door.

The Captain asked me to report the defect, which I did.

CHIRP Comment: The rules relating to defects such as that described are different for the two situations quoted: (1) during/after push-back and (2) during the take-off.

In the above case, the correct course of action was to report the defect to the flight crew and then to record this at the end of the flight. It would be appropriate to ensure that all the cabin crew members are briefed on the warning message, so that in the event of an emergency evacuation, they are aware that the power assist function may fail and increased force may be required to open the door.

Thereafter, subsequent flights may be permitted with the defect deferred for a limited period of time/number of flights in accordance with your company's Minimum Equipment List (MEL) for the aircraft type. However, if the fault should render the door inoperative, it must then be placarded as such and the number of passengers onboard adjusted accordingly.

ARE FOUR AIRCRAFT TYPES LEGAL?

Report Text: I am currently checked on three different aircraft types to fly as well as having completed a conversion course last year. As well as being an operating SCCM, I am also a ground training instructor.

All throughout training we were informing the cabin crew that they would drop the third aircraft type once they had completed a 'hands on' aircraft visit as this would replace the standard supernumerary flight. However, we are now being told that cabin crew can operate on all three previous types until the aircraft commences operations. For many crew including myself there will be a period of several weeks following the 'hands on' visit; I am concerned regarding the legality of this.

I have questioned this with my company management and have been told that it is OK.

I have flights rostered on all three current aircraft types in the days before the aircraft arrives, which will be shortly followed by my first flight; having my previous third type flight a couple of days beforehand. Many of my colleagues have approached me for guidance and I would be grateful for your comments on this.

CHIRP Comment: A request for clarification was submitted to the CAA Cabin Safety Department.

The CAA has advised that cabin crew are not permitted to operate on more than three aeroplane types with greater than 19 seats, unless an operator has been granted approval by the Authority. As at the date of our enquiry no operators have been granted this approval.

Where an operator does not hold such an approval, on completion of all of the required elements of ground training (including an aircraft or 'hands on' visit for the purposes of familiarisation), the crew member must be removed from one of the other types of aircraft.

Instructors may still continue to train on more than three aeroplane types, provided they are restricted to operating on no more than three types.
