

CHIRP Cabin Crew FEEDBACK

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WHO ARE THE MEMBERS OF THE CABIN CREW ADVISORY BOARD AND WHAT DO THEY DO?

In addition to the main CHIRP team who complete the day to day running of the Trust and the answering of reports that have been submitted through the Programme, there are three Aviation Advisory Boards – Air Transport, General Aviation and Cabin Crew. The Advisory Boards provide specialist expertise in the definition and resolution of issues reported through the CHIRP Programme. They are comprised of nominees from all of the principal relevant aviation interests.

The role of these Advisory Boards is to review the reports and issues that have been put forward for discussion at the quarterly meetings and provide counsel to the Chief Executive, Deputy Director (Engineering) and the Cabin Crew Programme Manager on the most appropriate way in which specific issues might be resolved. The reports that are submitted for discussion are disidentified of personal information and any other details that could infer the identity of the reporter or the operator that they work for. The Board's comments on the reports are then fed back to the individual reporters after the meetings. A selection of the reports are also included in the CHIRP FEEDBACK newsletter relevant to each Advisory Board.

Three editions of Cabin Crew FEEDBACK are distributed to cabin crew per year and are available in paper and electronic copies. Paper copies are available from the different operators and also the Unite Trade Union. Electronic copies are emailed to those who have asked to be included in the distribution list.

All Advisory Board members act as individual expert advisors and not as representatives of their organisations. The composition of the Boards is reviewed regularly to ensure that the membership is appropriate to the scope of the Programme and so that they retain relevant current operational expertise.

The Chair of the Cabin Crew Advisory Board (CCAB) is Debbie Elliott. Her current position is Training Manager for TAG Aviation based in Farnborough. Debbie has been a member of the CCAB since June 2011 and Chair of the Board since March 2014. Her career in aviation spans over 25 years with time spent working for Virgin Atlantic as Cabin Crew Onboard Manager, as well as UK & Ireland Pilot and Cabin Crew recruitment assessor and Base Manager for Thomson Airways. Debbie joined TAG Aviation in September 2009 to develop the Training Centre for their own crew and other third party clients who require EASA-compliant training. Like several other members of the CCAB, Debbie is an active member of the Cabin Safety Liason Group, a UK and Ireland-based committee which meets three times a year to help establish best safety practice for policy, procedural and training matters.

The current CCAB is comprised of experienced cabin crew representatives from a variety of operators including British Airways, Virgin Atlantic, Jet2, easyJet, Ryanair, Norwegian UK, Titan Airways, Aurigny and Eastern Airways; the Board also includes representatives from the CAA, Unite the trade union and flight crew members from different operators.

Stephanie Dykes
Cabin Crew Programme Manager

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CREW MEMBER UNABLE TO ARM/DISARM THE DOOR

Report Text: Departing downroute for base, a crew member was unsure how to arm the door for departure. They admitted they'd "breezed over it" in training and ended up in tears. I had to teach the crew member how to arm a door.

Lessons Learned – The Company training should be revised. Arming and disarming doors is not an on the day kind of coaching. Fundamental safety flaws.

CHIRP Comment: Incidents similar to those detailed in this report, should be reported directly to the operating SCCM at the time of the event but also via the company reporting programme on returning to base. By speaking with the SCCM at the time, it provides them with the opportunity to review the individual crew member's knowledge of door operations and allows them to make the decision as to whether the crew member can operate the flight or needs to be stood down from the duty. If it is determined that the individual crew member needs extra training before operating, this can then be arranged by the operator.

During both initial and recurrent courses, touch drills of door operations will be completed. Full door training, including the opening and closing of all aircraft doors that the crew member is trained on must be completed every 3 years. Each crew member is trained in the same way and shown how to operate the door/s and use the commands that must be voiced during the process. They will be assessed by the trainer conducting the session and will be advised whether they have passed or failed the door procedures.

The individual crew member discussed in the report above may have had limited experience of flying on this particular aircraft and had forgotten how to arm and disarm the door. There is a responsibility on each crew member to know on which aircraft they are operating that day and to refresh themselves on procedures before operating, if they feel that it is required. This should include safety equipment and procedures.

If current cabin crew are frequently seeing that new cabin crew have problems remembering door operations, this could suggest that there is an underlying issue with the standard of the training provided, rather than the individual crew member. It is important to ensure that concerns about training are reported to the company for monitoring purposes.

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PROBLEMS WITH AIRCRAFT EQUIPMENT VS SERVICE STANDARDS

Report Text: We left base with a number of items of cabin/galley equipment unserviceable. We were told that the aircraft had been like this for 5 days. The hot oven racks had to be swapped over on trolley tops with a full flight. I do not believe this was safe at all. The service in the cabin was not to the required standard due to this.

Due to the change in service, there is not enough time to complete the service and the crew are not achieving breaks. The company have told us that on some routes we will be getting another crew member but this has not happened due to the high number of crew leaving the company.

This service is hard for crew, sometimes they do not have a break. We are always in the cabin, we cannot complete our safety checks on the toilets as we have no time to leave the trolleys. When we need to complete them, there is a long line for the toilets. Sometimes we can't even have a drink of water.

When we stated this to the managers, they told us to take a bottle on the trolley. We do not have room on the trolleys for what we need never mind a bottle of water. One of our crew members fainted on a flight due to this.

We need more crew on these flights for this to work. The company does not seem to care about the crew or passengers as long as the flights leave.

CHIRP Comment: This report raises a number of concerns – inoperative equipment impacting on service and safety standards, high workloads due to minimum crew complements and the ability to achieve a nutritional break during busy duty days.

All inoperative equipment – whether it is in the cabin or the flight deck – must be recorded in the aircraft tech log for rectification. Most equipment will have alternative procedures to be adopted should an item be inoperable during the flight. These procedures should be communicated to all crew members before departure – if the fault has been found before departure. If the inoperable items are needed for the service aspect of the flight, again, the service must be adapted accordingly and reported internally to the company. Service standards should never compromise safety, so the operating SCCM must analyse whether the service can safely be completed with the equipment available or whether it needs to be adapted accordingly.

Toilet checks should be completed during the flight in accordance with the company Standard Operating Procedures. If there are passengers queuing for the toilets at the time that the cabin crew need to complete their checks, it is considered reasonable for cabin crew to advise the passengers that they have to complete this task before they can use the facilities.

It is important for cabin crew members to stay hydrated during flights. It is understood that high passenger loads and workloads can make this more difficult; however, by keeping bottles of water in the galley and the crew having a drink each time they return to the galley to complete different tasks during the service, this should help to alleviate dehydration.

CHIRP has received a number of reports about high workloads due to minimum crew complements. These busy flights must be reported directly to the company so that consideration can be given to reviewing the crewing levels to ensure that there are sufficient crew members to complete the tasks that are expected of them; or whether the tasks need to be reduced to be consistent with the crew complement, including any requirement for crew breaks.

ORO.FTL.240 states that during an FDP there shall be the opportunity for a meal and drink in order to avoid any detriment to a crew member's performance, especially when an FDP exceeds 6 hours. Operators should specify in the Operations Manual how the crew member's nutrition during FDP is ensured. The operating SCCM is responsible for managing breaks throughout the duty and should allocate them to their crew. If for some reason a break cannot be achieved due to lack of time or high workload, this should be reported to the company every time it occurs, via the internal reporting programme after the duty.

It is worth noting that on flights where crew members must achieve inflight rest to complete the duty, the rest period must not be reduced in order for the service to be completed. EASA FTLs and the company Operations Manual will state the rest period required to complete the duty and this should always be adhered to.

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NUMBER OF PORTABLE OXYGEN BOTTLES AND SAFETY CARDS ON THE AIRCRAFT

Report Text: We got on the aircraft and were completing the pre-departure SEP and crew checks when my colleague noticed their seat was missing a portable oxygen bottle. I notified the SCCM, who contacted Engineering to ask for another to be loaded. Engineering told the SCCM that the inbound crew on the aircraft had used 4 oxygen bottles and there wasn't any in stock to replace them, meaning we would have to go without them being replaced. This then meant that there was not enough onboard for every crew member. The crew member whose seat was missing the oxygen bottle was told they would have to not follow the procedures in case of a decompression and just take a seat connected to a drop down mask and stay there. We were also told that in case of a medical emergency, we must use the fixed and NOT the portable oxygen, which would be near impossible and completely impractical in the case of a cardiac arrest where CPR would need to be administered.

There was also a lack of safety cards on the aircraft. Over 30-40 seats were missing safety cards at the rear of the aircraft. We asked for some more and ensured every seat had a safety card.

Lessons Learned - No lessons learnt. I would suggest taking 1 spare bottle off every aircraft (some of our aircraft have 6+ in the rear galley alone) to allow Engineering to have a backup supply for when oxygen bottles do go out of stock, so no aircraft goes without minimum stock.

CHIRP Comment: This report was referred to the company engineering department for further comment, who advised that there must be one oxygen bottle available for each of the required crew members on the aircraft. In this case, the aircraft had over the minimum required complement for the required cabin crew, so was therefore permitted to depart. It was confirmed that the missing bottle was then replaced on return to base.

GM1 CAT.OP.MPA.170 Passenger Briefing states c) The safety briefing card should be designed and the information should be provided in a size easily visible to the passenger. The safety briefing card should be stowed in a location from where it is easily visible and reachable to the seated passenger and from where it cannot easily fall out.

Ideally each operator will place a safety card in each seat pocket. However, to meet the above requirement, one per row – depending on the size of the aircraft - would be sufficient. Depending on the operator's procedures, various departments will be responsible for replacing safety cards. In any case, seat rows with missing safety cards should be reported directly to the operating SCCM and via the company reporting

programme to allow the company to follow-up with the relevant department that this task is completed as per the company procedure.

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CARRIAGE OF LITHIUM BATTERIES – NO CHECKS COMPLETED BY THE GROUND STAFF

Report Text: I travel frequently between AAA-BBB with one particular operator. They have a policy of queue sweeping and tagging baggage for hold carriage at the gate. At BBB airport (a European airport), the aircraft loaders also stand at the boarding door and do last minute tagging of bags, as well as ground staff tagging at the gate and in the boarding queue. At no point are passengers asked if they have lithium batteries in their luggage (or any other dangerous goods that should not be carried in the hold). No questions are asked - passengers are simply told their bag needs to go in the hold.

I overheard a verbal declaration at the boarding door of a lithium battery being in the baggage, which the ground staff did not understand and appeared to ignore. The time restraints of boarding are such that passengers are practically pushed on to the aircraft and told to sit down, with numerous pleas on the PA from the flight crew. The whole process is so rushed with an absolute dedication to an on-time departure that it appears SOP's are not being adhered to.

Lessons Learned - I just feel this procedure is not conducive to safety. The whole indiscriminate tagging of bags during the entire boarding procedure, which is rushed anyway, doesn't allow sufficient time to check that hold baggage is safe for carriage.

CHIRP Comment: There are two types of Lithium batteries: Lithium metal and Lithium-ion (sometimes abbreviated to Li-ion batteries). Lithium metal batteries are generally non-rechargeable batteries that have lithium metal compounds as an anode. These type of batteries are usually used in watches, calculators, cameras and defibrillators. Lithium-ion batteries are rechargeable batteries where the lithium is only present in an ionic form. This type of battery is used in mobile phones, laptop computers, tablets and other personal electronic devices (PEDs), smart luggage, mobility aids and some portable medical devices e.g. portable oxygen concentrators.

PEDs, which includes mobile phones, tablets and laptop computers, some cameras, power banks and spare batteries should always be carried in the passenger's carry-on baggage. If such devices are contained within checked baggage, measures must be taken to protect the device from damage and to prevent unintentional activation and the device must be completely switched off (not in sleep or hibernation mode). Electronic cigarettes (including e-cigars) and vaping devices must also be stored in the passenger's carry-on luggage. The recharging of such devices is not permitted onboard the aircraft and the passenger should ensure that they cannot be accidentally activated. When carried in the cabin, mobility aids and smart luggage must have their lithium ion battery removed and stowed separately with the terminals protected.

The above report was referred to the operator for further investigation, who advised that the current company procedure requires ground staff to ask passengers if they have any medication, spare batteries or passports in their luggage whilst they are tagging the bag to ensure that these items do not go in the hold of the aircraft.

It has since been confirmed that the information in the report was passed to the Ground Operations Safety and Compliance Manager who issued a memo to all ground staff at the bases concerned, reminding them of the policy on the carriage of lithium ion batteries. A memo has also been circulated to the cabin crew.

We would like to take this opportunity to thank the reporter for highlighting this issue to CHIRP as they were unable to report their concerns directly to the operator in question. By reporting their safety concerns, we have been able to pass the information to the operator who has then been able to complete mitigation to ensure that the problem does not continue to occur.

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Reports received by CHIRP are accepted in good faith. While every effort is made to ensure the accuracy of editorials, analyses and comments published in FEEDBACK, please remember that CHIRP does not possess any executive authority.

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