CHIRP FEEDBACK

Issue No: 98 2/2011

EDITORIAL

Excess Cabin Baggage

In the last issue, we published two reports highlighting the difficulties experienced by cabin crew members arising from the stowage of excess carry-on baggage items. Following publication, we received the following query from an airline:

I read with interest Cabin Crew Report No 2. page 7 regarding the rather extreme case of 5/6 bags being carried on the flight deck and was interested in the final paragraph where it is states that "Stowing excess baggage in unapproved stowages or on the flight deck is both illegal and, in the case of an emergency situation arising potentially unsafe".

Whilst accepting that this is potentially unsafe, I would appreciate it if you could point me to the requirement / reference that makes stowing bags on the flight deck illegal. I did look in EU-OPS 1 but couldn't find anything.

The relevant EU-OPS references are highlighted below. The first relates to the aircraft commander's responsibilities:

EU-OPS 1.290 (b) 10. states:

(b) The commander shall not commence a flight unless he/she is satisfied that:

10. the load is properly distributed and safely secured

[Note: Our underlining]. Our understanding is that cabin baggage/items are covered by this requirement.

The operator's responsibilities include the following:

EU-OPS 1.270 (b) states:

An operator shall establish procedures to ensure that all baggage and cargo on board, which might cause injury or damage, or obstruct aisles and exits if displaced, is placed in stowages designed to prevent movement.

In addition, Appendix 1 to 1.270 states:

Procedures established by an operator to ensure that hand baggage and cargo is adequately and securely stowed must take account of the following:

1. each item carried in a cabin must be stowed only in a location that is capable of restraining it;

2. mass limitations placarded on or adjacent to stowages must not be exceeded;

3. underseat stowages must not be used unless the seat is equipped with a restraint bar and the baggage is of such size that it may adequately be restrained by this equipment;

4. items must not be stowed in toilets or against bulkheads that are incapable of restraining articles against movement forwards, sideways or upwards and unless the bulkheads carry a placard specifying the greatest mass that may be placed there;

5. baggage and cargo placed in lockers must not be of such size that they prevent latched doors from being closed securely;

6. baggage and cargo must not be placed where it can impede access to emergency equipment; and

7. checks must be made before take-off, before landing, and whenever the fasten seat belts signs are illuminated or it is otherwise so ordered to ensure that baggage is stowed where it cannot impede evacuation from the aircraft or cause injury by falling (or other movement) as may be appropriate to the phase of flight".

In addition to the above, the CAA also advised that the following statement published in CAP 789, "Cabin baggage may only be stowed in approved stowages. Operators should provide clear and unequivocal advice to flight and cabin crew as to which stowages are approved." is promulgated in most if not all UK AOC holders' Operations Manuals.

It is, of course, legal for baggage to be carried on the flight deck provided it is secured in a locker or wardrobe and does not obstruct access to the exits or emergency equipment such as fire fighting equipment which can often be found in the area of the jumpseat(s) behind the operating seats.

ATC REPORTS

A Good Working Environment (FB97) - A Comment

Report Text: Whilst agreeing with the comment on the ATC report 'A Good Working Environment' in the last issue (Pages 1/2), I and several colleagues wondered why on this occasion CHIRP had not raised the matter directly with the Unit management.

CHIRP Comment: It is important to remember that we only take action on behalf of a reporter with their consent. In this particular case, as the work had gone ahead in spite of representations directly to the Unit management, the preferred course of action was to bring the matter to the attention of the CAA; this was done.

Runway Inspection Procedures

Report Text: The runway inspection procedures at this airfield have changed. Previously, they were very simple. Inspections were carried out on an 'on/off' basis; that is to say they were carried out between movements; no gaps were created specifically for the inspections. For departures this meant using the wake turbulence separation gaps or SID separation gaps to

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allow the inspection vehicle on to the runway. In a landing sequence the runway was inspected between arriving aircraft, and called for good judgement and technique on the part of the ATCO and inspection vehicle crew. While there were some cases of misjudgement, there is little evidence to suggest this is an unsafe procedure when carried out correctly. Indeed, immediately prior to the change in procedures, it was agreed that steps should be taken to ensure that runway inspections were not leading to inappropriately late landing clearances.

However, something happened then that made the practice of 'on/off' inspections taboo amongst the unit management; both the Airport Authority and the ATCO workforce were presented with the intention that the only safe way to undertake runway inspections was to ensure a sterile runway (i.e. no departures or arrivals for the duration of the inspection). Only the mid-morning and mid-afternoon routine inspections were to be sterile runway inspections. To back up the argument, the ATC Safety department presented a selection of safety incidents that were ostensibly caused by human error during runway inspections. However, if one took the time to examine the data more thoroughly, it could be seen that the majority of these incidents did not occur during routine inspections and would not have been prevented by the change to a sterile runway.

There was a great deal of protest from ATCOs, but it is very difficult to argue against something that on paper is obviously safer in that vehicle/aircraft interaction is significantly lessened. We now have a sterile runway for both routine daytime inspections.

My objective in writing is to highlight my belief that we have actually performed a retrograde step, and the law of unintended consequences is coming into play.

Previously we had one runway inspection procedure. Everybody knew it and it was very simple. Now we have more than six different procedures, if you count all the variables; day, night, LVPs, CAT I, different runways, one or two vehicles. There is far more potential for confusion.

The Hazard Analysis identified that a significant hazard to the operation was the increase in delay due to either suspension of departures and arrivals. The mitigation stated was that, for the inbounds, flow control would be applied to decrease the pressure on the operation. I really don't believe that happens. This adds to the pressure and workload for both Approach and Tower controllers.

One of the main benefits claimed for the sterile runway procedure was that it would allow the inspection vehicles to be more alert to FOD on the runway and not keeping one eye on the aircraft. I now believe this to be specious. Recently I witnessed the inspection commence later than planned. The planned gap in arrivals was already halfway gone before the inspection commenced. The two inspection vehicles were attending another incident on the airfield and sped down the runway far quicker than usual, I assume to ensure that another gap was not required. Was enough attention paid to the runway? Was the pressure to begin the inspection detrimental to their duties at the previous incident? To me this shows that both ATC and the Airport Operations staff now have a great deal of pressure to get the inspection over with in the planned gap. The benefit of the old system was that there were no forced gaps, so there was no pressure on getting the inspection done by a particular time.

Conducting a safe and efficient arrival runway inspection was a mark of a competent controller, and showed high levels of situational awareness, and was useful practice in judging speeds of aircraft and what one could do safely with a certain gap. We have recently seen an increase in missed approaches due to crossing aircraft (both under power and being towed) still being on the runway, in many cases down to inappropriate choice of gap. I would suggest that ATCOs now have less opportunity to do this regularly due to the sterile runway inspections.

A rather confusing new development is that a procedure has been introduced where the airport authority can conduct training in 'on/off' inspections without requiring a sterile runway. We were told that the change to sterile runways was brought about due to the safety risk of a runway incident. That was with experienced ATCOs and experienced vehicle drivers. However, we could now be faced with trainee drivers going on and off the runway between movements, controlled by a newly valid ATCO who has never seen an 'on/off' inspection! The risk of an ATCO making a mistake was highlighted in the Hazard Analysis for this training, but the mitigation against a safety outcome was that ATCO judgement and experience would prevent it! Which is exactly what we were told by management and the safety department was not sufficient in the first place! If ATCO judgement and experience is sufficient for this procedure, then it is sufficient for the old runway inspection procedure.

***CHIRP* Comment:** **The reporter's concerns were represented to management and subsequently discussed with a senior safety manager.**

The safety risks associated with the interaction between landing/departing aircraft and ground aircraft/runway movements on the active runway led to local multi-disciplinary Runway Safety Teams being established at several airfields. As the reporter notes, the decision to introduce the sterile runway inspection was taken after a risk assessment that included a review of previous incidents related to 'on-off' inspections. The sterile runway inspection reduces the number of occasions that the potential for a confliction between an aircraft and a ground vehicle can exist. An invitation was extended to the reporter to discuss any continuing concerns either directly with the Chairman of the local Runway Safety Team or in confidence, if preferred.

The Air Transport Advisory Board noted the concern about driver training; if as reported, this aspect merited a further review for the reasons stated in the report.

ENGINEER REPORTS

DISTRACTIONS AT WORK

Report Text: In recent times there has been an increasingly tight squeeze on delivery performance and productivity levels within the company, with higher

efficiencies targeted and reduced downtimes/on-time delivery being the measure of 'great success'.

We seemed able to cope with these expectations moderately well; with an employee reward scheme based primarily on good 'on time' delivery performance, the majority of the workforce bought into this ethos and were 'engaged' in the company aims. Senior management has continually reminded us of the trading difficulties and our economic plight, emphasising that the future was by no means certain. To that end several steps were taken to drive efficiencies and productivity performance levels even higher.

To ensure the workload through the facility could be met with very lean capacity, the company used a core contracted workforce, flexing as required to accommodate peaks and troughs. The permanent staff felt a bit more secure knowing the contracted staff could be a buffer between job cuts if the situation became more difficult.

However, in a management briefing redundancies were mentioned and although it would be 'nice' to get rid of the contractors, they would be cheaper in the long term and thus were seemingly the favoured capacity. This had a huge effect on the well-being of the permanent staff. The permanent mechanics/technicians, who were already de-motivated by lack of any pay rise/bonus and no chance of overtime (all vital to the lowest paid grades), now knew that there was also no chance of future promotion whilst management favoured contract labour.

During all this wrangling there has been an increasing trend of quality lapses being reported, found both within the company and also in service post-maintenance. All the time the emphasis has been on performance/efficiencies and on-time deliveries, it seems only lip service was being paid to quality and safety standards. Coupled with this, there was also an ongoing process of restructuring the senior management within the company, cutting management headcount. This has been a very emotive situation with managers not knowing if they would hold down their job, leading to a great deal of uncertainty. During this time, quality lapses were occurring and being correctly reported.

Everywhere you turned all staff grades mentioned that there was a lack of confidence in the company's strategy to cope with the situation - with senior managers confused at the direction the company was taking. The key concern being the number and regularity of incidents and occurrences - remember all these were reported correctly and investigated. All departments saying there is a need to change to prevent a serious incident - people are genuinely fearful. The current environment and morale is not conducive to safe aircraft maintenance and it is far from being a no blame culture.

CHIRP Comment: The reporter's concerns were represented to a senior manager within the Quality department, who instigated an independent review utilising trained investigators from outside the organisation.

The main focus of the review was a thorough audit of maintenance processes and the safety culture that prevailed. With one exception, the audit did not identify any significant loss of control in the processes employed in the organisation. However, it did confirm a significant degree of uncertainty and the effect this was having, causing distraction at all levels.

A series of meetings were held involving all staff grades to permit a more open discussion, highlight quality issues identified within the organisation and provide feedback on the actions that had been taken to resolve them. The management's commitment for maintaining safety standards was also re-emphasised. This initiative was subsequently confirmed to have been received positively with action plans having been implemented to resolve identified shortfalls.

No Consistent Drugs and Alcohol Testing Policy?

Report Text: I was recently selected randomly by my company, along with others for a drugs and alcohol test carried out by our company nurse and doctor. They carried out the process clinically and very professionally, I must say, and I had full confidence that all would be satisfactory.

Whilst discussing the process with our nurse, I was shocked to learn that, although a regular check is made on Engineers, these checks are not made within the company for flight crew members; the reason cited was that BALPA do not permit testing of flight crew.

Surely recommendations in CAAIP 15-6 are effective for all individuals actively involved in aircraft operations.

My colleagues and I are happy to submit ourselves to testing; we are not above the regulations.

CHIRP Comment: Engineers in the UK are not required to undergo random drug/alcohol testing in order to maintain their licence under EASA regulations. However, random testing may be required in organisations holding a FAA Part 145 approval to support a maintenance contract for certification of 'N' registered aircraft; as was the case in this report. It should be noted that holders of FAA professional pilot licences and UK licensed pilots operating into/out of the USA are similarly subject to the FAA random testing requirements

It has been confirmed that BALPA's policy on random testing is consistent with the International Federation of Airline Pilot Associations (IFALPA). IFALPA supports a civil aviation workplace free of problematic substance use but does not support random testing due to operating distractions that it might cause and the effects of a possible failure of the testing procedure.

Notwithstanding the above, engineers do have a legal requirement to present themselves in a medically fit state to carry out their certifying responsibilities under EASA Part 145 and Part 66 requirements. Similar requirements also apply to flight crew and the other groups.

In the UK flight crew, cabin crew, ATCO licence holders and licensed aircraft engineers are all subject to Part 5 of the Railways and Transport Safety Act 2003, which

came into force on 30 March 2004. The Act makes it an offence for an individual in any of the above groups to carry out their duties with a blood, breath or urine sample above the prescribed alcohol level. Civil Aircraft Airworthiness Information & Procedures (CAP562) Leaflet 15-5 and 15-6 provide additional guidance for engineers.

THE RIGHT SKILLS FOR THE TASK?

Report Text: There have been several occurrences of aircraft returning to base with defects that have been found whilst down route which would have grounded them! All supported by Cat A mechanics that do not have the right qualifications flying with the aircraft to remote stations.

A recent case involved damage which was assessed when it returned to UK as being outside of limits and resulted in a major component being changed! This damage was found whilst down route with the engineer being told to ignore it by the company so that the aircraft could return to base.

I personally feel that this is a very dangerous practice and it is certainly not within the realms of a mechanic's capabilities! As Cat B licensed engineers, we are expected to cover up these defects and this is simply not on! When the aircraft arrive back we are usually confronted with a 'fag packet' defect list from the mechanic, as they are unable to do anything about them!

When local management have been confronted about this issue they reply 'stop moaning and get on with it'.

Lessons Learned: Only send correctly licensed engineers away with a/c

CHIRP Comment: **The reporter's concerns were raised with the company. The company's subsequent response did not accord with additional information submitted by the reporter. On the advice of the Air Transport Advisory Board, the matter has been referred to the CAA for investigation.**

On the general issue of engineer qualifications, the CAA has advised that whilst a Category 'A' licensed engineer is qualified to conduct a turnround inspection/ refuelling, he/she cannot carry out any defect assessment outside of their certifying scope. However, a Cat 'A' engineer is required to report defects even if he/she is unable to rectify them. In contrast, a Cat 'B' licensed engineer is able to diagnose defects and make technical assessments, defer defects if permitted, and certify defects when appropriate rectification has taken place.

It is important that the aircraft commander is aware of the qualification status of an engineer carried in similar circumstances, since the advice that he receives might be relevant to his overall responsibility for the safety of the flight.

Civil Aviation Authority INFORMATION NOTICES

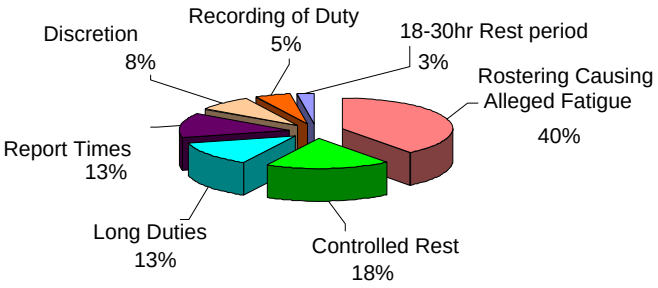
Details of recently issued CAA Information Notices are published on the CHIRP website at www.chirp.co.uk

FLIGHT CREW DUTY REPORTS 2009 AND 2010

Introduction: Between 2006 and 2009 the number of FTL related reports submitted by flight crew reduced year-on-year from a total of 98 in 2006 to 34 in 2009. A total of 41 reports in the same category were received in 2010

2009: In 2009 a total of 34 reports was received, involving 38 issues.

Flight Crew Duty Report Issues - 2009

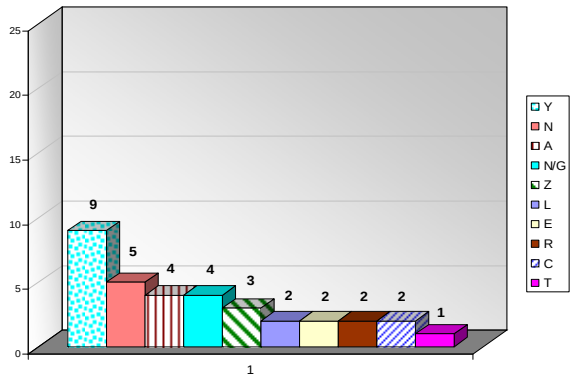


The largest category of reports, allegedly poor rostering practices (13 reports; 37%), was similar to previous years although the specific issues raised by reporters within this category were different and in several cases company specific, as detailed below. One of the more significant issues reported in previous years, the routine scheduling of rest periods between 18 and 30 hours, predominantly by one UK operator (Operator L), appeared to have been resolved.

The second most frequently reported topic involved rest (8 reports; 23%) and principally the practice of 'Controlled Rest', which had also been the subject of a number of cabin crew reports by cabin crew members employed on long haul operations by one UK operator.

Within the remaining categories, the publication of Flight Operations Department Communication (FODCOM) 10/2009 in April 2009 clarifying several rostering practices appeared to have been effective in addressing some of the innovative interpretations by some operators, such as the adaptation of standard FTL variations for use by more than one crew and extending the maximum Flight Duty Period by the use of additional flight crew members positioning in the main passenger cabin. No reports on these topics were received during the 2009 summer season. One issue referenced in FODCOM 10/2009, the adequacy of report times, continued to be reported; five reports expressed concerns about changes associated with pre-flight duties that were not acknowledged in the report times, either due to the report location being moved airside or changes in the method of obtaining the relevant operational information (hard copy replaced by downloading electronic data); four reports in this category were received in the final quarter of the period.

Duty Report Issues by Operator - 2009



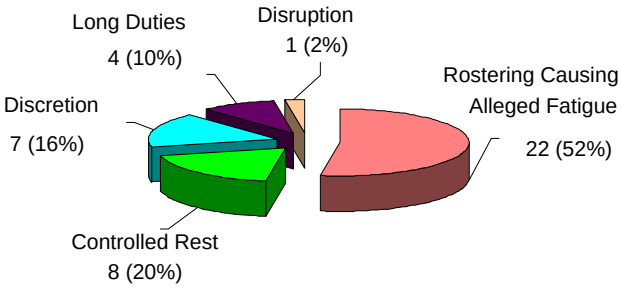
Nine reports (38%) of the total received referenced Company Y and involved two separate concerns. The first was the introduction of an additional schedule to the Far East and Australia in which the stopover periods had been reduced. The reports alleged a significant increase in tiredness levels on the return sectors, particularly the inbound sector to the UK. The schedule was assessed using the SAFE 'Work-Rest' computer programme developed by QinetiQ for the CAA; this showed that whereas the predicted level of tiredness was lower for the second outbound sector due to the re-timing of the schedule; that for the final sector was higher than the original schedule. Similar representations were also made to the Company regarding the levels of tiredness. The matter was brought to the CAA's attention; however, shortly thereafter, the Company elected to discontinue the additional schedule. The second issue was associated with the use of the two crew Florida 2 (F2) Variation to/from US destinations; the reports alleged that an increase in the frequency of use of the variation leads to crew members being rostered for the maximum number of F2 schedules permitted, causing fatigue.

The predominant issues in reports related to Company N were the poor planning and management of some rosters/duties; several quoted unrealistic sector/turnaround times associated with FDPs at or close to the maximum permitted. As noted above, all of the reports related to Company A were comments in response to cabin crew concerns about the frequency of use of Controlled Rest, as were the majority of unidentified reports. Among the reports submitted by pilots employed by other UK operators there were two points of note; the first was the difficulty experienced by flight crew members in completing required pre-flight duties within the time afforded by the scheduled report time (Company E, T, Y); the second was no/insufficient duty allowance for ground training tasks (Company R).

2010: In 2010 the number of duty related reports was slightly higher than 2009; a total of 42 reports (45 issues) compared with 34 reports for the previous year. The principal reason for this was a significant increase in the number of reports relating to one operator.

If you wish to contact the CAA Flight Operations Inspectorate or to report any safety matter which is outside the scope of the MOR Scheme please e-mail the CAA at: flightoperationssafety@caa.co.uk

Flight Crew Duty Report Issues - 2010



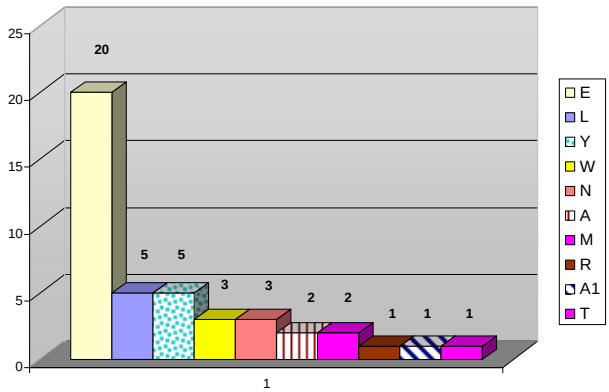
Of the 42 reports received, 22 reports (52%) related to crew rosters or rostering of flight crew. As in 2009, this was the most frequently reported topic. Of the total in this group, 11 reports (50%) involved one operator. Specific issues included allegedly questionable roster practices, alleged company pressure on individuals to accede to roster changes for delayed flights/duty changes due to a lack of availability of standby crews, scheduling of flights that were technically just within the maximum permitted Flight Duty Period but with allegedly unrealistic sector times and/or turnround times.

The second most frequently reported topic was rest (8 reports), also the same as in 2009. Within this group five reports raised continuing concerns about the use of bunk rest/controlled rest and involved more than one company. A related issue was the alleged deleterious effect of reducing an augmented three-crew operation on a long haul route under a Florida 2 variation to a two-crew operation.

Seven reports involved discretion and were sourced predominantly from one operator. Reports alleged an expectation by the company that commander's discretion would be exercised to complete the scheduled sectors irrespective of the circumstances.

Three reports related to the length of a scheduled flight duty. All alleged that the scheduled flight duty period could not be achieved in practice.

Duty Report Issues by Operator - 2010



Within the total of 45 FTL related issues raised during 2010, 20 issues involved one operator (Operator E), which interestingly, was operating a fatigue management programme during this period. The principal issue (11 reports) was similar to that for Company N in 2009, namely allegedly poor planning and management of schedules/rosters/duties; reported

problems included poorly planned schedules leading to delays, planned FDPs at or close to the maximum with unrealistic sector/turnaround times scheduled and a shortage of standby crew members. These problems contributed to the second issue, Discretion (6 reports), all of which alleged either pressure by management to exercise discretion or an assumption that a captain would exercise discretion. The remaining issues were associated with long duties by standby crews and inappropriate rest periods between long duty periods.

In the case of Company L, three reports involved the effect of roster changes at short notice involving switches from early to late duties or vice versa. Two raised concerns as to the adequacy of the pre-duty rest period after having being stood down from a standby duty to operate a later flight.

All of the five issues related to Company Y involved the operation of particular longhaul routes; aspects included the use of two crew versus three crew, the removal of the Florida 2 Variation and thus the removal of the restriction on the number of rotations that can be scheduled, and the effect of delays downroute.

FLIGHT CREW REPORTS

ALTIMETER SETTING ERROR

Report Text: On departure from AAA at 6,000ft we were instructed to climb further to Flight Level 80. As per company procedure, as pilot monitoring [PM], I set 8,000ft in the ASEL [Altitude Select] window; the pilot flying [PF] confirmed the 8,000ft setting in the ASEL window; he then armed the FLC [Flight Level Change] mode and began to follow the command bars of the Flight Director, as he was hand flying the aircraft at this time.

I became somewhat distracted by the high angle of pitch and the resulting better than 4,000ft per min climb with the aircraft in the FLC mode. As such, with the aircraft being hand flown, I wanted to ensure that we would not overshoot the required level as the aircraft went into ASEL capture mode and then ALT capture.

As the PF levelled at 8000ft, I immediately heard a TCAS advisory, "Traffic", "Traffic", which again diverted my attention away from the actual reason as to our situation.

I noted an amber display on TCAS approximately 900ft above our altitude, as I recall. Just as the TCAS ceased calling the Traffic Advisory, the radar controller instructed us to maintain Flight Level 80 and advised us to ensure we were operating 1013 standard, which immediately caused me to notice that we both had failed to set the altimeters to standard passing the 7,000ft transition altitude. We immediately set Standard Pressure Setting [SPS] and returned to flight level 80.

Both the PM and I normally work very well together. We receive company training in international procedures annually and we discuss incidents that have happened in the past with other operators. We also actively brief departures, including transition altitudes and when issued a climb to a flight level we are prepared to select standard on our altimeters. However, having been in three different cities in Europe over the last three days, I'm trying to fight off some mild feeling of fatigue and was not feeling at my best.

Lessons Learned: In hindsight, we as a crew learned and will apply several lessons from this incident.

First, the Flight Management System on our aircraft has the ability to set different transition altitude parameters into it as a message reminder during climb or decent to verify standard on the climb passing the transition altitude, and local altimeter on the decent passing the transition level. I assumed that all of our company pilots utilise this function within the FMS, but as I learned as the case here, ask and verify, don't assume.

Also, when an altitude is set into the ASEL selector, say "Altitude 8000 set"; if a flight level is set, say "Flight Level 80 set". I think had I done this, it would have alerted the PF to set the SPS on his altimeter. Our company habit always seems to call it "feet" when setting the ASEL selector; I will bring this point to management for further discussion.

CHIRP Comment: **This report highlights two additional points. The first is that a study of UK level bust incidents showed that there is an increased risk of a level bust from electing to hand-fly a Standard Instrument Departure, particularly one that is unfamiliar. The second is that the use of the Flight Level Change mode on some aircraft types may produce an inappropriately high rate of climb/descent for relatively modest height changes.**

The UK Aeronautical Information Package [AIP] states that when an aircraft is cleared for climb to a Flight Level, that vertical position will be expressed in terms of Flight Level, unless intermediate altitude reports have been specifically requested by Air Traffic Control. This report is a reminder to ATCOs that some operators' SOPs for re-setting altimeters during the climb require the change to be made on passing the Transition Altitude not when cleared by ATC to climb to a Flight Level.

EN ROUTE NAVIGATION ERROR

Report Text: After passing and reporting position GOMUP and receiving a successful SELCAL check Shanwick Radio instructed us to call Iceland Radio on 126.55 at 61N. Shanwick was asked if we should report 6220N and the answer was, "No".

At 61N we called Iceland Radio, who asked us for a position report for 6220N and advised us that radar showed us off route. After checking the FMS we discovered that 6220N had dropped out of the active flight plan and upon putting it back in found it to be behind the aircraft and off to the right by approximately 30 miles.

Iceland confirmed our routing, we confirmed the aircraft heading for next waypoint and that all further points were still in active flight plan.

Iceland Radio advised they would be filing a report.

Lessons Learned: The crew must be diligent in confirming routing and waypoints throughout the flight, not just at the beginning.

CHIRP Comment: The reason for the 6220N waypoint 'dropping out' is not known; however, the recommended 'good practice' crew procedures for operations in MNPS [Minimum Navigation Performance Specifications] airspace include checking the track and distance to the next two waypoints [North Atlantic MNPSA Operations Manual; Chapter 9]. If the company's SOPs had reflected this procedure, it is probable that the error would have become apparent.

Positioning by Road

Report Text: I have a general concern regarding taxi positioning for crew. My employer uses one 'executive taxi' firm for all ground positioning, which does a suitable job. However, increasingly - I assume in times of operational stress and I gather as a backup when communication has failed - I find my employer/their taxi operator is using sub-contracted hire car firms of various standards.

I positioned back to base on a recent weekend with one such 'subbed' operator. We found the driver asleep at the wheel in the staff car park - perhaps reasonable, but not an encouraging start. At three points in the subsequent two-hour journey on a motorway, my colleague and I were startled out of our conversation by the sound of tyres going over rumble strips - not whilst changing lanes - whilst in a steady motorway flow in the fast lane.

Having spoken to assorted drivers many times I am aware they tend to work a 6 days on/2 days off pattern, with regular split shifts and duties beyond 12+ hrs, sometimes significantly longer. Even our lenient FTLs would baulk at such a prospect. Furthermore, there usually seems to be a tale of woe attached to each driver along the lines of 'this job is all I could get, I don't enjoy it but I had a bereavement/divorce/other'.

For a similar job of operating machinery at high speed with little room for complacency these operators would be the obvious weak link in the safety chain. There should be a more rigorous procedure in place, particularly when sub-contracted drivers are used for crew positioning. The avoidance of an accident thus far is pure chance - taxis are not the place for a restful post-duty 40 winks or indeed any calm moment before operating a flight; indeed, I would counter that some drivers, and it is only some, add another stressor into the equation.

CHIRP Comment: Taxis and private hire vehicles (PHVs) are required to be licensed by the relevant local council, although the latter may be regulated with a lighter touch. Drivers of both taxis and PHVs are also legally required to hold a local council licence.

In the case of positioning by road, although the responsibility for sub-contracting might be that of the prime contractor, the airline has a 'duty of care' in relation to the safety of employees when on duty. Positioning by road has similarities with the level of safety afforded by positioning crew members in light twin piston aircraft in comparison to the level of safety when performing their duties.

If you have a concern about the standard of driving/safety when positioning by road, report it to your company with details of the vehicle registration number and driver licence, if displayed.

Roster Planning

Report Text: In FEEDBACK 96 [Page 10], the CHIRP comment included the following extract from CAA FODCOM 10/2009 [Para3.4] relating to the use of commander's discretion:

"....rosters should never be planned in such a way that minor unforeseen events will automatically require the use of discretion."

How do you view, therefore, the regular roster planning of long-haul flights which are just 15 minutes [in one case 0 minutes] inside of the maximum flight duty period (FDP) limit?

Two examples are:

1. Two crew. Pre-duty rest period usually 24hrs followed by planned FDP 15 minutes less than maximum FDP - Delays due to passenger boarding/delivery of final loadsheet figures are common.
2. Two crew. Planned rest period 29hrs followed by a planned FDP that is the same as the maximum FDP.

Controlled Crew Rest and Recovery are the norm on these flights rather than an occasional use.

CHIRP Comment: This is one of a number of reports received where the practice of rostering close to the maximum permitted FDP, which is relatively common in some operations, is perceived in itself to be inappropriate.

However, a key point is whether the rostered schedules can be routinely achieved. For example, some operators incorporate some contingency in the sector planning used for their schedule, such as basing the scheduled sector time on the longest routing, thus permitting minor delays to be accommodated within the planned FDP. In such cases, the planned schedules are not unreasonable. Also, several UK operators have an FTL audit procedure in place; this should identify those cases where a particular schedule does require discretion to be exercised and how often.

Another point relevant to this and similar reports is the rostering of long legal duties in combination with a preceding rest period of between 18 and 30 hours. CAP 371 contains a recommendation that rest periods of between 18 and 30 hours should be avoided whenever possible. Some such rest periods are relatively benign whereas the anecdotal evidence is other rest periods of between 18 and 30 hours may not provide an opportunity to gain adequate rest. Individuals are obligated to report fit to perform their duties for the maximum duty period relevant to their report time; this includes organising their pre-duty rest accordingly. However, the operator also has an obligation to schedule a rest period that provides a reasonable opportunity for adequate rest to be taken, particularly in the case of a long-haul two-crew operation.

LARS Traffic Service

Report Text: The aircraft was on autopilot while I was checking map for distance to run until let down under London TMA, I looked up and ahead. I noticed a large dark object 12 o clock at similar level. It appeared not to be moving. It was so stationary in my scan, that I could not deduce if it was approaching or moving away. I contacted the radar controller who replied, "No, nothing on radar."

In that short time (10 secs) the object could now be seen to be growing in size at a fast rate immediately in front of me and was much larger that previously thought. As I initiated a right turn, the Military four-engine turbo prop transport turned to his left and descended. I also turned left to avoid. At about the same time we passed, the radar controller then passed a traffic alert to me, regarding the contact.

We both "Saw and Avoided" no problem and I realise that a "Traffic Service" does not remove the responsibility of The Captain to see and avoid, but I was surprised to hear that radar support could not give me more information about a large four-engine aircraft that I specifically drew their attention to?

LARS units can reduce sensitivity to remove "Clutter", but if they had my PA34 on the screen, why could they not see a much larger, heavier aircraft?

Lessons Learned: I have always found LARS units to be extremely helpful and always use the facility if available. My course of action will always to request a higher level of service (when available) for my flight. (De-confliction)

I believe I may have placed too much trust in LARS units.

CHIRP Comment: **Under a 'Traffic Service', the controller provides specific surveillance-derived traffic information to assist the pilot in avoiding other traffic. However, other controller tasks, such as co-ordinating traffic with another ATSU, may prevent the controller from being aware of even a seemingly obvious confliction, such as that described in this report.**

As the reporter correctly notes, the responsibility for avoiding other aircraft is that of the pilot(s).

Although not the case with this reporter, there is still a misconception among some pilots that when receiving a 'Traffic Service', the radar controller will provide pilots with avoiding action.

CABIN CREW REPORTS

Cabin Door Indicator Problem

Report Text: On boarding the aircraft, the inbound SCCM advised that there was a problem with a cabin door in 'Automatic' mode.

As the flight crew were operating both sectors I asked them what the problem was with the door, they said it was only an indicator on the flight deck regarding the door being in manual or automatic and a ground engineer had 'cleaned the sensor'. Given the info the inbound SCCM had given me, I asked if we could test the door while the cleaners were on; the flight crew agreed.

The arming lever was not flush with the door and no indicator was displaying in the cabin. The flight crew insisted this was 'fine'. I insisted that it was not and placed the opposite door to 'Automatic' to highlight the difference. Only then did they agree to look at the door/slide again.

It was discovered that there were wires hanging from left side of slide pack which prevented the girt bar engaging with the left part of the slide and, hence, no 'automatic' indicator in the cabin and the handle not being flush with the door.

I am concerned that the flight crew said it was only an indicator problem on the screens on the flight deck and then insisted it was fine when it quite obviously was not. Cabin crew being dismissed by pilot colleagues in this manner *is patronising and dangerous.*

The 'fix' for this problem was for the ground engineer to push the wire back into place; when I asked the Captain if the issue had been entered into the Tech Log the reply was, "No; no need".

CHIRP Comment: **The basis for the Captain's decision not to make a Technical Log entry is not known; however, it should be noted that in such a case, irrespective of whether the defect was repaired, a Tech Log entry would be required, as such entries are used to assess system reliability on an ongoing basis.**

Excessive Cabin Temperature

Report Text: We were delayed for three hours downroute due to adverse weather at our destination airfield.

The APU wasn't working and there was no ground equipment so it was very hot in the cabin. The SCCM called the rear galley to say that the Captain had ordered the back door to be 'cracked' to allow air into cabin. I refused to open the door as we had no ground equipment in place. The SCCM visited the rear galley to open the door themselves, to stop the door slowly opening they tied the cord of the oxygen demo mask between the two grab assist handles on the door and frame. 20 minutes later the SCCM came back to the galley and secured the door by the same handles.

CHIRP Comment: **Whenever an aircraft door is opened, it must be in accordance with an approved procedure, such as ensuring that an appropriate set of steps/ground equipment is correctly positioned at the door. Also, if passengers are on board the effect of the door configuration/ground equipment location on an emergency evacuation should also be considered.**

Whilst 'cracking' a door might appear to be innocuous in itself, the risk of injury, or worse, to crew members, passengers and particularly small children is significant.

Civil Aviation Authority SAFETY NOTICES

Number: SN-2011/01 - Issued 23 February 2011

Requirement for Post-flight Engine Checks Schweizer 269C-1 Helicopters

Number SN-2011/02 - Issued 5 April 2011

Safe Use of Airstairs