



TACARE NEWSLETTER

TAIWAN Confidential Aviation safety REporting system
TACARE-08 October 2003

THE LATEST NEWS

→ TACARE Newsletters Directly to You!

You can return the postage paid form on the back page of this Newsletter to our office to request for your personal copy of the newsletter. Please be specific of the method of receiving (email or mail). We will send the Newsletters and flight safety related information directly to you.

→ Token of Appreciation ! ! !

In order to show our appreciation for your support to TACARE, from now on, every time you provide us with safety related information, we will send you a small souvenir to show our appreciation. Please do not forget to leave your mailing address when making reports.

→ Standard Departure/Approach Procedures Too Complicated???

Recently we received reports that concerned about airports' Standard Instrument Departure (SID) and Standard Terminal Arrival Route (STAR). The reporter stated that the SID/STAR are causing confusion among the flight crew. If you have the similar concerns or experiences, please send us a report. We will get to the authority when we gathered more information.

EDITOR

Aviation Safety Council (ASC) conducted a Survey in 2002. The groups that the Survey had sent to included flight operations, maintenance, in-flight services, and air traffic controls. The purpose of the Survey was to understand how well did those groups know about ASC and its function, including TACARE system. As for the part of TACARE, the result showed that 72.4% of the pilots, 29.3% of the flight attendants and 52.2% of the controllers participated in the survey were aware of the TACARE system. And only 13.7% of the maintenance personnel participated in the survey were aware of the TACARE system.

The major reasons for not using the system, given by those participated in the survey were: "Lack of confidence in the confidentiality of the system"; "Do not understand the report handling process"; "Do not know the reporting channel"; and "Do not expect any improvement, even with report submitted."

To facilitate the TACARE system and introduce it all the personnel who work in this field, the TACARE working group designs a series of promotional activities, including sending out posters, advertising on the aviation publications and making promotional presentation to concerned groups, etc. from the second half of the year 2003.

A more detailed description of TACARE will be

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presented hereunder. It's our sincere hope that more people will get to know the system better, have more confidence in this system, and start to use the system. All your comments and criticisms will be contributing to the improvement of our flight safety.

TACARE

Objective

Under the principles of "confidential, non-punitive, independent, reliable and professional", TACARE is to collect, analyze and share the safety concerned issues with all the aviation personnel which include pilots, controllers, flight attendants, mechanics and ground staffs. And encourage them to provide safety related events, incidents or potential hazards, without the fear of being punished.

Currently, the CAA and airlines have their own mandatory or voluntary reporting systems. However, the information received by those reporting systems may not be passed out to all the aviation personnel. As for TACARE, the system is designed with the spirit of sharing. Therefore, we not only welcome you report directly to us, but also the report that has been given to the CAA or the airlines. For we believe, it is our common goal to improve Taiwan's flight safety and make our sky safer and safer.

Area of Coverage

According to the civil aviation regulations, safety occurrences can be categorized into accident, serious incident, incident, and flight or ground operations safety events. The first two categories have to be reported to ASC and the CAA. As for the latter two, the reports should be made to the CAA. Currently, the events potentially may endanger the flight safety are not covered in the mandatory reporting system.

We consider each single safety factor is important to flight safety, including those potential ones. Therefore, it is not necessarily a recurrence that has to be reported. Anything you think is safety concerned is welcome to be submitted to TACARE.

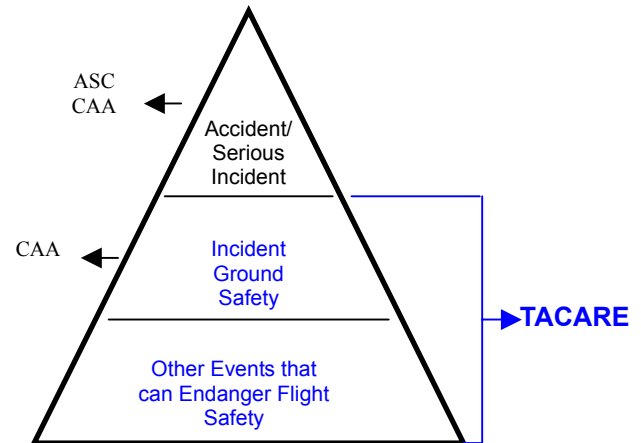


Diagram 1 Area of Coverage of Mandatory Reporting System and TACARE

RESULT OF SURVEY

The Survey ASC had conducted in 2002. A total of 4,650 questionnaires had been distributed to the aviation personnel. We received 1,952 returns, 42% of the total circular for the Survey. The overall returns indicated a positive view of ASC and TACARE. However, there still were some doubts and questions reflected in the Survey about TACARE especially on the confidentiality and handling process of the system. The followings are the doubts we summarized from the Survey. For each doubt, we have an answer which we hope it would provide a clearer picture for TACARE.

Doubt 1: Lack of confidence in the confidentiality of the system

Answer: The first confidentiality protection mechanism of TACARE is to handle the reports by designated personnel in a designated office which equipped with its own phone line and fax machine. The original information regarding the report is not

accessible to non-working group staffs (including other members of ASC.) Working group members are requested to sign a non-disclosure agreement to ensure that no information or identity of the reporter will be released.

The second protection is to de-identify the information in the report that may reveal the identity of the reporter (such as his/her name, way of contact and employment status, etc.). Only the working group staffs know the identity of the reporter. Once the clarification of the report content was completed, or indicated by the reporter that no further contact will be necessary, all the identification information will immediately be destroyed. No record or file will be kept.

Since the day TACARE has operated, no information regarding the reporter or the identity of the person involved in the report has been leaked out. It will never happen in the future either.

Doubt 2: Do not know the reporting channels

Answer: Currently, TACARE reporting channels include toll free number, fax, postal services, email and on-line reporting. Reporting can also be made by using the postage paid “ Aviation Safety Reporting Note” (From hereon it will be referred as Reporting Note) on the last page of the Newsletters.

In order to make reporting more convenient and allow everyone having a better access to get the Report Note, starting from August 2003, we have placed Reporting Notes in a specially designed holder (see Diagram 2) near the place you work.



Diagram 2 TACARE fliers and Reporting Notes

Doubt 3: Do not understand the report handling process

Answer: Once the TACARE working group receives the report, the processes shown in Diagram 3 will be followed. If the reported information is significant to the improvement of flight safety, it will be made available to the CAA or airlines in a de-identified form. Information gained through reports will also made as widely as possible through the Newsletters and TACARE website.

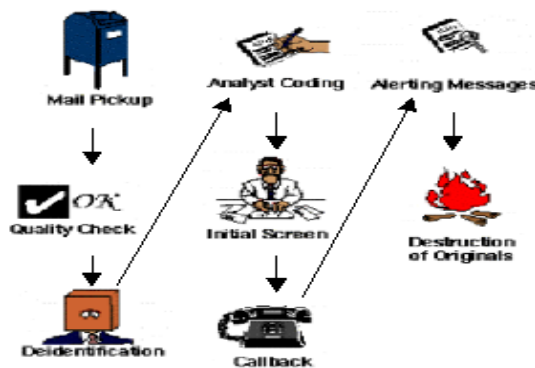


Diagram 3 Report Processing Float Chart

Doubt 4: Do not expect any improvement, even with report submitted

If the report received is of urgency to flight safety, the respective organizations will be given immediate

notification. For example, a report was received in July 2002, the pilot pointed out that Jeppesen Manual's RCTP C.K.S. INTL 18 Jan 02 runway and taxiway layouts were incorrect. As soon as we received the report, CAA was notified.

Also, TACARE system has set up a reply mechanism. If a reply is required, the system will report back to the reporter with the result.

Future Plan

1. Protection to the reporters through legislation.

"A reporter of the voluntary incident reporting system should be granted conditional protection." International aviation industry is putting its effort toward this direction. ICAO Annex 13, Chapter 8, November 1, 2001 revision stated:

8.3 A voluntary incident reporting system shall be non-punitive and afford protection to the sources of the information

And from the legal aspect, in the United States of America, law making has already been completed. FAR 91.25 stated :

The Administrator of the FAA will not use reports submitted to the National Aeronautics and Space Administration under the Aviation Safety Reporting Program (or information derived there from) in any enforcement action, except information concerning accidents or criminal offenses which are wholly excluded from the program

Through amendments of aviation regulations and making laws to offer conditional protection to those who makes report to TACARE, will be the direction of working group's future effort. Hopefully, besides the confidentiality mechanism, we can offer liability free protection as well.

2. To establish direct communication channel.

Up to now, the newsletters were distributed through the airlines or CAA Air Navigation and Weather Services to the readers. We wish the newsletters and safety information can reach individuals directly in the future.

Please use the postage paid Reporting Notes on the back page of this newsletter to let us know that you wish to receive the newsletters from us directly. Please include the method (mail or email) that you will like to hear from us.

REPORTS

Discrepancy Between NOTAM and Actual Condition

Pilot performed transpacific duty from Station A to CKS Airport. During pre-flight NOTAM check, noticed that during estimated landing time, airport authority planned to close runway 06/24 at night for rubber deposits removal. Thus, Runway 6 would be closed. However, upon arrival, in ATIS announcement, the actual runway that was closed was Runway 5.

The reporter thinks that the two runways are respectively for CAT I and CAT II instrument landing. It may create certain degrees of deviation from the expected planning. Thus, improvement action by airport control unit is recommended.

TACARE Office Comments

According to air traffic controller, for long haul flights, the information provided in NOTAM prior to take off may be changed at time of landing. Airport ATIS should be the most updated information.



Main Landing Gears Safety Pins Not Removed

After relocated the airplane, maintenance personnel removed only nose gear pin and forgot the main landing gear pins. During walk-around check, the Captain spotted the pins, however, no action was taken because of no maintenance staff was around. When the Captain entered the cockpit, he started to discuss flight duty with his crew and forgot about the safety pins.

After airborne, while attempted to retract the landing gears, the crew found two main landing gears red lights were on. The flight crew followed QRH and attempted to retract the main landing gears two times without success. When found out that there was only one pin kept behind the first officer's seat, the Captain followed the procedure, maintained FL180, airspeed 280 knots, landed at the destination safely.

TACARE Office Comments

1. Many safety procedures have double-checking protective mechanism to prevent system failure due to single person's error. However, this incident provides us with a very good lesson. It reminds us not to make the assumption that the other person will do the job so we can omit it ourselves.
2. We appreciate the reporter for sharing the experience with us. It allows all of us to learn the lesson from each other and raise the level of self-awareness.



Pilot's Suggestion Regarding Approach Procedure

The flight was from south on M-750 to CKS Airport.

After entered TPE FIR, communication was established with ATC. Clearance issued by ATC was "After TONGA, Clear to TIA, Via BC2 RNAV arrival." There are quite a lot of transit routes in BC2 RNAV Arrival procedure. ATC did not give any instruction regarding the transit route to be used. Since this procedure is not pre-set in the FMS computer, the crew has to key in all the waypoints manually.

Usually, when switch over to Taipei Approach, we will proceed with radar vector. We may be cleared to KARAN (If runway 5 is in used). However, KARAN is not in BC2 RNAV Arrival procedure. Crew will then have to make changes in the FMS. Doing so will increase flight crew's workload as well as radio communication. Suggest redesigning the CKS approach procedures.

TACARE Office Comments

CAA states that all waypoints and arrival/departure procedures of CKS Airport were discussed in a discussion meeting in April. The amended arrival/departure procedures were published on July 10.



Passengers Not Seated during Pushback and Taxi

Reporter stated that in the three flights he took recently, he had noticed that during pushback and taxi, there were passengers not yet seated.

The reporter took operator A's flight to go abroad in early this year. When the airplane was pushed back toward Runway 6, the taxi speed was high. By the time the airplane reached taxiway S5, there were still passengers moving around and changing seats. All the passengers were finally settled down in more than

three minutes after pushback. If for any reason, the plane had to be stopped, it could have caused some injuries.

TACARE Office Comments

1. After reviewing the Civil Aviation Regulations and Aircraft Flight Operation Regulations, there is no relevant regulation restricting passengers from leaving their seats during pushback or taxi.
2. CAA stated that usually the requirement for passengers to be seated during pushback and taxi should be included by the operators in their Flight Operations Manual or Cabin Crew Operations Manual. These manuals will either be approved or accepted by CAA prior to their publication.
3. After reviewing several airlines' Cabin Crew Operations Manual, there is no such rule that airplane cannot move on the ground unless all passengers were seated.
4. Several Flight Attendants who accepted our telephone interviews stated that although there is no regulation requires the passengers to be seated during pushback or taxi, they will remind the passengers not to move around at such time to avoid possible injury.

CASES FROM OTHER COUNTRIES

Starting from this issue, TACARE working group will extract some reports that are worthy of learning from the other countries' voluntary reporting systems. The following three reports are from the British CHIRP (Confidential Human Factors Incident Reporting Program). Because TACARE very seldom receives report from flight attendant or maintenance personnel,

thus in this issue we have included reports from these two areas to share the information with all aviation personnel.

CHIRP Introduction

The United Kingdom has established the Confidential Human Factors Incident Programme, know as CHIRP in 1982 under a joint project of Civil Aviation Authority (CAA) and Royal Air Force Institute of Aviation Medicine. The aim of CHIRP is to complement the CAA Mandatory Occurrence Reporting System. In the very beginning, CHIRP was only available to flight crews, now is to air traffic controllers, maintenance engineers and cabin crews.

In November 1, 1996, CHIRP was established in its present form, as a registered charitable, non-profit company and funded by CAA.

The management of CHIRP is held by an independent Board of Trustees. As for the technical part, A Advisory Board will review the reports and some safety issues and provide counsel to resolve some specific issues.



Evac Alarm /Light Switch Confusion

I wanted to turn the cabin lights down whilst at the rear of the aircraft. It is very difficult to see the panel and I almost pressed the evacuation button instead of the light switch.

The evacuation command button should be guarded to avoid accidental actuation.

CHIRP Comments

CHIRP contacted the Company to represent the reporter' s concern. The Company was already aware of the problem with this touch-sensitive panel and is

investigating means of preventing inadvertent operation of the evacuation button.



Airframe Vibration

I am anxious about flying with one particular aircraft in my Company's fleet. This aircraft continues to experience airframe vibration and has done so for the last two-three weeks. The vibration appears to start in the rear of the cabin and then through the rest of the aircraft. It occurs in the cruise but could also, possibly, be in climb and/or descent; it is not been apparent during take off or landing.

My colleagues and I are increasingly apprehensive about flying this particular aircraft. Flight crews are aware of the problem and it had been reported in the Tech Log. However, none of the flight crews I have spoken to are aware of any rectification action taken.

CHIRP Comments

The Engineering department had been alerted to this problem. The vibration could be felt through the airframe but did not register to any significant extent on the aircraft instruments. The level of vibration reported was not considered to be a safety issue, however, in view of crew and passenger apprehension, a standard engine vibration survey run was carried out and some balance adjustments made. The vibration was again reported. After consultation with the manufacturer, a more complex survey run was undertaken and further adjustments made. No further vibration reports have been received since.

If entered in the Tech Log, good CRM principles would lead the flight crew to brief cabin crew members before flight to reassure them. Of course, if any unusual aircraft/engine behaviour is detected, cabin crew should always report this to the aircraft commander.



Fit For Flight?

On this particular shift, morale has been disrupted. The reasons for this are the questionable work practices and the technical knowledge of some of the members of the shift, which is of a much lower standard than the other members.

The problem is a stubbornness and unwillingness to accept help or assistance, preferring to carry on sometimes in very erratic ways. In fact, some of us with similar time and experience on the ### (aircraft type) have had problems and have even refused to sign work that has been carried out. One person now has full CRS Approval and refuses to accept any advice from others with experience and JAR-66 licences but currently with a lesser Company Approval.

The main point of this report is to question the comment a senior manager made when he said that engineers had no right to tell the Approved person when he was doing something wrong.

Recently, an aircraft arrived with a defect outside the MEL limitations. The Approved engineer told the Captain that the fault was clear, and he accepted the aircraft. Another engineer argued that the aircraft was not fit for flight but was ignored. The aircraft departed.

On the next sector, the fault came back, and the aircraft spent several days AOG.

The engineer was told to shut up due to not having an Approval. He was told that if he wanted everything done right, he was in the wrong job. This did not inspire anyone with confidence.

In a climate where Human Factors is being highlighted, someone who has been trying to maintain professional standards has been labelled as a complainer and has been offered very little support.

CHIRP Comments

The concerns of the reporter and his colleagues were brought to the attention of the senior Quality Manager, as a result of which appropriate action has now been taken to monitor individual work standards more regularly and to audit maintenance procedures more rigorously.

There is a natural expectation that a licence holder with full authorisation is at the top of the chain of certification. A number of incidents have occurred because such individuals have deviated from established procedures and taken it upon themselves that they know best. A licence reflects a point in time assessment. It marks an individual's basic capabilities but does not indicate that that individual has performed or been involved in every task. With time, additional experience of tasks not previously done and the application of knowledge through defect diagnosis will increase that individual's overall competence. It is unlikely however that there will ever be a point at which the individual stops learning. It should be remembered that an unlicensed mechanic with 20 years experience on a particular type will often have something to contribute and such opinions or views should not be too readily dismissed by the licence holder.

There should be no place for arrogance.