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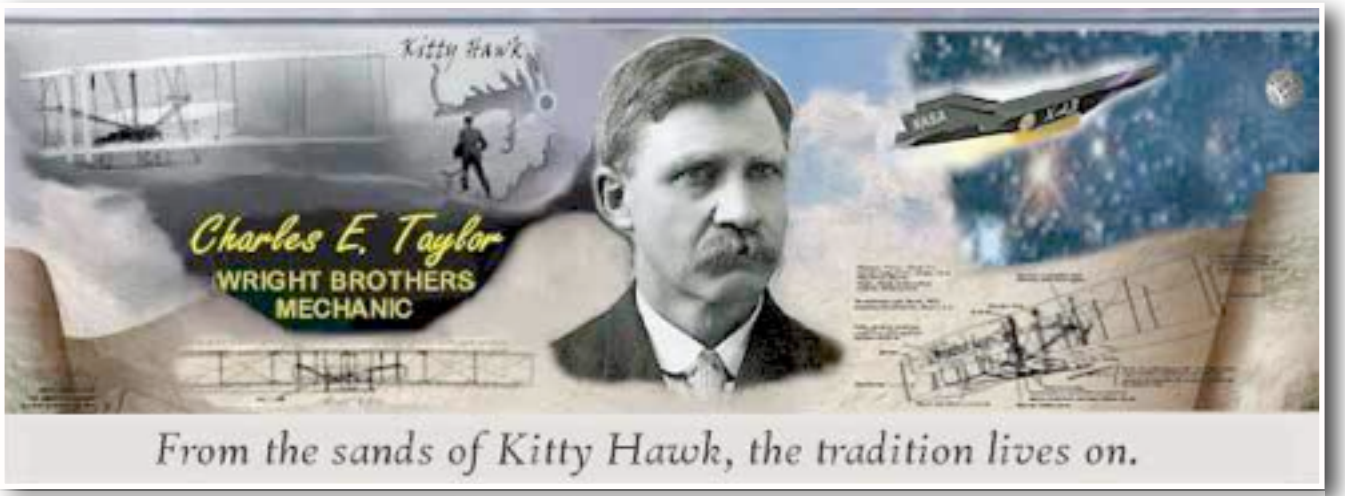

Hello all,

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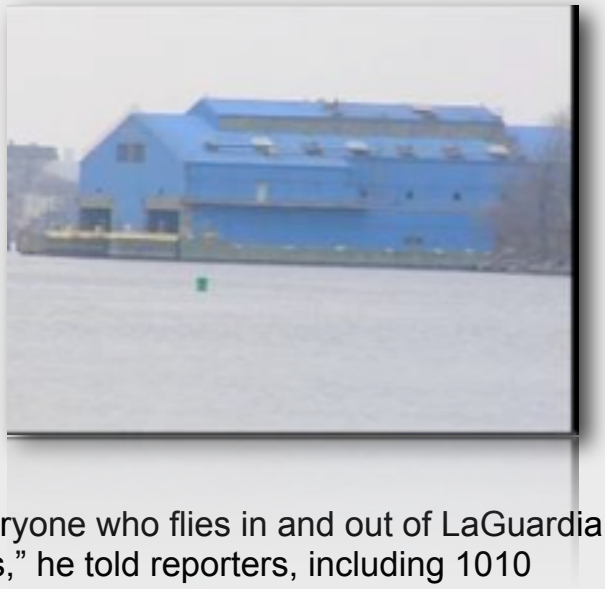
In this weeks edition of *Aviation Human Factors Industry News* you will read the following stories:

Critics Blast Proposal That Would Put Garbage Transfer Station Near LaGuardia

Experts Say Facility Is Sure To Attract Birds That Could Pose Danger To Planes



There was plenty of “trash talk” in Queens last Thursday night over a proposed garbage transfer station near LaGuardia Airport.

Aviation and wildlife experts took turns taking shots at Mayor Michael Bloomberg’s administration. Former NTSB chairman Jim Hall said the transfer station is sure to be a bird magnet.“It will endanger the lives of everyone who flies in and out of LaGuardia Airport as well as the citizens of Queens,” he told reporters, including 1010 WINS’ Al Jones.

Hall said when he first heard about the garbage transfer station plan for College Point, he couldn’t believe the proximity to the runways of LaGuardia Airport.

“It is mind-boggling to think that after the miracle on the Hudson, that this project was not scrapped,” he said.

The Bloomberg administration said the College Point transfer station will be fully enclosed, but bird expert Ron Merritt said that’s not enough.

“Have you’ve ever seen a trash truck and didn’t have something hanging off of it? Smelling something, leaking something. Well you can increase the number of birds from two to 200 in minutes,” Merritt said.

Merritt also continued his criticism, saying “Even if you cover this up as best you can, there’s still gonna be more birds in the atmosphere around that facility regardless of what you do.”

One of the main opponents of the plan, Friends of LaGuardia, is in federal court to try to stop to construction of the transfer station.

Assemblywoman Grace Meng, who helped put together the town hall meeting to discuss the plan, said the Bloomberg administration, the Port Authority, and the FAA were all invited to attend and answer questions, but none did.

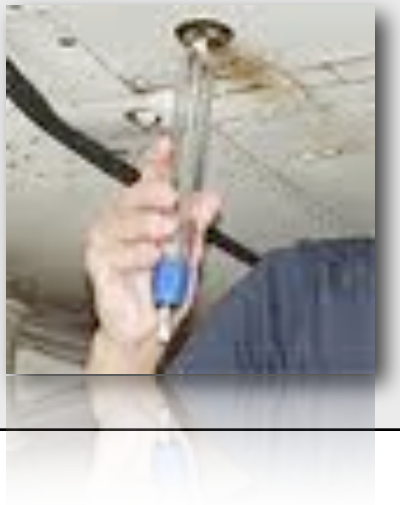
FAA Issues $400,000 Fine to Atlantic Southeast Airlines

FAA is proposing a $400,000 civil penalty against Atlantic Southeast Airlines (ASA) for allegedly operating a Bombardier regional jet on passenger flights, while it was not in compliance with FAA regulations.In January of 2012, ASA merged with ExpressJet Airlines and changed its name to ExpressJet Airlines Inc.—although FAA announced the proposed civil penalty was issued against ASA on Wednesday.

"The FAA alleges that ASA maintenance returned the aircraft to service after routine work, but without an authorized signature on the airworthiness release and without an appropriate entry in the aircraft's flight discrepancy log," said FAA in a statement.

The Atlanta-based carrier allegedly made 49 revenue passenger flights with the aircraft in July 2010—prior to obtaining FAA approval to return the aircraft to service.

NTSB Cites Water In Fuel Tanks, Pilot Training For Deadly Plane Crash



Water contamination of fuel and a pilot who could have been better trained are the two main reasons the National Transportation Safety Board gives for why a private plane crashed and killed five last year in Long Beach.At about 10:30 a.m., March 16, 2011, a Beech Super King Air 200 plane took off and promptly swung around and crashed back on Long Beach Municipal Airport grounds.

The fiery accident killed Thomas Dean (Naples), Mark Bixby (Long Beach), Jeff Berger (Manhattan Beach), Bruce Krall (Ladera Ranch) and pilot Kenneth Cruz (Culver City). Firefighters were able to pull Long Beach resident Mike Jensen from the plane alive, and Jensen has survived his injuries.

Since then, data from the crash has been combed over for about a year by multiple federal and state agencies, along with airplane and part manufacturers. The NTSB final report — which included multiple witness accounts — was adopted on Aug. 29.

The report found the following causes to the accident:

• The pilot's failure to maintain directional control of the airplane during momentary interruption of power from the left engine during the initial takeoff climb.

• Contributing to the accident was the power interruption due to water contamination of the fuel, which was likely not drained from the fuel tanks by the pilot during preflight inspection as required in the POH (Pilot's Operating Handbook).

Witnesses reported that the airplane's takeoff appeared to be normal, but shortly after it stopped climbing, the plane yawed left. They also said they heard several abnormal noises. Security camera feeds showed the airplane made it to the midpoint of the runway at 140 feet above ground and at a groundspeed of 130 knots before it began to yaw.

A mechanic, who had experience with similar planes, was a witness to the accident. He said he heard a pop and attributed the noise and some smoke to one of the engines of the plane intermittently relighting and extinguishing.

The investigation found no anomalies with the plane itself and there were no contaminants in the fuel. However, the investigation did find that the pilot's previous employer did not require him to drain the fuel tank sumps before every flight — instead a mechanic would do it at an unknown interval.

"There were six fuel drains on each wing that the Pilot's Operating Handbook for the airplane dictated should be drained before every flight," the report says.

Cruz was the only person who had flown the aircraft for its last 40 flights — there was no way to know definitively whether he did or did not drain the sumps.

All the information gathered indicates that the left engine experienced momentary power interruption during the takeoff initial climb, which was consistent with a power interruption resulting from water contamination of the left engine's fuel supply.

Also, investigators found that there was no documentation that the Cruz had ever received training in a full-motion King Air simulator.

“Although simulator training was not required, if the pilot had received this type of training, it is likely that he would have been better prepared to maintain directional control in response to the left yaw from asymmetrical power,” the report says.

“Given that the airplane’s airspeed was more than 40 knots above the minimum control speed of 86 knots when the left yaw began, the pilot should have been able to maintain directional control during the momentary power interruption.”

The preliminary report had mentioned that the plane was 650 pounds heavier than the maximum allowable gross takeoff weight of 12,500 pounds, but the final report said that shouldn’t have affected the pilot’s ability to regain control.

Crew of ditched Westwind criticized for flight planning

The low-fuel ditching of an Israel Aircraft Industries Westwind 1124A business jet (VH-NGA) near the remote Australian Pacific territory of Norfolk Island was the result of inadequate flight planning and en route weather monitoring by the crew, according to the Australian Transportation Safety Bureau's final report.The ditching occurred at night off the island's southern shore on 18 November 2009, and although the fuselage broke in two, all six occupants were rescued by surface craft. The planned flight by Australian business aircraft operator Pel-Air was an aeromedical operation from Apia, Samoa, to Melbourne, Australia, with an en route fuel stop at Norfolk Island. On board were the two pilots, a doctor, nurse, the patient and a passenger. The report observes that the crew's participation in "wet drills" and the medical team's training for underwater escape from helicopter ditching was influential in ensuring their survival.

The crew had positioned from Sydney via Norfolk Island to Samoa the previous day, and having failed to obtain adequate en route weather for the return journey, the captain elected to apply the same upper air condition for planning purposes. Unfortunately, the 50kt (93km/h) tailwind on the inbound leg turned out to be an 80kt headwind for the return, and although the reported weather for Norfolk Island was adequate for an approach, it was deteriorating. The crew failed to get an update sufficiently early to enable a viable diversion to Noumea to be flown, so they continued to the planned destination. Norfolk Island's remoteness means diversion decisions have to be made by a certain point in the route.

The ATSB records that the crew made two non-precision approaches to runway 29 using the island's VOR/DME navigation beacon, but did not make visual contact with the runway in squally weather in darkness, so carried out missed approaches from both.

Two more attempts followed, the first to runway 11, and then a last approach to 29, after which the crew was committed to a ditching. They prepared for a gear-up ditching and judged their flare height using radio altimeter readouts because the dark sea surface was invisible.

The report gives the cause as inadequate flight planning and en route weather monitoring, and emphasizes how vital accurate and careful planning is for remote destinations such as Norfolk Island.

Forklift truck driver fined £150 for causing £1 million damage to aircraft

A Heathrow fork-lift truck driver caused more than £1 million damage to an aircraft after he misjudged the size of his baggage cart, a court was told.

Dennis Jackson, 60, sliced through the tail of an SAS Airbus 321, with 175 passengers on board, as it prepared to fly to Copenhagen on June 12.
Uxbridge magistrates were told he had forgotten which vehicle he had been driving.

Engineers later found that his high loader was only inches away from the fuel line.

Such was the force of the impact that one member of the crew was knocked off her feet as she was standing in the cockpit.

The 175 shaken passengers were evacuated from the aircraft.

"Unfortunately the difference in size led to the accident occurring - Mr Jackson is used to driving the regular-sized one.

"He misjudged the distance and failed to take into account the width and height."

Jackson, who was employed Dnata, ground handling firm, had an exemplary record since joining the company in 2006.

Marilyn Levene, the chairman of the bench, said he had made a "genuine mistake".

Jackson, of Linkscroft Avenue, Ashford, west London, admitted driving without due care and attention. He was fined £150, ordered to pay £85 costs and a £15 victim surcharge at Uxbridge magistrates court.

"This collision was due to the defendant not following instructions contained within the Heathrow Airport Operational Safety Instructions."

The plane was evacuated and on inspection, engineers found the rear door had been jammed shut.

Bethan Charnley, defending, said Jackson was responsible for an 'expensive accident' after forgetting he was driving the largest type of the vehicle.

The high loader in question had earlier that day been used to lift a car into an aircraft's hold, she said.

"This wasn't needed any more, and he was asked to take that back," she said.

Texting While Taxiing

Texting While Tired

Several factors led this B737 Flight Crew to miss a taxiway turn on the last flight of a long duty day. The First Officer's report includes a "texting while taxiing" factor that involved inputting data in the FMS.

- Ground Control told us to taxi north on Echo and hold short of Echo 11…. The intersections are not in numerical order. Still, that's no excuse and by the time we recognized the mistake, we had taxied past Echo 11.

The Captain immediately stopped the aircraft and notified Ground Control. He also apologized to them. They were very understanding and told us to continue taxiing on Echo to Runway 18C….

It was fairly congested and we missed the Echo 11 sign. I was heads-down as I finished inputting weight and balance in the FMS. It was a fairly high-workload situation at the end of a four-leg, twelve hour day.

In the future, we both need to be much more vigilant; not only in reading airport diagrams, but in staying heads-up, slowing down, and realizing that we are prone to mistakes at the end of a long day.

Signing Off a Mistake From the U.S. Navy

Working as an E-6B CDI always comes with high op tempo. Reduced manning levels during the holiday leave period and an unusually high phase maintenance workload had me working overtime. Running two shifts instead of the normal three had me on night shift working until all downing discrepancies were corrected, easily extending my shift an additional two or three hours per night. This pace had been in effect for over a week. Looking back, I realize that fatigue had already set in.
I had begun installing a slide valve for the aerial refueling system with a junior third class who was new to the shop and eager to learn. I was soon interrupted, however, when I was called to the flight line to troubleshoot a discrepancy on a different alert aircraft. The acronym describing our platform is TACAMO: Take Charge and Move Out. That means our alert aircraft are ready to go, around the clock, every day of the year.

I hurried to the flight line after leaving instructions to the junior mech on how to continue with the next few steps on the slide valve. An hour later, I finished the troubleshooting and returned to follow up on the slide valve assembly. To my surprise, the valve was not only assembled but attached to the fuel line. After referencing the pubs for Quality Assurance (QA) requirements,

I went about the work of inspecting the completed job and congratulated the young mech on his efforts. With no further fanfare, a leak check was performed, the work order was signed off and the holidays enjoyed.

A couple of months into the new year, during a routine preflight inspection, an air crewman found what looked like a mesh screen near the flight engineer's station on the flight deck. I was soon shocked to find out that the mesh screen was supposed to be inside the fuel line that attaches to the slide valve, to prevent debris from contaminating the fuel system during in flight refueling. And I had signed it off!

QA was immediately notified and I was called in to relay what happened. Thinking back over the craziness of that holiday maintenance period, I couldn't say for sure if that screen was installed or not, and it appeared it was not. Looking back over the maintenance pub and thinking through the steps I inspected on the job, I verified that all QA steps were performed. However, the mesh screen installation was not a QA procedure.

We had to disconnect all the fuel lines from the slide valve, reinstall the mesh screen and check the screens on the remaining lines. In total, we lost about 120 man hours. I could try to place the blame elsewhere, but I know as a Collateral Duty Inspector it was my responsibility to verify that the work was done correctly. I submitted a Technical Publication Deficiency Report to add the mesh screen installation as a QA step. I'm glad that my mistake was found and hope that others can learn from my experience.

The Aviation Consulting Group

Introducing a new Human Factors Recurrent Course
Designed Just for Trainers and Instructors!

This course is designed specifically for those people that train others in human factors subjects. It is assumed that attendees already have a solid foundation of human factors knowledge and therefore will be able to contribute significantly to the course objectives which include high-level thinking, sharing of knowledge, best practices and recommendations.
With a core focus on current HF issues as well as training methods and techniques this course is highly interactive and conducted in a workshop fashion. Attendees are required to make a short presentation in order to facilitate a group learning and sharing experience.
COURSE NAME: Human Factors Recurrent for Trainers and Instructors

WHO SHOULD ATTEND? Human factors trainers and instructors. This course is not limited to maintenance trainers. HF instructors from all industries and domains are encouraged to attend

PREREQUISITES: Must be a current HF instructor with a significant, demonstrable knowledge base

COURSE DURATION: 8.0 hrs. (1 day)
TIME: 8:00am-5:00pm (includes a one hour break for lunch)
WHAT TO BRING: Laptop computer with Adobe Acrobat, Word and PowerPoint
WHAT TO WEAR: Casual
NEXT COURSE: October 24, 2012. Myrtle Beach, SC, USA
Myrtle Beach Marriott Resort & Spa at Grande Dunes
FEE: $795.00 USD
INCLUDED IN COURSE:
- Presentation Handouts
- Certificate of Training

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