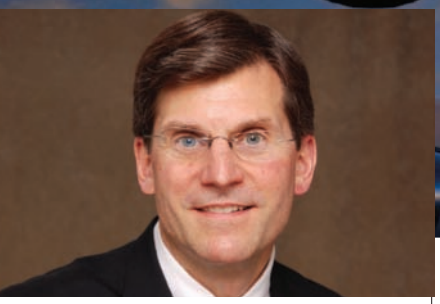
PREMIUM ON SAFETY

ISSUE 07 YEAR 2011

INSURING SAFE SKIES

IN THIS ISSUE



A MESSAGE FROM USAIG

Greetings!
The NASA Aviation Safety Reporting System (ASRS) allows pilots and others in the aviation community to report safety risks without fear of reprisal ***(http://asrs.arc.nasa.gov/).***

Likewise the Air Traffic Safety Action Program (ATSAP) provides air traffic personnel a confidential reporting forum ***(www.atsapsafety.com).***

A recent ATSAP alert warned of increasing conflicting RVSM (Reduced Vertical Separation Minimum) information in flight plans and flight progress strips, causing aircraft to be inadvertently cleared into RVSM airspace. Home in on "RVSM or non-RVSM" (page 2) for a closer look at the culprit.

Safe skies.

David L. McKay
President and COO, USAIG

Life of a corporate pilot

Rewarding adventure or fickle flight?

BY CHIP WRIGHT

In the bizjet world, it's a common practice for an airplane owner to contract out his airplane for use in a charter operation when he isn't using it. This helps offset the bills, keeps all the parts in regular use (and thus working more reliably) and it may even earn a small profit. This is often referred to as "aircraft management." The pilots that fly the aircraft on these charters may be the ones employed by the owner, or they may be employed by the management company.

Passengers that truly pressure pilots to cross the bounds of safety are rare, but they do exist.

Pilots that work in this type of environment can have a work lifestyle that runs the gamut from doing everything to simply flying the airplane. Take flight planning. Several companies offer professional flight planning services that address every aspect of the flight—the route, the weather, the best altitude, the best fuel stops, and any other specific needs or desires of the passengers such as limos, rental cars, etc. Others prefer to handle everything internally, using their own flight planning software and other tools to personally see to the needs of their customers.

But what happens when the airplane is airborne? Corporate pilots have a never-ending supply of stories about problematic customers or bosses. Two themes are prevalent when discussing the corporate world of flying in the negative sense. First is the miser owner/boss/client. Because aircraft are so expensive to own and operate, it can be tempting to disregard something that isn't deemed immediately necessary. For example, if the crew realizes that a fuel gauge is broken, it might be tempting for the boss to say, "Just fill up the tanks." But if the MEL doesn't allow for that kind of relief, or if filling the tanks will result in an overweight landing, then the crew needs to have the backbone to stand up for the proper remedy.

Another example might be ensuring adequate rest. Take a red-eye flight from Los Angeles to Cincinnati, which will cross three time zones. If the crew is an east coast-based crew, it is quite possible that their circadian rhythms are completely disrupted due to the trip; add a midnight Pacific Standard Time departure—which is 3 a.m. EST—and there is a real risk of a severely degraded crew performance. The airlines have a combination of FAR's and union agreements that address

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DID YOU KNOW?

RVSM or non-RVSM

BY MACHTELD SMITH

Increasing reports of conflicting RVSM (Reduced Vertical Separation Minimum) information in flight plans and flight progress strips are being highlighted by the Air Traffic Safety Action Program (ATSAP), which identifies unsafe conditions reported by air traffic personnel. From a recent ATSAP Alert:

"…The aircraft filed as /Q, the data block indicated it was RVSM capable and I applied RVSM procedures. I was informed by management approximately one hour and thirty minutes later that the aircraft was negative RVSM. The pilot was on an international flight and had extensive remarks. The last statement in the remarks was 'non RVSM.' Due to character limitations of the RCRD and URET [user request evaluation tool] this information is not displayable to the controller."

Sometimes flight plan remarks are ambiguous:

"…We did not know that the aircraft was not RVSM capable because it had an equipment suffix of /Q which means the aircraft is RVSM capable. When center told us the aircraft was NOT RVSM capable we went back and read the remarks, which were not very clear. 'RVSM EQUIPPED NOT APPROVED REQUESTING CLEARANCE.'"

Heads up! To be correctly identified on the controller's display, correct the equipment suffix rather than amending the remarks if your aircraft RVSM status changes. If you're unable RVSM due to equipment while en route inform ATC immediately.

For more information on the ATSAP program see ***www.atsapsafety.com.***

Visit the FAA's web site ***(www.FAA.gov)*** for updates on RVSM requirements in the U.S. and foreign countries.

Machteld Smith is a senior aviation technical writer for the Air Safety Institute and a multiengine instrument-rated commercial pilot.

Life of a corporate pilot *(continued from page 1)*

this and provide the crew opportunity to gain adequate rest. If the corporate operator does not, a pilot or crew may accept an assignment that they are not physically prepared for.

Corporate clients are also an issue. They are spending an inordinate amount of money for the convenience of traveling on a business jet or turboprop. As such, they expect to arrive on time. But that client is not the pilot, and does not have to answer to the FAA for potential violations. Passengers that truly pressure pilots to cross the bounds of safety are rare, but they do exist. They may push for a departure or arrival into severe weather. They may not understand that ground stops don't just happen to the airlines; or that while the airplane they flew last week could do a non-stop trans-continental flight, this one can't. And some of the issues that come up may be more cabin-centric, such as an out-of-control party in the cabin. Again, it is rare, but it happens.

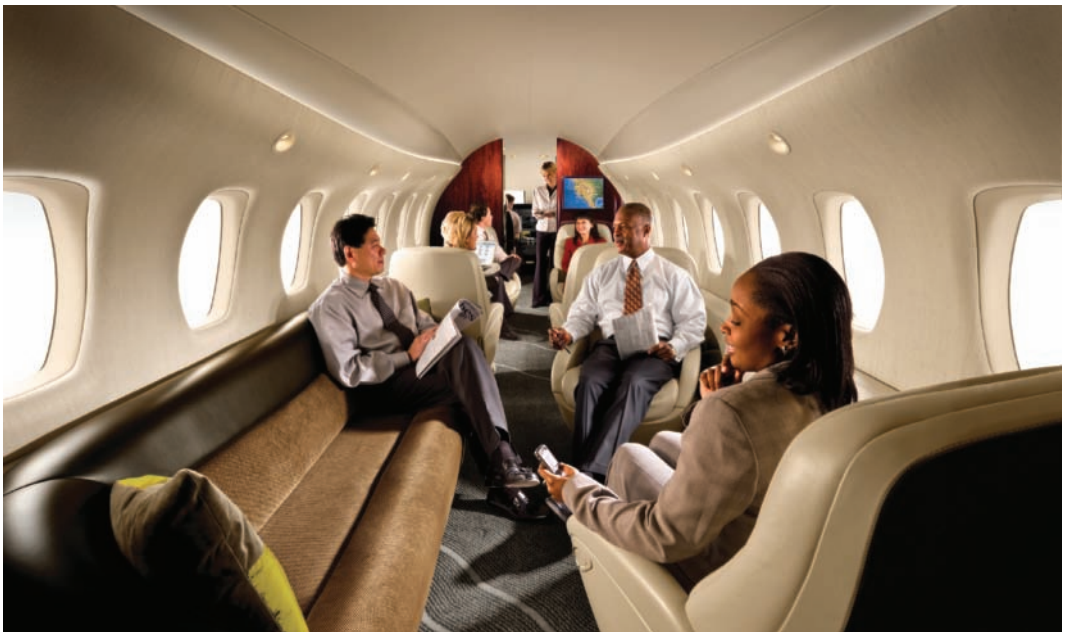
Are you as a pilot willing and able to say, "I am not doing this flight/trip on account of safety?" Are you willing to divert due to unruly passengers that are paying thousands of dollars an hour? It may cost you a job, but it may save your life and that of your passengers.

Too many people do not understand that our aviation system is as safe as it is because so many safeguards are built in to the system, accompanied by at times reams of paper documentation. But no amount of regulating or policy making will ever stop human factors from poor decision making. Part of aviating means truly taking command, and making the hard, unpopular decisions at what might appear to be the worst possible times. Again, those decisions may save everyone's life.

…if the crew realizes that a fuel gauge is broken, it might be tempting for the boss to say, "Just fill up the tanks." But if the MEL doesn't allow for that kind of relief, or if filling the tanks will result in an overweight landing, then the crew needs to have the backbone to stand up for the proper remedy.

Corporate flying is a unique style of work, primarily because of the expectations of the client or owner who is spending a large sum of money to avoid flying on the airlines. But along with the variety and crazy schedules, it can be a very rewarding adventure.

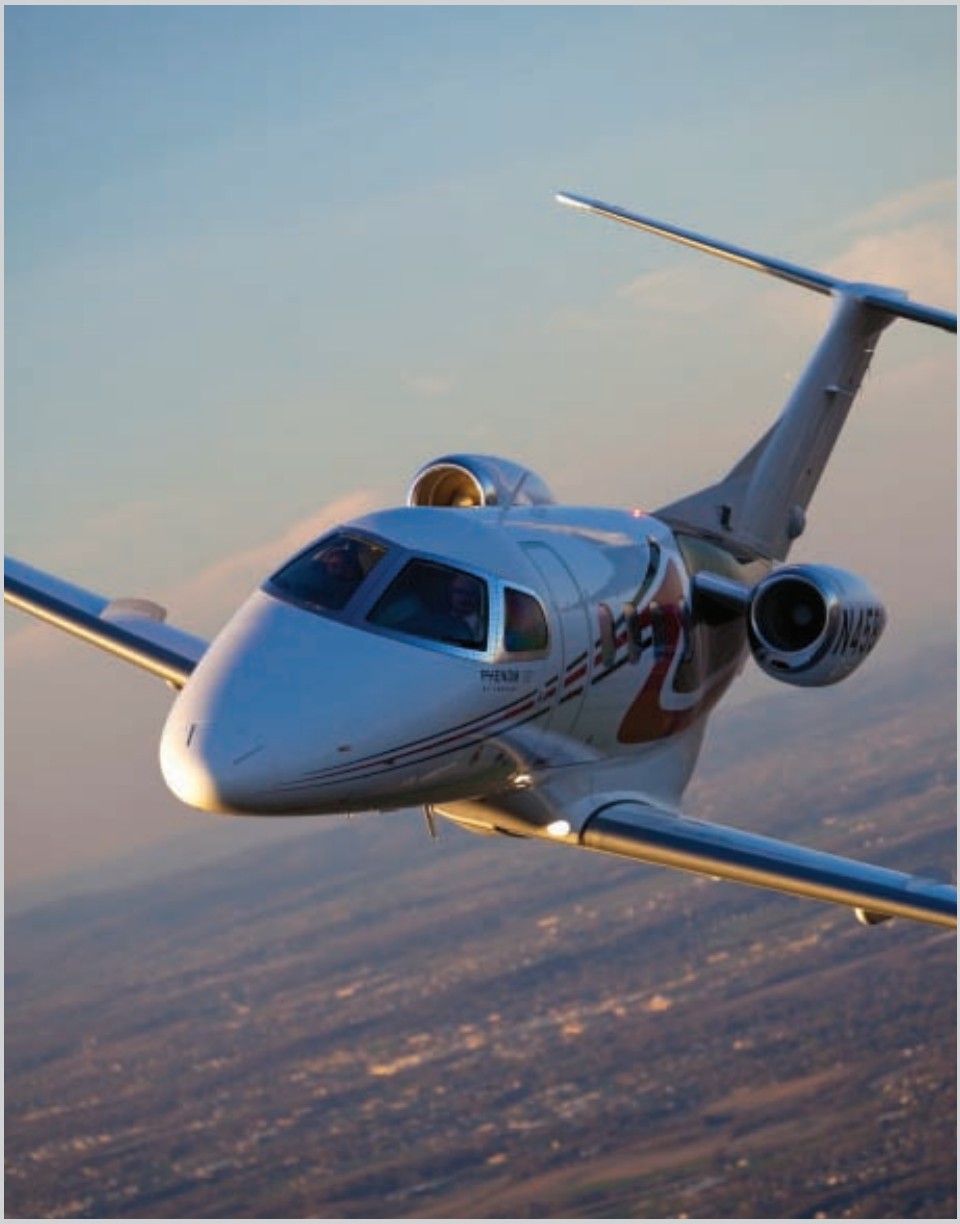
Chip Wright is a CFI, ATP, and a Canadair Regional Jet captain for Comair.



Turbine trouble

Phenom failure

BY CHIP WRIGHT



Modern aircraft, especially jets, have incredibly sophisticated self-diagnostic tools. More importantly, they are very accurate and reliable. Further, any reasonable training course spends a fair amount of time emphasizing not just the technical information needed for troubleshooting, but also the effect of certain malfunctions on aircraft performance. Once this information is reviewed in the classroom, it is usually reinforced in the simulator. The sessions in the sim can be a mix of scenario-based training or demonstration-type training. The point of such training is to combine the knowledge gained in the classroom with the ability to actually see and experience such performance degradations in the simulator.

Recently, an Embraer Phenom experienced damage during landing. The crew acknowledged during the investigation that they had received a Crew Alert System (CAS) message after takeoff that indicated a failure of the braking system. The flight departed Tucson, Arizona, and the crew elected to continue on to their destination in Brenham, Texas. From the preliminary report by the NTSB:

"According to the pilot's statement, they received a brake fail warning soon after takeoff from TUS and the crew continued to their destination. The crew conducted an instrument approach to a straight in landing on Runway 16 at the 11R airport…[O]n the 6,003-foot-long by 75 foot-wide runway, the pilot discovered 'zero' braking and reverted to emergency braking. Both main tires blew after application of emergency braking, and directional control of the airplane was lost…skid marks show that the airplane was still moving when the nose rotated approximately 120 degrees to the left. The airplane departed the left side of the runway…The right main landing gear collapsed after contacting the soft muddy turf on the east side of the runway."

The immediate question is simple: Why did the crew elect to continue the flight? Were they pressured to do so? If so, by whom? Was there a belief that better maintenance would be available in Texas? Or were there concerns about landing in TUS? Or was the crew itself just focused on completing the mission?

A brake failure is a big deal, and the Quick Reference Handbook (QRH) undoubtedly provided guidance on choosing an acceptable field for landing. Further, the crew's systems knowledge should have prepared them for what the QRH would say before they even started the procedure…assuming of course that they even referenced the QRH. At this point, it is unknown what they did or did not do, but such a fundamental mistake in basic airmanship makes you wonder what tasks they may have accomplished or ignored. This very likely was a complete system failure, and it should have resulted in an emergency being declared so that fire and rescue personnel could be positioned. Ironically, they would be on the scene not for a fire, but in case the crew was unable to keep the plane on the runway; their role would have been to facilitate an evacuation and treat any potential injuries.

The longest runway at TUS is nearly 11,000 feet, and that does not include an unusually long taxiway that extends from the northwest end. The field elevation is 2600 feet MSL. The only variables really left to consider would be temperature (and the resulting density altitude), wind, and the effectiveness of reverse thrust. If the crew was uncomfortable with the potential landing performance, then a diversion to a better field would be warranted, but an emergency still should have been declared. While a problem with the landing gear is

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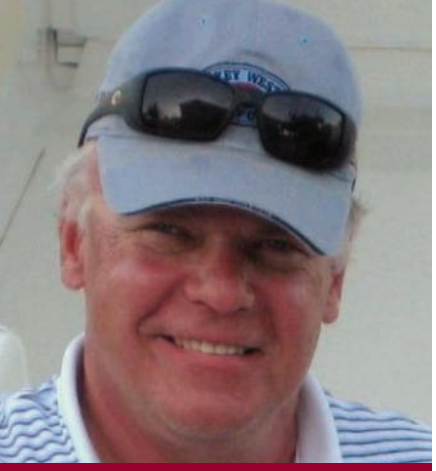


Real Pilot Stories

Lessons from the Cockpit

Ditching in the dark

Relive a pilot's nightmare

Clinging to a crab buoy the pilot glimpsed far-away shore lights. Trying not to think of lurking predators as his airplane submerged into the dark depths of the Gulf he wondered if anyone would find them in the shrouding darkness... could they survive the night?

Enter ASI's new "Real Pilot Story: Ditching in the Dark" as the Mooney pilot relives that eerie moment when N2558Y's engine

failed over the Gulf of Mexico, about 28 miles short of their destination in Marathon, Florida. That fateful October night the pilot realized he wouldn't be able to reach land. With only one option—ditch his aircraft in the rough dark waters below—he briefed his two passengers to brace for impact. But, did he prepare adequately for what was in store?

Watch the video and listen to important lessons learned ***(www.airsafetyinstitute.org/ditchingrps).***

Turbine trouble *(continued from page 3)*

significant, it is not the same as a fire. Time was on their side to consider all options while at the same time burning fuel to decrease the landing weight, thus decreasing the stopping distance.

If the crew was pressured into continuing the flight, they would not be the first corporate pilots exposed to such pressure. However, they should have made the situation clear to all involved, and invoked their

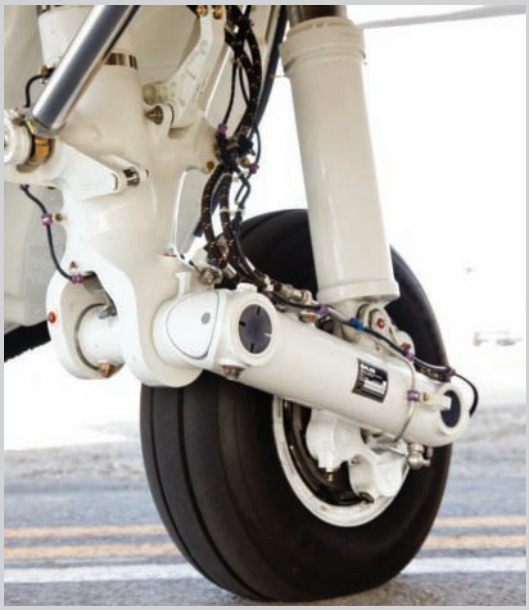
"According to the pilot's statement, they received a brake fail warning soon after takeoff from TUS and the crew continued to their destination."

PIC authority to land at the most suitable airport, and not one with a runway that was only 6,000 feet long, of which they were probably only able to use 5,000 when considering a normal approach and landing.

As soon as the CAS message advised them that the brakes had failed, the original flight plan should have been ignored, and the new plan should have been to put the airplane on the best runway possible for the situation at hand. The report indicates that the crew was surprised to find that no braking was available after touchdown. This should have been anticipated and planned for as a result of the nature of the emergency.

We'll know more once the final report is issued, but there are some early lessons.

First, know your systems and the various failures they can experience. Second, when a normal system has failed or potentially failed, assume the worst and plan accordingly. Third, in addition to relying on basic airmanship and flight training, do not fail to use common sense. Fourth, as a pilot, do not submit to undue pressures to complete a flight that needs to be aborted, and as a non-pilot, remember that you are paying the pilot for his judgment and expertise. If he's wrong on occasion, be grateful to be alive to discuss it.



Finally, if in doubt, always select "more airport" than you need.

Chip Wright is a CFI, ATP, and a Canadair Regional Jet captain for Comair.

IN THE NEXT ISSUE

Business aircraft operations—managing your flight department under Part 91 vs. Part 135

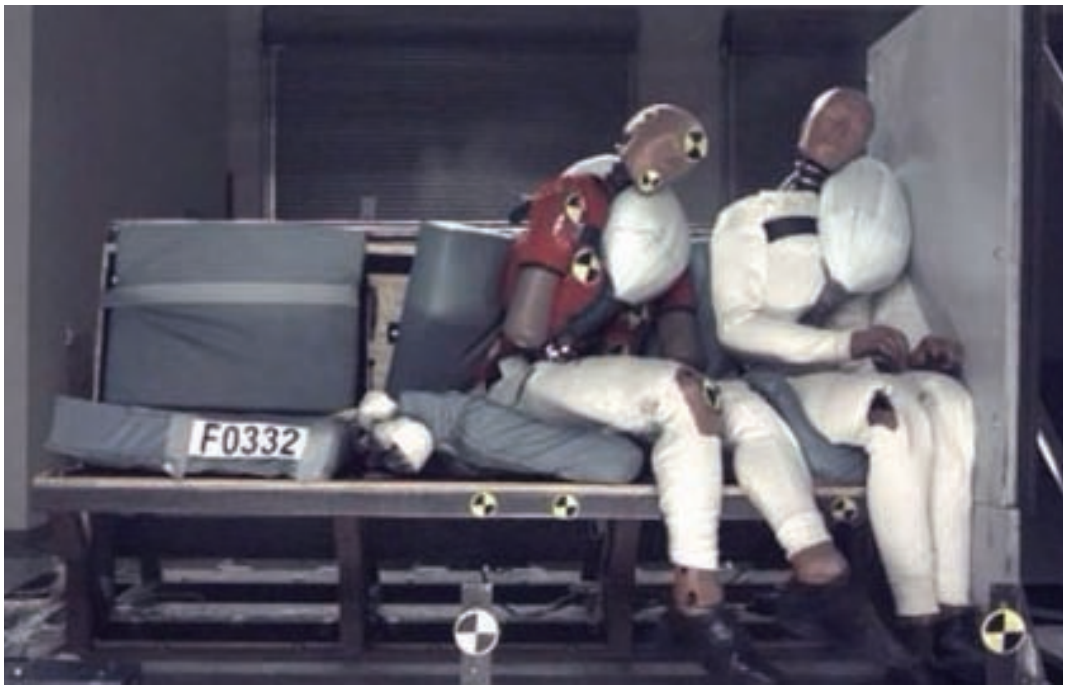
Safety Brief: Airbags and bizjets

New airbag solution allows bizjets to fill the seats

BY THOMAS B. HAINES

What's an extra seat on a business jet worth? A lot. An aircraft manufacturer's ability to call an airplane a 10-seat jet versus a nine-seat jet can increase the sticker price by six figures in some cases. But, until recently, manufacturers could not allow side-facing divan seats next to a bulkhead or pillar to be counted as seats for takeoff and landing. The fear was that in a crash, those passengers would slam their heads into the obstacle and be injured more severely than those one seat away.

Aviation airbag manufacturer AmSafe Industries ***(www.amsafe.com)*** and B/E Aerospace ***(www.beaerospace.com/index.htm)*** have teamed to offer a solution in the form of the industry's first airbag system designed for side-facing seats. Whereas aviation airbags typically deploy forward out of lapbelts or shoulderbelts, the ones at side-facing divan seats next to the bulkhead deploy sideways out of the shoulder harness next to the passenger's head.



B/E Aerospace, a leading manufacturer of business jet seats and other interior components, will be working with airframe manufacturers to incorporate the new style of airbags into interiors.

"The Seatbelt Airbag is the most practical and cost-effective solution to reduce neck loading and provide head and body-to-body contact protection for side-facing divan occupants. It allows for more flexibility in cabin layouts and demonstrates our proactive commitment to address side-facing occupant protection," said Chuck Barresi, vice president and general manager of B/E Aerospace's Business Jet Group.

"By equipping side-facing divans with the AmSafe Seatbelt Airbag, business jet passengers will enjoy an additional level of protection that is offered on nearly 50,000 seats on commercial and general aviation aircraft around the world," said Bill Hagan, president of AmSafe. "The AmSafe Seatbelt Airbag enables all positions on the divan to be occupied for takeoff and landing. With every major manufacturer offering aircraft models that include side-facing divans, we anticipate a rapid adoption industry-wide."

The announcement from AmSafe and B/E Aerospace came several weeks before the NTSB issued a report encouraging the use of aviation airbags ***(www.aopa.org/airbagsntsb)***.

See a video demonstration of the AmSafe airbags for side-facing seats ***(www.aopa.org/aopaliveairbags).***

Tom Haines is Senior Vice President AOPA Media and Editor in Chief of AOPA Pilot.

This article appeared on www.aopa.org in 2011. Reprinted with permission.

DID YOU KNOW

A note from the publisher

The Air Safety Institute (ASI), a division of the nonprofit AOPA Foundation, serves all pilots—not just AOPA members—with free or low-cost education programs, while it examines safety data and conducts safety research. You've come to know these programs as award-winning interactive online safety courses, safety webinars and seminars, Flight Instructor Refresher Clinics, safety quizzes, Real Pilot Stories, Accident Case Studies, the ASI accident database and analytical reports—the list goes on.

USAIG enthusiastically supports ASI's mission and world-class aviation safety research and educational initiatives. ASI is unequalled in providing the scope and quality of safety information focused directly on the owner and pilot community. The Institute funds its important work through AOPA's philanthropic arm, the AOPA Foundation ***(www.aopafoundation.org)*** and, although support from organizations like USAIG helps, it is primarily funded through dedicated pilot philanthropists. The foundation funds several efforts addressing key issues critical to the future of general aviation, but aviation safety, rightly, always heads the list.

Please consider joining us in supporting our friends and colleagues at the Air Safety Institute by supporting the AOPA Foundation. It is good for everyone who flies ***(www.aopafoundation.org/donation).***

—David L. McKay

Data Diving: Bigger, faster, better?

BY DAVID JACK KENNY

Turboprop airplanes offer a lot of advantages. Few piston aircraft even begin to compete in terms of speed, payload, range, or dispatch reliability. With onboard radar, effective deicing, and service ceilings in at least the mid-twenties, the pressurized models come close to all-weather capability with lower operating costs and better short-field performance than most jets. But while it's widely presumed that these performance gains also bring increased safety, the record isn't so straightforward.

In 2009, 60 of the 1,272 airplanes involved in GA accidents—just under five percent—were turboprops. More than a third of these (21) were crop-dusters. Six accidents took place on part 135 flights, two in Caravans and the other four in King Airs. The 33 accidents on Part 91 flights were almost equally divided between single-engine models (16) and twins (17).

At first glance, the numbers are encouraging. The 2010 Nall Report ***(www.airsafetyinstitute.org/nall)*** cited an overall rate of 6.60 accidents per 100,000 flight hours for non-commercial fixed-wing flights that year. The accident rate for turboprop singles on non-commercial flights was almost 45 percent lower at 3.74. In turboprop twins it was 70 percent lower at 1.99. However, two confounding factors make direct comparison misleading: Turbine flight includes a much higher proportion of corporate transport and other work, and the overall non-commercial rate is pushed up by homebuilts, which had almost four times as many accidents per flight hour as manufactured aircraft while scarcely entering into the turbine record (though there was one Epic LT whose fuel-control unit failed).

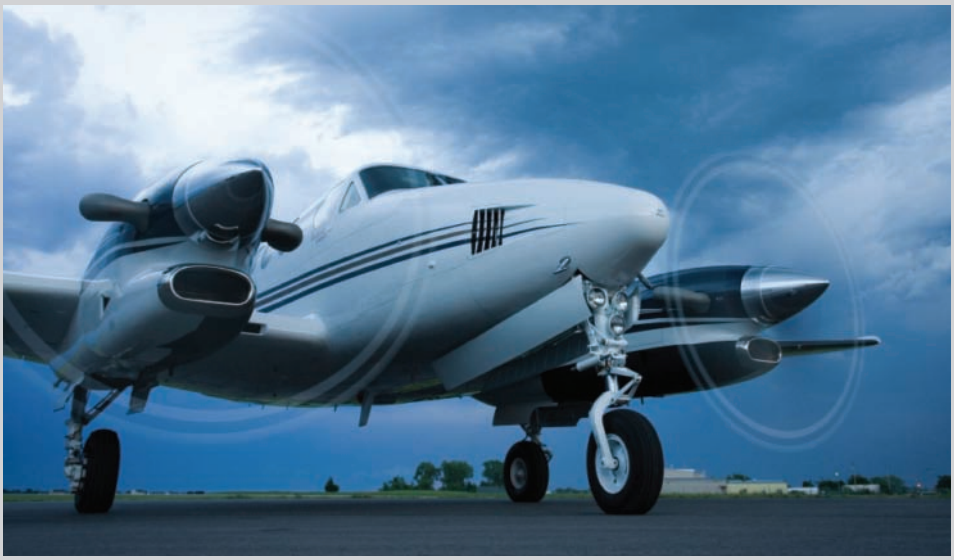
Just two turboprop accidents occurred during corporate flights, one in a PC-12 and one in a King Air 90, though corporate transport accounted for almost a quarter million hours of combined single- and twin-engine flight time. Excluding these, the accident rates of 4.26 for singles and 3.25 for twins still compare favorably with the 5.57 accidents per 100,000 hours in all manufactured GA airplanes, but their advantage is less dramatic. And other differences in the uses of these aircraft still distort the comparison.

Turboprop GA Accidents in 2009

	Accidents	Flight hours (100,000s)	Accident rate
Parts 91 and 91K:			
Single-engine	16	4.28	3.74
Excluding corporate	15	3.52	4.26
Personal flights*	10	0.99	10.10
Personal flights in piston singles*	631	61.69	10.23
Twin-engine	17	8.56	1.99
Excluding corporate	16	4.92	3.25
Personal flights*	5	1.21	4.13
Personal flights in piston twins*	36	5.40	6.67
Part 135:			
Single-engine turbine	2	2.23	0.90
Twin-engine turbine	4	2.47	1.62
Part 137:			
Single-engine turbine	21	4.15	5.06
Single-engine piston	31	3.42	9.06

Visit www.airsafetyinstitute.org/accidentdatabase for custom searches.

** Excludes amateur-built airplanes.*



ASI has long noted the excess risk of personal travel, and if we restrict attention to personal flights, the results are startling. While the numbers are admittedly small, the 10.10 per 100,000 hours of personal travel in single-engine turboprops is no better than the 10.23 rate for piston singles. Twins fare better; their personal-accident rate of 4.13 is still almost 40 percent lower than the 6.67 rate in piston twins.

Why personal flights don't show more evidence of a safety advantage is a subject for another issue. The small number of Part 135 accidents makes rate estimation unreliable—chance differences in the level of aircraft damage could change the reported rate by 50 percent—but in aerial application, the evidence does seem to be clear. Turbine-powered crop-dusters did 20 percent more flying but had one-third fewer accidents. Not only was their accident rate 45 percent lower than for piston airplanes doing the same job, but only one-third as many crashes were blamed on powerplant problems.

David Jack Kenny is manager of aviation safety analysis for the Air Safety Institute, an instrument-rated commercial pilot, and owner of a Piper Arrow.

NTSB report may lead to new Part 135 training requirements

Board rules fatigue, lack of proper CRM contributed to 2008 fatal accident

BY ROB FINFROCK

In March, the National Transportation Safety Board issued its Probable Cause determination in the fatal July 31, 2008 crash of a Hawker 800A business jet near Owatonna, Minnesota. That ruling included several recommendations to the Federal Aviation Administration that—if implemented—would change how Part 121 and 135 operations conduct pilot-in-command line checks, bring new regulations about crew resource management, and conduct thorough training about the effects of fatigue.

The flight crewmembers exhibited poor aeronautical decision making and managed their resources poorly, which prevented them from recognizing and fully evaluating alternatives to landing on a wet runway in changing weather conditions.

The NTSB ruling comes after a nearly three-year investigation into the accident, which claimed the lives of the two pilots and six passengers onboard the mid-size business jet. The nonscheduled charter flight was en route to Owatonna Degner Regional Airport (OWA) from Atlantic City, New Jersey. Most of the flight was operated under an IFR flight plan, though it was cancelled on approach to the airport. A thunderstorm had passed through the area about 20 minutes before the jet's arrival, and visual meteorological conditions prevailed at the time of the accident.

The aircraft struck a localizer antenna and impacted terrain off the departure end of Runway 30 at Owatonna airport following an attempt by the flight crew to execute a go-around after touching down on the rain-slicked runway. No anomalies were found with the aircraft by investigators, and the Board focused on the human factors behind the accident.

The NTSB ruled the pilot did not properly deploy spoilers and flaps after touchdown, and attempted the go-around too late when the aircraft failed to slow satisfactorily during the landing rollout. Contributing causes to the accident, according to the Board, were "the pilots' poor crew coordination and lack of cockpit discipline" and "fatigue, which likely impaired both pilots' performance."

On the latter point, the Board noted its investigation revealed "significant acute sleep loss, early start time, and possible untreated sleep disorders, and fatigue might have especially degraded the captain's performance and decision-making abilities."

The Board also determined the captain did not follow sterile cockpit procedures on the approach to OWA, and showed a lack of checklist discipline throughout the descent and approach phases of the flight. Also noted was the captain's failure to obtain a full weather briefing for Owatonna, and that he may not have effectively utilized the first officer to handle tasks during the approach and touchdown.

"The flight crewmembers exhibited poor aeronautical decision making and managed their resources poorly, which prevented them from recognizing and fully evaluating alternatives to landing on a wet runway in changing weather conditions," the Board states in the Probable Cause ruling.

Those determinations led to a total of 14 NTSB recommendations to the FAA relating to this investigation. Among those is a recommendation that Part 135 operators conduct line checks for pilots-in-command separately from other required checks, and in situations that better represent the actual operating environment, to "ensure that thorough and complete line checks, during which pilots demonstrate their ability to manage weather information, checklist execution, sterile cockpit adherence, and other variables that might affect revenue flights, are conducted."

Also included are recommendations for both scheduled and on-demand operators, and Part 142 training schools, to establish and follow crew resource management training and standard operating procedures for pilots–and, for those SOPs to be consistent throughout training and actual operations. The Board directly noted "the failure of the Federal Aviation Administration to require crew resource management training and standard operating proce-

Shut-eye

BY BRUCE LANDSBERG

By now, most of us have not only heard of the snoozing air traffic controller at Reagan National Tower (KDCA), but also formed an opinion about the pilots' decisions to land at the airport. The two airliners landed without incident as they were talking to Approach Control, who noted no airborne conflicts.

A recent *Wall Street Journal* article discussed the divide splitting safety experts on whether the pilots should have landed while the tower snoozed. "Now, a number of safety experts inside and outside government contend the pilots also shoulder blame in the incident. These experts fault the cockpit crews for forgoing what they contend would have been a safer option to land elsewhere, or at least stay in a holding pattern to determine why the Reagan National tower went silent for more than half an hour," according to author Andy Pasztor.

I disagree. FAR Part 91.3 allows the PIC to deviate from any rule or procedure in the case of an emergency. The IFR lost comm rule says in VFR or upon encountering VFR conditions the "pilot shall continue and land as soon as practicable." And, FAR Part 121 operators have DCA specific lost comm procedures for reasons of national security.

So-called pundits allege the pilots' actions created ground hazards. Really? Anything moving on DCA's surface must have a certified operator at the controls—they would likely be aware the tower was off-line.

Perhaps the greatest irony is that we're still debating this incident when the crews made their decision in less than ninety seconds!

What do you think? Share your opinion at ***www.airsafetyinstitute.org/secondguessing.***

Safe Flights…

Bruce Landsberg

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NTSB report...

(continued from page 7)

dures for Part 135 operators" as a contributing cause of the accident.

The Board also recommends the FAA require those operators to use checklists requiring pilots to call out actual flap position, instead of using non-standard terminology such as "set" or "as required."

Operators should also incorporate more thorough initial and recurrent training about the effects of fatigue on flight crew performance, the Board notes. It also recommended better education and training of doctors and pilots on common sleep disorders such as insomnia, and "for aero medically appropriate evaluation, intervention, and monitoring for sleep-related conditions."

"This accident serves as a reminder that aviation is an unforgiving environment; no detail is too small to be overlooked—not the winds, or the communication between crew members, or even how much sleep they get," said NTSB Chairman Deborah Hersman in the ruling. "The small things do matter and in this case they accumulated to result in tragedy."

Also among the recommendations by the NTSB is a call for manufacturers of turbine-powered aircraft to include in Aircraft Flight Manuals a "committed-to-stop" point in the landing sequence, after which point a go-around should not be attempted. A full summary of the Board's investigation and findings may be found here: ***www.ntsb.gov/events/2011/Owatonna_MN/synopsis.html.***

Rob Finfrock is a licensed sport pilot and formerly managing editor of an online aviation news service.

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