

# Aviation Human Factors Industry News

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*From the sands of Kitty Hawk, the tradition lives on.*

Hello all,

To subscribe send an email to: [rhughes@humanfactorsedu.com](mailto:rhughes@humanfactorsedu.com)

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## Human Factors training is just common sense... Or is it?

Gordon Dupont - System Safety Services

Many times over the years, I have had class participants tell me that they don't need human factors training because it is [just common sense](#). Nothing could be farther from the truth. For example, look at the picture of the plumbing fittings on the right. It is just common sense that even your grandmother would know to tighten every single one of those fittings. Yet in my seven years of accident investigation I have met all too many [very qualified, conscientious and loaded](#) with common sense maintenance personnel who have left a line loose on an aircraft.



Human Factors training is nothing more than training the person on [how to avoid the error they never intended to make](#).

It calls for providing the person with information on what can set him/her up to make an error and more importantly, what [“safety nets”](#) the person can put in place in order to prevent an error from occurring or to prevent any error from becoming an accident.

What is a “Safety Net”? A safety net is a regulation, a policy, a procedure or a practice which if in place, might break a link or prevent a link from forming. An example is: developing the habit to always go back three steps in your work after being distracted. In Human Factors training you are taught that your mind can work faster than your hands and thus you may think and believe you have completed a task when in fact you have not. Now take a look at our plumbing lines, a safety net of always using [TorqueSeal](#) to mark lines as you tighten each fitting would let you and others know that each fitting is correctly tightened. A [dual inspection](#) by a second person would also help ensure no lines were left loose.

## To error is human

Ever since Eve made the error of eating the forbidden apple, we humans have been making human errors. To lessen errors being made we have tried to “Murphy-proof” everything we have come into contact with. For example; you can’t start your car unless it is in neutral or park or you can’t retract the landing gear on the ground.

We also have come up with rules, laws and regulations to reduce human errors. I.e., You must stop at a red light even though common sense tells you there is no one around and it would be safe to not do so. If you do make an error we have put up warnings to prevent it from causing an accident or at least lessen its consequences. I.e., A [warning horn](#) to let you know that you forgot to lower the landing gear before you land or a seat belt to keep you Safer if you choose to ignore the horn.

Today we have “human-proofed” the aircraft to the extent that we have a whole new set of problems. The pilots and crew on many occasions don’t even know what the aircraft is doing.

We also have so many rules nowadays that there are rules for the rules and because there are so many, few of us can remember them all. But the fact still remains that [human error is still our biggest problem](#) and in order to lower human error we must provide the correct training to all humans in the organization because EVERY human can make a mistake even with years and years of experience.

## But what is the correct training?

We believe that by providing training that each participant believes in, can understand and easily apply to his work, to be the correct training. There are some terrible training courses out there. Courses that pilots call “Charm School” and maintenance call “Hug a Tree 101”. These courses are simply a waste of time and money. Human factors training for everyone (maintenance and pilots included) center around the “[Dirty Dozen.](#)” The Dirty Dozen consist of 12 contributing factors that can set you up to make an error.

While human factors (HF) training will help lower human error we must also provide a work environment that is resistant to human error. This is the role of a [Safety Management System \(SMS\)](#) of which HF training is a part of. HF training will help ensure the success of any SMS and is an integral part of any SMS seeking to lower human error to as low as reasonable.

## Most plane accidents happen while still at airports

**KUALA LUMPUR,**

Aviation statistics show that flying is still very safe, despite the headline-grabbing losses of flights MH370 and MH17 this year, said Allianz Global Corporate & Specialty SE.

In its Global Aviation Safety Study report, the Allianz Group unit said a very significant part of insurance claims made in recent years is actually due to aircraft being [unable to leave the airport](#) in the first place. Such insurance claims are largely due to the planes being declared unsafe to fly due to [“ground equipment damage”](#) or [“mechanical failure”](#).



The report noted that damage caused by accidents while the plane is still at airport ramps are on the rise, costing the aviation industry about [US\\$10 billion](#) (RM35 billion) a year.

[“Ineffective communication](#) is at the heart of most incidents. Contact between airplanes and ground service equipment accounts for more than [80%](#) of incidents.

“Damage from [foreign objects](#) continues to be an issue for the aviation sector, with this being the fifth highest generator of insurance claims by number.

“Bird strikes are a notable cause but incidents on runways with animals such as zebras and cows can also cause losses.”

The unit’s global head for Europe, Middle East, Africa and Asia Pacific Henning Haagen said: “Today, there are fewer fatalities or total hull losses compared with the past.”

When aircraft losses do occur, the report estimated that 70% of fatal accidents are related to [human error with pilot fatigue](#) as a major contributor.

“Initiatives such as crew resource management and the automated cockpit have improved safety levels, but automation can also have a downside as a number of incidents have raised the question of whether pilots are too reliant on automation in the cockpit.”

But such automation also has a downside, the report noted. “Newer aircrafts are highly exposed to [cyber crime](#) due to the prevalent use of data networks, onboard computer systems and navigation systems.

“The expected increase of drones in commercial use also poses as another risks as an anticipated future shortage of a skilled workforce including pilots.”

Looking back, the report added: “In 2012 [88%](#) of global aviation fatalities occurred in Africa (45%) and Asia (43%).

“Africa currently uses the highest percentage of second generation aircraft – over 50% of the total fleet analyzed. Upgrading the airline fleet to current generation aircraft is one of the safety initiatives which have lowered the global accident rate.

“In some parts of Africa, [safety and training standards](#) are comparable to those of 50 years ago in the US or Europe.”

## **Three Air-bag Accidents At Boeing Plant Lead To Extra Safety Measures**

Workers at plane-maker Boeing's Everett plant near Seattle are following extra safety measures after three air bag-related accidents, [including the death of a technician](#) last month, the company said on Friday.

No one was seriously hurt when an air bag deployed on Dec. 13 as a seat supplier technician was working on a Zodiac Aerospace seat on a plane being readied for delivery, Boeing spokesman Wilson Chow said.





"We understand that employees are concerned," Chow said, adding the company [was holding meetings](#) with workers and was implementing additional safeguards and inspections.

"We are confident the system is safe to work on and to be around, and the seat-belt air bag poses no risk to the flying public," Chow said.

The accidental discharge of a seat-belt airbag happened because [a bent connector pin caused a short circuit](#), he said.

Chow confirmed a third incident but could not provide specifics, such as injuries or cause.

A technician for aircraft interior supplier Jamco America died after being struck in the face when a passenger seat air-bag inflator discharged while he and another technician from a different supplier were working on a 777 on Nov. 13, the Seattle Times newspaper reported.

A source who declined to be named said that workers were [now following extra safety measures](#), including using caution tape to cordon off the seats.

The Dec. 13 incident involved an actual air bag deployment, Chow said, while the Nov. 13 incident happened as the system was partially assembled.

"There is widespread concern," Connie Kelliher, spokeswoman for International Association of Machinists, District Lodge 751, told the newspaper. "We are actively involved and working to ensure our members concerns are addressed."

## **Pilots safe but Daily Air plane damaged after landing on belly**

A Daily Air plane landed on its belly at Taitung Airport during a training session on Sunday after the co-pilot [forgot to lower the landing gear](#) during the approach, the Taiwanese carrier said.

The Dornier Do 228 aircraft was carrying two pilots when the accident occurred at Taitung Airport in southeastern Taiwan on Sunday afternoon. Both pilots are reported to be safe. The pilots were practicing take-offs and landings and were returning to the airport from outlying Green Island for one of their practice runs, according to Daily Air Corp.



They were simulating a left engine failure as they approached the airport, and the co-pilot, whom the airline said may have been **too focused on the simulated problem**, forgot to lower the landing gear.

The airplane skidded over 200 meters on its belly before coming to a stop, the airline said, adding that it was still investigating the accident.

## **NTSB: Pilot in ocean crash had not trained for stunt**

The pilot in last year's fatal plane crash over Ocean City may not have been trained properly in the aerobatic moves he loved to perform, according to a federal review of the incident. The June 30, 2013, crash over the ocean killed the pilot and aircraft owner, Thomas Geoghegan, 43, and passenger Joshua Adickes, 27. Both were off-duty Ocean City police officers out for a pleasure ride on a sunny Sunday afternoon.



The National Transportation Safety Board determined the crash was caused by the pilot losing "situational awareness" during the prolonged spin and misjudging his altitude. He was unable to recover from the spin.

"There were multiple cues available to the pilot that the maneuver should be terminated," the report states, "including an increasing ground presence/perspective from the out-the-window view, and the rapidly decreasing altitude indicated on the altimeter in the panel. However, the pilot failed to terminate the maneuver at an altitude adequate to prevent impacting the water."

According to the Dec. 10 NTSB report, an investigation and review of Geoghegan's flight records showed "no evidence of formal aerobatic training," despite records indicating he had conducted aerobatic maneuvers in his Nanchang China CJ-6A aircraft.

Geoghegan's log book noted three pilots who provided "CJ training." Each were interviewed for the NTSB report, and all of them told investigators they provided "familiarization training" to the aircraft, but never aerobatic training. Only one of the three was a flight instructor, the report says.

NTSB investigators also interviewed the mechanic who worked on Geoghegan's airplane, who was identified as an experienced pilot and flight instructor. He told investigators he didn't believe Geoghegan ever had received any formal aerobatic training.

When investigators told the mechanic that there was video proof of Geoghegan performing aerobatic moves, he replied, "if I had known that, I would have put a stop to it," according to the report. "Aerobatics over water is dangerous. It's disorienting."

Geoghegan first started flying in 1996. He was issued a pilot's license in 2007, and in 2010 bought his two-seater airplane, a Chinese military trainer. He logged 859 total hours of flight experience, including 231 in his CJ-6A, the report states. His plane had been built in 1980 and most recently was inspected about 13 weeks before the accident.

Tommy, as friends knew him, was known to offer joyrides to friends and fellow police officers. He mounted video cameras in the cockpit to capture his passengers' reactions, and share them on Facebook.

Investigators said they recovered two cameras from the wreckage that showed the entirety of the flight, from takeoff at the West Ocean City municipal airport at 3:32 p.m. to the crash at 4:05 p.m. One was a cockpit-mounted camera. The other was held by passenger Joshua Adickes, who was seated in the the rear.

Video recovered from the flight showed Geoghegan performed an aerobatic move known as a stall, where the aircraft climbs vertically at full speed before coming to a stop in midair.



Coming out of the stall, he rolled the plane on its back. It began to spin, completing 22 revolutions before hitting the water, with the engine running smoothly throughout.

Footage showed "no signs of pilot distress or incapacitation," the report says, "and indicated that the pilot was actively engaged in controlling the airplane and was providing control inputs to maintain the spin to impact. There was no indication of any distracting event or of the pilot attempting to diagnose, troubleshoot, or respond to a perceived in-flight control, system, or engine anomaly."

Hundreds of beach-goers watched the plane go down. One unnamed witness familiar with Geoghegan's flights over the beach told NTSB investigators that he had never seen the aircraft flying so low, or that close to shore, and that the plane "pancaked" into the sea with a slapping sound, like a hand smacking the surface of the water.

Another unnamed witness provided the NTSB with video footage of flights he had taken with Geoghegan. It showed the airplane operating at low altitude over the ocean and making climbs that penetrated clouds. The report says the vertical climb, stall, and spin captured in this video footage "was consistent with the accident spin."

Maryland State Police divers found the plane about a quarter-mile from the beach, under 30 feet of rough and murky water. The plane was mostly intact and a majority of the wreckage was recovered within a week of the crash.

There was no evidence of any pre-impact mechanical anomaly, the report said. Post-mortem toxicological testing on Geoghegan by the FAA came back negative for drugs, alcohol, and carbon monoxide, the report also noted.

<http://www.delmarvanow.com/story/news/local/maryland/2014/12/16/report-oc-fatal-plane-crash/20475007/>

## What a Field Trip!

This is Very cool video and definitely worth the 17 minutes for anyone with an interest in aviation. Its hard to believe that anyone would put this much time, effort & money into this. [Talk about dedication to the task](#), these guys did a fabulous job on what could be said was a mission impossible, love these old DC3.



[https://www.youtube.com/embed/9ruArctYYbM?feature=player\\_detailpage](https://www.youtube.com/embed/9ruArctYYbM?feature=player_detailpage)

## Complacency Revisited

We are used to looking at [human factor](#) problems with a focus on the employee, so let's turn this around and look at human factors problem focused on [management](#). I'll only look at one issue: complacency. In this respect, complacency is failure to act appropriately and resting too much on our laurels.

Complacency, at first blush, is not a problem. Don't we have a moment of complacency when we have completed a big project and reflect on what was accomplished? It becomes a problem when it hinders other activities or blinds us to other problems. Excess complacency is the problem.

There was an accident on the "L" train blue line going to Chicago's O'Hare Airport. The operator failed to stop and ran through the boarding area, went through the barriers and proceeded partially up the escalator toward the airport terminal. It was all caught on a security camera and was a devastating accident. Surprisingly, no one was seriously injured. The investigation revealed that several safety devices were designed to stop the train automatically. The barrier at the end of the track had failed in its task. The train operator admitted that she had dozed off just as the train entered the terminal — [aha, a victim was found and terminated](#). The train was not speeding but the train had produced enough kinetic energy even at slow speed to climb the escalator to the airport terminal. The train operator was a fill in, so she works different shifts at different times to fill in for manpower gaps. The operator was trained properly; however, she had a previous incident with dozing off and missing a stop. What would you do?

The transit authority has had a "[zero accident](#)" policy in place for some time. Its instant decision was to fire the train operator and also find out why the safety devices, although activated, failed to stop the train. I see this all too often — "let's have a fair trial right after the hanging." All in all, this sounds like a reasonable approach, a perfect example to tag some "[Dirty Dozen](#)" labels on it and put it to rest. Fatigue comes up immediately; we can also add a cup of lack of awareness and complacency and throw in a dash of pressure and a pinch of stress. The recipe all points to a person, the operator, being the cause — but does it solve the problem? Aren't they missing something?

I'll admit that all those Dirty Dozen labels fit but they should lead us to a root cause. The Dirty Dozen is not a list of root causes or any kind of cause. The Dirty Dozen is a list of symptoms and the finger is always pointed toward the employee. We are good at addressing symptoms and shooting the last person to touch the object because it is staring us in the face. Get rid of the symptom and you don't have anything staring at you. Remove the obvious and we can pretend that the cause has also disappeared and we can be content with being oblivious. Unfortunately, the Dirty Dozen is seen as the great list of causal human factors. We place too much emphasis on its usage. It has become a crutch to lean on to identify causes but problems persist. I wonder why.



## setting people up for failure

It's quick and simple solution — get rid of the person. If it weren't for people mucking up the works, everything would work perfectly. Really? Think again. Machines break, wear, and need maintenance and upkeep. If your car gets a flat tire, do you get rid of it and get another car, thinking that solved the flat tire problem? That sounds ridiculous, doesn't it? In the previous scenario, the train crashed due to the operator falling asleep because the system had her working relief shifts and she crashed the train. [Will firing the train operator fix the problem?](#)

If you have ever worked a relief shift, you know the problems that can arise. You get off work at 4 p.m. and go home expecting to have a nice quiet evening, planning to retire to bed around 10 p.m. At 8 p.m. you are called into work the late shift, [midnight to 10 a.m.](#) This will put you in a sleep-deprived mode from going more than 24 hours without sleep. Add to the fact this is a midnight shift that strains a human's [circadian rhythms](#), even when it is your normal shift. This is a recipe for disaster.

We continually set people up for failure. Managers are surprised when the failure occurs and they blame the individual. I never could understand that. I am always reminded of the scene in Casablanca when Captain Renault, Claude Rains, shuts down Ric's Café, stating, "I'm shocked, shocked to find gambling is going on in here," as the croupier hands him his winnings from the table. Management becomes complacent with settling for the status quo. We seek quick answers and short-term results.

## zero tolerance

While employed at a major airline, I went through a root cause training session. It was a robust training course in sound root cause analysis, but the odd thing was that the root cause analysis was done [after employee discipline has been administered](#). Yes, you read that correctly: ready, shoot, aim. This is zero-tolerance at work; complacency is illuminated because it simply won't be tolerated. No brain matter is required, thinking is not required, merely shoot the person who touched it last.

Zero is an absolute. Zero-tolerance policies are upper management's message to everyone that we don't trust you to do any thinking so we will do it for you. Crash a train and you're fired, get a paper cut and you're fired. Wait a minute, that's ridiculous. Hey, zero is zero, remember? If we allow paper cuts, what else will be on the allowed list? If zero isn't zero anymore, then what is it? Now everyone is confused.

Complacency occurs when we step back and relish our accomplishments, but we shouldn't lose focus of what got us there and rest on our laurels too long.

BP was celebrating six months of achieving its goal of zero quality escapes when it incurred the largest oil disaster in American history. [Surprisingly, the celebration was on the platform that exploded.](#) No executives were injured in the blast although several employees were killed. Aiming for zero quality escapes and zero accidents is a noble goal but it also has a tendency to promote what you are trying to prevent. Zero is also a fleeting accomplishment and not sustainable. When touched upon, it is time for celebration but with the reality that it is temporary. Trying to sustain that level is distressing; however, letting up is not an option. I'll age myself with this analogy but you have to wind a clock every day to maintain the time; if you don't wind it enough, it loses momentum during the day and doesn't keep accurate time. Wind it too tight and it breaks. [Seeking zero as a goal is winding things too tight.](#)

### **What's wrong with chasing zero?**

Zero sounds like a logical target. There was even a bestselling business book call "Zero Defects" some years ago. Unfortunately, zero accidents and zero quality escapes set up what is referred to as binary thinking. You are either perfect or a failure. Upper management message of "zero accidents" or "zero defects" or "zero tolerance" sends a mixed message because they are just words without substance and actually exacerbate what they purport to denounce. The pursuit of zero sets an admirable but unachievable goal. Management 101 teaches that setting unachievable goals frustrates the workforce and reduces productivity. [With a zero mentality, anything less than zero is a failure,](#) so why put forth extra or any effort when failure is inevitable?

The argument will no doubt come up that if I am not pro "zero accidents," "zero defects" and "zero tolerance," then my goal is to plan for accidents and defects to occur and I'm tolerant of all aberrant behavior. This is thought-limiting mentality and binary thinking in action again; life is not black and white and just comprised of zeros and ones. The fact that I see the fallacy in perfection doesn't mean that I pursue imperfection. On the contrary — I recognize imperfection for what it is and don't hide behind the perfection poster. I also recognize that the phrase "all incidents are preventable" is hindsight thinking that cannot predict future events, as many may think. It should more correctly be stated, ["All incidents were preventable."](#) We need that hindsight as a learning tool but it is not predictive. It is our nature to learn from our mistakes and the mistakes made by others, the idea is not to repeat them.

### **more on predictive actions**

That seems to go right in the face of proactive activities that are designed to prevent things from occurring before they happen. It is true that this is a predictive action but it is based on probability and severity. There is a probability of anything occurring with varying degrees of severity.



Aliens from another planet could attack us tomorrow — but if they can travel between planets and galaxies, they are obviously more advanced than us. If they wanted to destroy us, we would be helpless. Should we gain international support and promote huge capital expenditures to develop a defense against an interplanetary attack? That's not going to happen. Even though the severity of the attack means the annihilation of the human race on this planet, the probability is too low to take action. It is better to spend money on defenses that are more necessary even though the severity is less than total extinction. We refocus but it doesn't mean that we completely ignore this issue. We might revisit it occasionally to see if the probability has changed. Never be complacent, even if it is absurd.

Zero is an absolute number. A void is a void. Perfection is also an absolute. Zero is not sustainable and if it is reached, we should not be complacent. We should be attentive enough not be lured into a sense of permanence, [knowing that zero is temporary](#).

Thomas Jefferson said, "Our new Constitution is now established, and has an appearance that promises permanency; but in this world, nothing can be said to be certain, except death and taxes.

## **Many US Workers Sacrifice Sleep for Work Hours, Commutes**

A new study shows that paid work time is the primary waking activity exchanged for sleep and suggests that chronic sleep loss potentially could be prevented by strategies that make work start times more flexible. Results show that work is the [dominant activity exchanged](#) for less sleep across practically all sociodemographic categories. Compared to normal sleepers, [short sleepers](#) who reported sleeping 6 hours or less worked 1.55 more hours on weekdays and 1.86 more hours on weekends or holidays, and they started working earlier in the morning and stopped working later at night.



The highest odds of being a short sleeper were found among adults working multiple jobs, who were 61% more likely than others to report sleeping 6 hours or less on weekdays. Respondents who were unemployed, retired, or absent from the labor force also obtained significantly more sleep and were less likely to be short sleepers.

“The evidence that time spent working was the most prominent sleep thief was overwhelming,” says lead author Dr Mathias Basner, assistant professor of sleep and chronobiology in psychiatry at the University of Pennsylvania Perelman School of Medicine in Philadelphia, in a release.

Short sleepers also traveled more, started traveling earlier in the morning, and stopped later in the evening than normal sleepers. The travel pattern, with peaks at 7 AM and 5 PM, strongly suggests that the majority of travel time is associated with commuting.

According to Basner, the results point to several possible solutions for workers’ lack of sleep. “Potential intervention strategies to decrease the prevalence of chronic sleep loss in the population include greater flexibility in morning work and class start times, reducing the prevalence of multiple jobs, and shortening morning and evening commute times,” he says.

Results show that with every hour that work or educational training started later in the morning, sleep time increased by approximately 20 minutes. Respondents slept an average of only 6 hours when starting work before or at 6 AM and 7.29 hours when starting work between 9 AM and 10 AM. Self-employed respondents with more flexible work times also obtained significantly more sleep than private sector employees and were 17% less likely to be a short sleeper.

Study results are published in the December issue of the journal Sleep.

“Getting at least 7 hours of nightly sleep is essential to be at your mental, emotional, and physical best for whatever you will pour yourself into, either at work or at home,” says American Academy of Sleep Medicine (AASM) president Dr Timothy Morgenthaler, who was not involved in the study.

Basner and colleagues Andrea M. Spaeth, PhD, and David F. Dinges, PhD, analyzed responses from 124,517 Americans 15 years and older who completed the American Time Use Survey (ATUS) between 2003 and 2011. The computer-assisted telephone interview, which is sponsored by the US Bureau of Labor Statistics and conducted annually by the US Census Bureau, asks participants how they spent their time between 4 AM on the previous day and 4 AM on the interview day.

Responses were combined into 40 distinct activities that captured 99.1% of the 24-hour day. Responses combined into the “sleeping” category included napping, waking up, and dreaming.

According to the Centers for Disease Control and Prevention (CDC), 30% of employed US adults **typically sleep 6 hours or less** in a 24-hour period, which represents approximately 40.6 million workers. The AASM recommends that adults get about 7 to 9 hours of nightly sleep for optimal health, productivity, and daytime alertness.

The study was supported by funding from the National Institute of Nursing Research (NINR) of the National Institutes of Health (NIH) and by the National Space Biomedical Research Institute (NSBRI) through NASA. The work was performed at the Division of Sleep and Chronobiology, Department of Psychiatry, at the University of Pennsylvania in Philadelphia.

<http://journalsleep.org/ViewAbstract.aspx?pid=29770>

## **2 Female Pilots Fly With Elite Blue Angels**

Two female pilots are on the elite **Blue Angels squadron**, which made a pit stop Monday in North Texas.

First female marine Captain Corrie Mayes and 'Fat Albert' Captain Katie Higgins will return in September for the Fort Worth Alliance Air Show. Capt. Higgins qualified to fly the C-130T Hercules aircraft, affectionately known as "Fat Albert," by logging at least 1,200 flight hours. "She's very honored to be in that position and the two of us, in addition to the rest of the females in this squad, **we are proud to be here** to represent our sisters," said Captain Mays.



A total of 16 officers voluntarily serve with the Blue Angels. Each year the team typically selects three tactical (fighter or fighter/attack) jet pilots, two support officers and one Marine Corps C-130 pilot to relieve departing members.

The Blue Angels haven't appeared at the air show since 2011. The Alliance Air show takes place Sept. 12-13, 2015.

## **Thunderbirds, Blue Angels Announce 2015 Schedules**

The U.S. Air Force Thunderbirds and Navy Blue Angels have finalized their 2015 show schedules as the International Council of Air Shows met this week in Las Vegas. The [Thunderbirds](#) will open their 62nd season Feb. 22 at the Daytona International Speedway in Florida. The team will perform at 39 locations and end the season Nov. 7-8 at Moody Air Force Base in Georgia. Prior to the official season, the Thunderbirds will make their first public flyover of 2015 at Super Bowl XLIX in Phoenix on Feb. 1. The [Blue Angels](#) are scheduled to fly in 65 demonstrations at 35 locations next year, starting March 14 in El Centro, California, with a show added in Rochester, New York, May 23-24. The team's last show will be Nov. 7 in Pensacola.

Click on the links below:

[Thunderbirds](#)

[Blue Angels](#)

## **FAA Releases Video For New Small UAV Operators**

Geared To The Consumer Who Receives A New UAV As A Holiday Gift

If you think you might be receiving a small UAV as a holiday gift, the FAA has released a video outlining some of its [rules and recommendations](#) for operating the aircraft.

The video was produced in conjunction with the Academy of Model Aeronautics (AMA) AUVSI, and the Small UAV Coalition. The video lays out some "[best practices](#)" for safe operation of a UAV for hobbyists.

"Fly your unmanned aircraft below 400 feet," the agency says, and "don't fly your unmanned aircraft beyond your line of sight."

The video also recommends taking a lesson before flying the aircraft, and don't fly near people or stadiums. It also says not to fly anything "that weighs more than 55 pounds."

And finally, "Do fly for fun. Don't fly for payment or commercial purposes, unless specifically authorized by the FAA."



FMI: [Watch the Video](#)

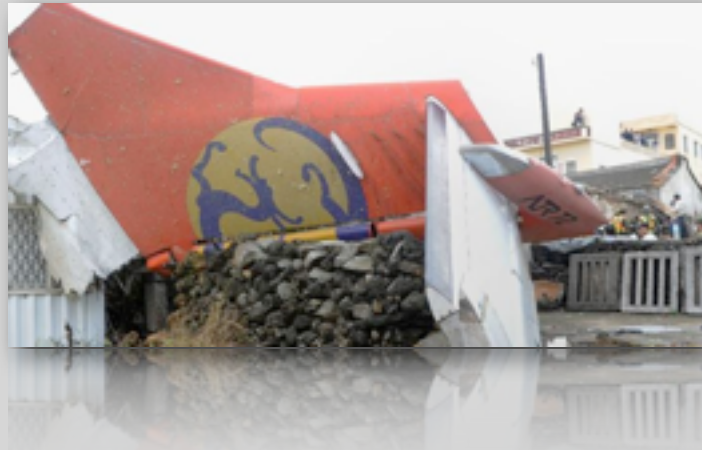
## **TransAsia pilots could not see runway before crash**

A deviation from its flight path and altitude could have led to a TransAsia Airways plane crash in Taiwan five months ago, according to a preliminary report by Taiwan's Aviation Safety Council.



But the council said the exact cause of the crash will need further assessment and it will finalize its conclusions by June next year.

TransAsia Flight GE-222's black boxes showed that 20 seconds before its crash on July 23, the pilot and co-pilot [had lost visibility](#) of the runway of Magong Airport on the offshore island of Penghu.



They then talked about the possibility of a 'go around' approach just a few seconds before the plane crashed, which claimed 48 lives and injured 15 people.

But a probe by the 56-member investigation team of Taiwan's Aviation Safety Council has found that the pilots were unaware of the fact that [the plane had deviated from its flight path by 4 degrees](#) before they called for another landing attempt.

Taiwan's Aviation Safety Council's Executive Director, Thomas Wang, said: "This was their dialogue in the cockpit. But did they have visual of the runway? What decisions were made? Why did they decide to drop altitude? Many questions remain and [we have to take all factors](#) into consideration before we can determine the actual cause."

While many are still inclined to blame the bad post-typhoon weather for the worse-than-expected visibility, aviation expert Cannon Lee urged the council to pay more attention to the reason behind the plane's dropped altitude, [which he believes the crew had overlooked](#).

Mr Lee, a retired Air Force Operation Commander, said: "Whether incorrect weather reports attributed to the crash should be further determined by aviation authorities. But from our experience as senior pilots, it appears that the pilot had [failed to abide by the rule of minimum descent altitude](#) (MDA). Otherwise, the plane wouldn't have had crashed."

Much more needs to be combed through before the actual cause of the crash, the deadliest in Taiwan for more than a decade, can be finalized. The council said it needs another six months but experts said that to avoid a similar tragedy, what is pressing for authorities is to facilitate a better approach mechanism for planes to land in Penghu.

## KLM MD-11 Converted To Luxury Bed And Breakfast

### **A Night In The Airplane Apartment Part Of Vacation Site Promotion**

A recently-retired KLM MD-11 widebody airliner has been converted into an "Airplane Apartment" by some [enterprising entrepreneurs](#), and how they are giving the public an opportunity to win an overnight stay in the converted jet.

Airbnb.com has listed the "Airplane Apartment" in Amsterdam on its website and three available dates. Prospective guests were asked to write an essay of 100 words or less about why they should be chosen to "win a night at a KLM airplane." Winners will also get coach-class airfare aboard KLM to Amsterdam, and 500 Euros on an Airbnb coupon.

[There are a few house rules](#) ... such as "no flying; no marshmallow roasting with the jet engine; and don't use the inflatable emergency slide."

The two-bedroom apartment has Wi-Fi, two kitchens, 116 windows, and a view of the cockpit.



FMI: [MD-11 Apartment](#)