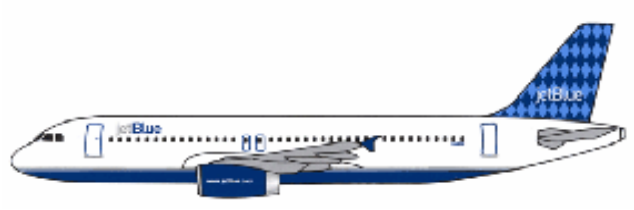

Aviation Human Factors Industry News

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Japan: Missing bolt led to DHC-8-400 nosegear-up landing

Failure to insert a bolt during maintenance work led to an accident in which an All Nippon Airways DHC-8 plane skidded onto a runway on its belly in March 2007.
The Japanese Ministry of Land, Infrastructure, Transport and Tourism's Aircraft and Railway Accidents Investigation Commission found that failure to insert a bolt into a part that was replaced before the plane was delivered to ANA led to the accident at Kochi Airport.

The commission has decided to issue a safety recommendation to aviation authorities in Canada, requesting that authorities instruct Canada's Bombardier company to strengthen quality control.

FAA Mandates More Precise Taxi Instructions

Under new FAA procedures that take effect this week, air traffic controllers must provide specific taxi routes to pilots, instead of simply OK'ing them to proceed to a stated destination. Controllers now must name the taxiways the aircraft should follow at each step along its route. FAA safety officials developed the new procedure as part of an effort to reduce runway incursions. A panel of risk-management experts and aviation user groups analyzed risk factors associated with the new procedures, such as longer periods of communication between controllers and pilots, and the increased chance of miscommunication. They concluded that the new procedure was safe.

U.S Navy Maintenance Mishap Summary – March 2008

Flying with tools and hardware. It is beaten into our heads that tools, when not accounted for will kill people and destroy our war fighting assets. How do we continue to not account for our tools? How do we continue to fly aircraft with them hidden in engine nacelles? How do we sign ATAF, without actually having all tools accounted for?

The same goes for the consumable hardware that we use to hold these machines together.

What do we do when we can't find that bag of hardware that was originally removed? Replace it with new? This happens more frequently than our readers realize.

Here are two more near mishap stories involving aircraft flying with tools and hardware where they don't belong.

Prior to flight operations, an AME and CDI changed a garlock seal on the #3 engine of the scheduled go P-3 aircraft. The CDI had inventoried the tool box mid-way through the job. Following completion of the evolution, the toolbox was closed up without a proper inventory. The toolbox was not inventoried again until shift change, at which time the CDI realized that he was missing a scribe from the toolbox. The aircraft had been released safe-for-flight two hours earlier and was on station 150 miles east of the field. Upon notification of the missing tool, maintenance control recalled the aircraft. The scribe was found in the same location the CDI recalled setting it down.

While performing routine engine maintenance on an E-2C, an AD1 found a very small piece of plastic protruding from the oil cooler access panel on the #2 engine. He had opened the access panel and discovered a plastic bag. Several bolts and washers began falling from the bag while attempting to pull the bag through the access panel. He stopped the evolution and reported the discrepancy to maintenance control. With a QAR present, the entire access panel was removed and the bag was retrieved. The bag contained approximately 3.5 lbs of bolts, washers, fasteners, and nuts. No items within the engine nacelle were missing bolts, washers, or fasteners. There was no evidence to indicate that the access panel screws had been removed since the aircraft was last painted.

What is going on here? We are all human, and can make mistakes. This is the very reason why we have a tool control program and FOD control program implemented in our standards of aviation maintenance. Not just one set of eyes for our tools, always two sets, sometimes even three. What about FOD?

Supervision is a must, when hardware is removed from the aircraft, those items must be bagged and tagged and held accounted for. Not left in the aircraft for the other guy to find. Again, we are lucky we did not destroy a vital asset or worse yet get someone killed!

FAA Bans Chantix Drug For Pilots, Controllers

The Federal Aviation Administration on Wednesday banned pilots and air traffic controllers from using a popular anti-smoking drug after a study found that it had apparently contributed to auto accidents and other mishaps that posed risks to both users and others.

The drug, marketed as Chantix, has been hailed as an innovative treatment to help smokers quit. But a study by a medical safety group — also issued Wednesday — linked it to a variety of unusual and serious side effects, including loss of consciousness and seizures. That prompted the FAA to act, spokesman Les Dorr said.

The aviation agency had approved the drug last summer, before federal safety regulators began investigating reports of serious psychiatric problems, including suicidal behavior, sharp shifts in mood and vivid nighttime episodes some patients call "Chantix dreams."

A new warning came from a report by the Institute for Safe Medication Practices.

"We have immediate safety concerns about the use of Chantix among persons operating aircraft, trains, buses and other vehicles, or in other settings where a lapse in alertness or motor control could lead to massive, serious injury," the study said. It also cited other serious reported side effects, including vision problems, heart rhythm disturbances, seizures and skin reactions.

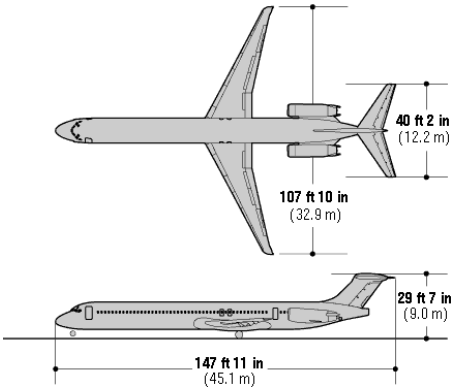
The nonprofit group that conducted the study advises hospitals and doctors on the prevention of medication errors.

Federal Food and Drug Administration spokeswoman said the agency would be investigating. It has recently issued warnings about the drug's effects on mental health, as well as the possibility that taking it could impair driving.

Manufacturer Pfizer Inc., based in Connecticut, strongly defended Chantix.

Smoking "is one of the largest problems we face in the world," said Dr. Anjan Chatterjee, a Pfizer medical director. "When you think about it in that perspective, the risk-benefit analysis is still substantially toward benefit. Even medications most people consider innocuous have side effects."

U.S. DoT calls for better FAA - airline coordination on AD compliance



Citing lessons learned from reports submitted by the Federal Aviation Administration and American Airlines in response to last month's grounding of hundreds of MD-80 aircraft, the U.S. Secretary of Transportation called on the FAA and airlines to better ensure mutual understanding of what constitutes compliance with an Aviation Directive.

Secretary Peters added that the FAA and airlines need to review and improve procedures for understanding the process, timing and criteria for requesting and approving alternative solutions for safety directives, known as Alternate Means of Compliance.

The Secretary also said she is calling on airlines and the Federal Aviation Administration (FAA) to review existing protocols for communications to make sure that significant safety decisions are made using a clearly documented process.

"When situations of this magnitude evolve, it is critical that all parties have the right information so the right decisions can be made," Secretary Peters noted. She said the reports make clear that the FAA is the ultimate arbiter of what constitutes a safety of flight issue and that safety deadlines must always be met on time. "It's important to note that both American and the FAA agree when it comes to aviation safety, there are no soft deadlines." (U.S. Department of Transportation)

Pilot Chowdry and airplane fingered in fatal L-39 crash

The NTSB's recently released factual report of the crash on January 24 last year of a privately owned Aero Vodochody L-39 former Czech Republic military jet trainer that killed Wall Street Journal aerospace editor Jeff Cole riding as a passenger and pilot Michael Chowdry, founder and CEO of cargo carrier Atlas Air, draws attention to the pilot's skill, experience and attitude, as well as a possible severe and sudden

change in the airplane's handling characteristics when it lost the aft canopy during takeoff from Colorado's Front Range Airport.

Chowdry became one of the first customers to own and fly a Boeing Business Jet, and he worked with Boeing to publicize the BBJ. Chowdry received an ATP certificate in August 1999 and he was a CFI. He also had a type rating in the BBJ. On his last FAA physical in July 2000, he reported that he had 5,100 hr of flight experience, with 250 hr during the last six months. On his last insurance policy, Chowdry stated he had completed a biennial flight review and instrument competency check in August 2000. But the sum of his flying experience is not clear because he reportedly never kept a logbook. In addition, former BBJ pilots who flew with Chowdry do not paint a flattering picture of him as an aviator.

Chowdry reported in that August 2000 insurance application that he had 150 hr in the L-39, but his flight instructor estimated he had between 40 and 50 hr, and maintenance logs suggested that Chowdry had 38.6 hr of L-39 experience, 6.6 of which were in the 18 months preceding the accident.

Chowdry made his first flight in the airplane in October 1997, then purchased it and registered it as N602MC in December. In March and April 1998, he received 13 hr of ground school and 11 hr of flight training in the airplane. On April 17, 1998, the FAA issued a letter of authorization (LOA) to Chowdry that was valid through April 30, 2000. The LOA required him to make at least three takeoffs and landings in the L-39 within the preceding six calendar months, or the LOA would be rescinded. In July 2000 he received an estimated two hours of ground instruction and two flights in the airplane with an instructor for a total of 2.3 hr. The FAA issued Chowdry a new LOA that was good through the end of last month.

The NTSB investigation will consider the possibility of pilot fatigue as a factor in the accident. According to the Safety Board, an employee of Chowdry said he flew to Washington in his BBJ for the Presidential inauguration and associated events on January 20 last year. On January 21 and 22 he flew (with three other crewmembers) to Europe and on to Shanghai, China, with stops at several locations for business meetings. On January 23 he was in Seattle, Wash. for a five-hour meeting, and then flew home to Denver that evening.

At about 11:26 the next morning he took off in the L-39 and crashed less than a minute later. Witnesses reported the airplane never reached more than 300 or 400 ft agl, appeared slow for a jet, was oscillating and, just before the crash, made a medium to steep left bank before straightening out. The FAA estimated the speed of the airplane was 200 kt when it crashed.

Was C.G. Change a Contributing Factor?

Witness statements and maintenance records indicate that Chowdry had nearly all of his L-39 flight experience with his airplane's empty weight c.g. between 34 and 35 percent MAC. In October 1999, during its annual inspection, about 200 lb of weight was placed in the airplane to produce an empty weight c.g. of 27.6 percent MAC.

Maintenance records and a flight-tracking sheet suggest that the pilot had 6.1 hr of flight experience with the airplane at this c.g. moment.

In October 2000, during its next annual, the 200 lb of weight was removed from the airplane to create a c.g. of about 34.98 percent MAC. Witness statements and maintenance records indicate that the accident flight takeoff was Chowdry's first since the c.g. had been adjusted back to the 34- to 35-percent MAC range.

The Safety Board will also try to determine if the c.g. of the airplane shifted considerably aft. An experienced L-39 pilot told the NTSB that the flight controls become "very sensitive" in an aft, out-of-c.g. condition. An L-39 instructor pilot told of an owner who had lost his rear canopy while on climbout, without a passenger in the seat. That owner reported that when he was trimming the nose down, the rear canopy suddenly separated from the airplane.

The airplane immediately "nosed up in a dramatic fashion" and that "aggressive nose-down trim and forward stick movements were required to re-stabilize the airplane."

Another experienced L-39 pilot said that an aft c.g. would cause the airplane to oscillate. "At a given oscillation amplitude, the airstream will get under the airplane's nose to produce a violent pitch up." L-39s are "very pitch sensitive" and the trim works "very fast," according to this L-39 pilot. L-39s have a "tendency to oscillate" right after takeoff. The airplane is "very easy to over-control, particularly if the pilot is startled," said another L-39 pilot. "You've got to be well trained and current to fly the airplane."

A pilot witness to the accident said the airplane was "moving up and down very quickly, in a real quick jerky manner." He said the up and down movements were so fast that there was no apparent altitude change.

History of Canopy Problems

An employee pilot of Chowdry, who had LOAs in MiG fighters, said he flew with Chowdry in the back seat of the L-39 on Nov. 18, 2000, about three months before the crash. He said that while in flight, during high-g maneuvers, he could hear and feel the rear canopy chatter loudly. This abnormality, along with a persistent intermittent canopy ajar light, persuaded him to end the flight after approximately 30 to 35 min in the air. This was the last flight before the accident.

Another L-39 pilot said that on two occasions he has had passengers inadvertently move the blue seal depressurization knob (deactivating the rear canopy seals) while getting into the back seat. He said that for low-altitude flights, the front-seat pilot probably would not be aware of it.

During an L-39 flight in March with Chowdry at the controls, a non-pilot passenger said they flew around the airport at approximately 100 ft "and the airplane seemed to be wallowing around." After an uneventful landing and taxi to the hangar, the engine was shut down.

"When Chowdry opened his canopy, it swung all the way over" and fell to the ground, said the passenger. It was also discovered that one of the engine air intake covers had been left in place and had made its way "some distance inside the engine air intake duct."

Following the crash, an examination of the damage to the rear canopy and the aircraft's structure by the Life Science Laboratory in San Antonio led investigators to believe both the front and rear canopy locks were not properly secured. Pieces of the failed acrylic transparency of the aft canopy were also sent to the U.S. Air Force Research Laboratory in Ohio. Its representative stated that the back canopy transparency failed because of acrylic "embrittlement" (chemical contamination to the acrylic substrate). He said this could be a result of "aggressive cleaning fluids getting into the canopy frame and staying there during thermal and structural loading."

Although the accident airplane was a 1996 model, the canopy design comes from the 1950s, and there are no channels in the canopy frame to allow fluids to dissipate.

Former Atlas Pilots Comment on Chowdry

A former pilot for Chowdry's BBJ said he never saw him "keep any sort of logbook–a perennial problem with our insurance carrier." Another former BBJ pilot who worked for Chowdry told NTSB investigators he "didn't like to follow the rules, had weak situational awareness skills, had aviation-oriented attention deficiencies, panicked easily and had spontaneous incapacitations." Chowdry had "weak crew communication skills, poor utilization of checklists and weak procedural skills," according to another former Atlas BBJ pilot. (Atlas sold the BBJ shortly after Chowdry's death.)

Yet a Cessna 401 pilot who watched the accident L-39 as it pulled up next to the Cessna on the runup pad before its last flight said "it appeared [Chowdry] was following a full-blown checklist." There were several "high engine" runups over a five- to seven-minute period.

All the pilot witnesses but one said they could not recall hearing any radio transmissions from the jet, in flight or while taxiing. But one pilot witness in a Piper Comanche on final before the jet took off said Chowdry reported on Unicom that he was "departing Runway 26."

It will be several months before the NTSB sorts out all the discrepancies and details of this tragic accident and issues the probable causes and related factors.

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Nationwide engine report still not out

Six months after a Nationwide plane lost its engine during take-off, a full report on the incident has still not been released.

Although the probe into Flight 732 has been completed, Civil Aviation Authority (CAA) spokesman Moses Seate said the report "still needed to be finalized and would be made available soon".

He would not be drawn on an exact date, nor would he explain the investigative process, saying only that "we are in control of the investigation".

The delay has been questioned by civil aviation employees, who claim it could be due to a lack of expertise in the aviation field.

A pilot with more than 20 years' flying experience said the process should have involved a team of investigators retrieving all the parts of the plane that broke off during the incident, after which the parts would be sent to a US-based agency for analysis.

"The US has the most advanced metallurgical equipment, so they would have been able to determine which parts of the engine broke first and in which sequence of events," said the pilot, who spoke on condition of anonymity.

The point of the report was to determine what went wrong during the take-off.

"If there was a problem with the aircraft, then the CAA would demand that the entire fleet of that particular model was modified," he said.

The secondary conclusion was to establish whether there was human error involved, which, said the pilot, would be followed by disciplinary action.

"Either way, the report would have answers on how to prevent something similar happening."

The Cape Argus has it on good authority that the plane, which was en route to Johannesburg in November, had almost reached its flying limit.

After an aircraft reaches a certain number of flying hours, it is grounded.

Another pilot, who also declined to be named, said the publication of the report was delayed because of a lack of experts in the field.

"In my opinion, we might still have to wait a while for the highly anticipated report … because we have so few experts in the aviation authority in South Africa, the report hasn't been published yet," he said.

Meanwhile, it is understood that the defective plane is still stationed at Cape Town International Airport.

Nationwide, who filed for liquidation last week, could not be reached for comment on what would happen to it.

All other aircraft belonging to the fleet have been flown to Johannesburg, presumably to the company leasing the planes to Nationwide.

FAA Says Emergency Medical Helicopters Need Safety Improvements

Three men died last weekend when an emergency medical-services helicopter crashed near Madison, Wis., and this week the FAA responded with an update on its work to address safety concerns about such flights.

The NTSB reported on the helicopter emergency medical services fleet in 2006, and asked the FAA to impose stricter requirements on all such operators.

"While the FAA has not ruled out proposing new or changing existing rules, the agency has prompted significant short-term safety gains that do not require rulemaking," the FAA said in a statement on Tuesday. The agency said it is focusing on better training for flight crews; encouraging the use of technology such as night-vision goggles, radar altimeters, and terrain awareness and warning systems (though such systems don't work optimally in helicopters, the FAA says); and more detailed, airline-type FAA oversight for operators. "Safety improvements are needed," the FAA said.

Last weekend's fatal crash occurred shortly after takeoff on Saturday night, when the helicopter hit a wooded hillside. The crew did not have either night goggles or a terrain warning system on board. Air Methods, based in Denver, was the operator for the helicopter that crashed. An official of the company told The Capital Times on Monday it is installing the goggles and terrain warning gear as quickly as possible on its fleet of 330 aircraft.

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Case implicates free speech

The King County Prosecutor's Office is pursuing a criminal case against a former Boeing employee with dangerous implications for whistle-blowers, the flying public and free speech rights.

After the first trial resulted in a hung jury a few weeks ago, King County prosecutors, will soon announce a second trial date for former Boeing quality assurance inspector Gerald Eastman. The prosecutors likely will charge Eastman with "computer trespass"-- a euphemism for Eastman's unauthorized whistle-blowing to the media, which is not an illegal act. Jurors in the first trial were conflicted about the judge's instructions not to consider the issue of whistle-blowing.

Most of Eastman's concerns related to the safety implications of what he considered poor quality assurance at Boeing. While Eastman clearly violated Boeing policy, the criminal charges against him raise serious issues, especially in regards to the First Amendment right of free speech.

In other words, it is one thing to fire a whistle-blower for breaking company policies, quite another to try to jail one for the act of whistle-blowing, which is protected by law.

"Bringing criminal charges in this type of case is a very extreme reaction. However, it is another example of the disturbing trend of punishing whistle-blowers with criminal prosecution," said Dave Colapinto, a partner with the whistle-blower law firm Kohn, Kohn and Colapinto, which runs the National Whistleblower Center.

Eastman is not alone in his concerns about quality control and accountability. In 2000, a Federal Aviation Administration special technical audit on Boeing's production and quality problems, found "in some cases, manufacturing planning was not adequate, requirements were not followed, inspections were not specific or personnel were not knowledgeable about requirements."

Eastman's whistle-blowing came from his belief that Boeing had not adequately resolved the issues found in this FAA audit. He perceived that the practice of "roller-stamping" was widespread. Roller-stamping is approving work as complete without performing a thorough check.

In addition, an internal January 2004 Boeing document titled "Status Report: Investigation of 'Dual Failures' " underscored Eastman's concern. It states, "There appears to be a systemic issue within BCA (Boeing Commercial Aircraft) involving parallel process breakdowns of mechanics and inspectors involved in assembling and inspecting aircraft, assemblies and parts."

The FAA also examined 55 issues at Boeing between 2002 and 2003 and found that "24 percent of these issues have involved instances where the mechanic and inspector created and accepted nonconforming conditions."

And, in February 2008, the Department of Transportation IG issued a report of all the major aerospace manufacturers, including Boeing, faulting them for their quality assurance systems for their suppliers.

The employment consequences for Eastman's breaking company policy have been severe. A second round of a dubious criminal prosecution threatens to ruin this man's life and further hurt his family. But the issue is greater than that.

Does a whistle-blower have a First Amendment right to inform the public in a manner that should be considered protected speech without being jailed? If Boeing and King County prosecutors get their way, the future for whistle-blowers and the public is grim.

Criminalizing air accidents blocks safety progress

The European Regions Airline Association (ERA) is calling for European states to adopt a non-punitive voluntary reporting system for air safety occurrences, rather than encouraging a culture of blame and criminal prosecution which discourages the sharing of safety information.

Antonis Simigdalas, ERA President and COO of Greek carrier Aegean Airlines, says: *"The open and transparent reporting of safety incidents is crucial for accident prevention and the further enhancement of air safety. However, all aviation personnel, including pilots, cabin crew, maintenance staff, air traffic controllers, flight safety officers, even administrative staff, must be willing to disclose and share such information and be confident that they do so without penalty or fear of prosecution."*

Addressing delegates this week at the ERA Regional Airline Conference in Malta, Simigdalas' words hold particular relevance as the UK Corporate Manslaughter and Corporate Homicide Act 2007 came into effect on 6 April. The new law allows for the prosecution of a corporate body - as opposed to an individual - for any death(s) caused by failures within senior management and applies to any company or corporate body that operates in the UK.

"Prosecution is justified when it can be shown that willful disregard for established procedures, deliberate misuse of equipment, abuse of substances or anything similar has recklessly endangered the safe operation of a flight.

However, where the cause of an incident or accident is due to human fallibility and all involved have used their best endeavors to ensure the safe operation of a flight, the use of reported data for criminalization purposes acts directly against the larger public interest and the future safety of European flight operations," **Simigdalas continued.**

Human factors remain a crucial element in most serious air incidents or accidents. ERA has strongly advocated the Europe-wide implementation of a 'no-penalty' reporting system since the late 1990s. The justification and purpose for such a system is clear and is in the interests of the overwhelming majority of EU citizens and air travelers. It enables:

- **management action (e.g. training, amendment of procedures, revision of maintenance schedules) to correct problems that would otherwise be unknown, including the detection of trends**
- **sharing of this safety information across the industry so that lessons can be learned by other operators**

Report: Passenger Jet Makes 10,000-Foot Climb as Pilot 'Shows Off' to Child

Horrified passengers on a Paris-bound jet claim they suddenly climbed 10,000 feet to avoid another plane because their pilot was "showing off" to a boy who was with him in the cockpit, the U.K.'s Daily Mail reported.

The Air France flight had 143 passengers on board when it suddenly veered back and forth at 33,000 feet before climbing rapidly. The crew later announced that the plane had gotten "too close" to another plane, the Mail reported.

Shaun Robinson, 40, of Rossendale, England, told the paper that the jet "rocked and rolled" like a carnival ride and terrified passengers said prayers aloud while children cried.

Air France launched an investigation after several passengers near the front of the plane claimed they saw a French boy, about 13, being escorted into the cockpit.

"The young boy shouldn't have been allowed into the cockpit in the first place," said Robinson, who was on a business trip. "He had a big smile on his face when he came out and the steward ruffled his hair and took him back to his seat."

An Air France spokeswoman told the Daily Mail: "Air France takes these allegations extremely seriously. We are investigating."

No deaths in 2007 accidents on scheduled US airlines

No one died during 2007 in accidents among larger scheduled U.S. airlines and smaller commuter aircraft, and deaths in private plane accidents dropped to 491, their lowest total in more than 40 years, the government reported.

But on-demand aircraft — charters, air taxis and tours, and medical flights with a patient aboard — saw accident deaths jump from 16 in 2006 to 43 in 2007, according to preliminary annual figures from the National Transportation Safety Board.

"The U.S. aviation industry has produced an admirable safety record in recent years," said NTSB Chairman Mark V. Rosenker. "However, we must not become complacent. We must continue to take the lessons learned from our investigations and use them to create even safer skies for all aircraft operators and their passengers."

The government figures showed that scheduled U.S. airlines flew 18.7 million hours in 2007 with 24 accidents, but no deaths. There was one fatality among nonscheduled U.S. carriers: A mechanic was fatally injured while working on a Sky King Inc. Boeing 737 in Tunica, Miss., on July 10, 2007.

Commuter airlines had 3 accidents in 302,000 hours of flight, but no fatalities.

On-demand carriers 43 deaths in 62 accidents over 3.7 million flight hours.

General aviation saw its accident fatalities plummet from 703 in 2006 to 491 in 2007. But during 23.8 million hours of private flights in 2007 the number of accidents rose to 1,631, from 1,518 in 2006.

Foreign registered aircraft accounted for 11 accidents in the U.S. in 2007 with three deaths in a single accident. Unregistered aircraft had 14 accidents which claimed 7 lives.

On the Net:

- **NTSB 2007 statistics: http://www.ntsb.gov/aviation/Stats.htm**

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Air disasters on rise, landing 'most risky'

The rate of aviation accidents is on the rise with half taking place during landing, says a new safety report.

Incidents in Africa, Indonesia and Brazil caused the number of crashes to rise in 2007 from lows in the previous year, the International Air Transport Association (IATA) said in its annual report on safety.

Despite the number of fatalities declining, the report showed the 2007 global accident rate of 0.75 losses for every million flights by Western-built jet aircraft was higher than the 0.65 rate recorded in 2006.

The number of global fatalities declined 19 per cent to 692, as passenger numbers increased by six per cent to over 2.2 billion passengers in 2007.

Many of those accidents could have been avoided if pilots made a second attempt at the runway, or if obstacles on the ground were properly cleared, according to the report by the Geneva-based industry group.

One-fifth of the accidents in 2007 caused deaths. The most serious crashes were in Brazil, Indonesia and Africa, deemed by IATA the most dangerous region in which to travel by air.

In total, there were 100 accidents in 2007 – 57 for jet aircraft and 43 for turboprop – compared with 77 accidents in 2006.

The industry group, which represents some 240 airlines comprising 94 per cent of scheduled international traffic, said the accident rate for its members was lower than the overall total at 0.68 per million flights.

"Air travel is the safest mode of transportation. In the 10 years from 1998, the accident rate was reduced by almost half," said Giovanni Bisignani, IATA's director general.

Russia and the former Soviet states had no accidents last year, and North America and Europe had lower accident rates than the world average, according to IATA, whose 240 member airlines represent 94 per cent of scheduled international air traffic.

The biggest accident last year was a TAM Brasil flight crash on July 17, followed by a Kenya Airways crash on May 5 and one involving an Adam Air Indonesia flight on January 1.

IATA said poor flight crew training contributed to 20 per cent of air accidents in 2007, and flight control and manual handling errors were factors in nearly 40 per cent.

Maintenance problems played into 20 per cent of the accidents recorded, it added.

Fast WWII bomber visits air museum

Winnipeg's Western Canada Aviation Museum welcomed a new visitor to its flying family yesterday.

An authentic Second World War Douglas B-26 bomber, owned and piloted by local businessman and aviation buff Ross Robinson, will be on display until June 30 before swooping on to the next stop of a North American tour.

"I think the public will find a visit to the museum very interesting," said Shirley Render, the museum's executive director. "Not only are we expecting lots of school children, but we hope the public will also turn out to see this gem."

The 1944 aircraft -- which could carry nearly three tons of bombs and up to 14 .50-calibre machine guns -- not only saw active Second World War service in the Pacific and Europe, but also served in Korea and Vietnam.

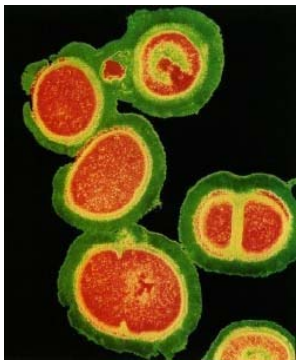
One of only 2,500 B-26s produced, the plane was the fastest twin-engined single pilot bomber of its type, surpassed only by De Havilland's Mosquito in the speed stakes.

After years of active service, it eventually changed jobs and became a water-bomber to help fight fires in Alberta until being retired. Robinson picked it up last year.

The B-26 will be squeezed between good company for its seven-week museum stay, Render said.

It is parked in the museum hangar between a Fokker Super Universal, which Render called "a workhorse of the Canadian North during the '20s and '30s," and a CF-101 Voodoo, Canada's first all-weather interceptor fighter.

Don't let a hospital kill you



'People Need to Start Participating'

The splashy headline reads, "Don't let a hospital kill you," but behind the hype are a few home truths, or rather, hospital truths. Bacterial infections are rife in American hospitals. According to the Centers for Disease Control (CDC), 99,000 people a year die of hospital-related infections. "People need to start participating," says one interviewee, "instead of just being spectators." If you've ever been a patient, or know someone who is, you should read these simple instructions to help keep disease at bay. If you're a healthcare provider or worker, that goes double.

Josh Nahum, right, died at 27 from a bacterial infection he got while being treated for skydiving injuries.

Like many young men, Josh Nahum loved a thrill. That's why he took up skydiving. But on Labor Day weekend in 2006, he had an accident while skydiving in Colorado, fracturing his femur and skull.

Josh spent six weeks in the intensive care unit. Slowly, his condition improved, and his doctors predicted that with rehabilitation, he could fully recover in a year or two.

But instead of recovering, Josh developed a bacterial infection. He died two weeks later at the age of 27.

"One nurse, who was trying to be comforting, said, 'These things happen,' " says Victoria Nahum, Josh's stepmother. "That's true, but they happen way more often than they need to happen."

According to the Centers for Disease Control and Prevention, Josh is one of 99,000 people who die each year because of infections acquired in the hospital. As Betsy McCaughey, the former lieutenant governor of New York, put it, "You don't often come across such a big problem that you can prevent."

After being contacted by families like the Nahums, McCaughey started the Committee to Reduce Infection Deaths. After Josh died, the Nahums started the Safe Care Campaign.

These groups, and others, have advice about what you can do to keep yourself safe in the doctor's office and hospital, from the waiting room to the operating room.

1. Bring your own toys

At the pediatrician's office, don't let your child play with the toys or books in the waiting room. "They're covered with bacteria," McCaughey says. Also, don't let your child crawl on the floor; bacteria there could get into cuts on their knees or hands. "This is one place you ought to keep your child sitting still or on your lap," she says.

2. Heat up your car

Yes, we know that sounds strange. But studies show staying warm before and during surgery can help you fight infection. So the Institute for Healthcare Improvement suggests that in cold weather, you heat up the car, wear warm clothes on the way to the hospital, ask the hospital staff to give you plenty of blankets while you wait for surgery, and ask how they plan to keep you warm during surgery.

3. Want to touch me? Wash your hands first.

Many people feel uncomfortable asking this. Nahum suggests putting it like this: "I didn't see you wash your hands. Do you mind doing it in front of me?"

Dr. Vicki Rackner, a patient advocate, also has a few ideas for lightening things up. "In the hospital, you can have the grandkids make a sign that says, 'Please wash your hands and keep Grandma healthy.'

Another suggestion: Put a dish of wrapped candy near the sink and say 'Could you please wash your hands, and oh, please take some candy with you when we're done.' "

If the doctor or nurse has gloves on, are you safe? "Don't be falsely assured by gloves," McCaughey says. "If they put on gloves without washing their hands first, those gloves are immediately contaminated."

4. Ask where that syringe has been

Doctors offices sometimes reuse syringes -- it's unusual, but it happens. In fact, there have been 14 documented outbreaks of hepatitis since 1999 because of reused syringes. The recent outbreak in Nevada, where 50,000 people will be notified that they might have been infected at a colonoscopy clinic, is one example.

It's not an easy question to ask, but when someone's heading at you with a syringe, ask if this is the first time it's been used.

Dr. Thomas Frieden, commissioner of the New York City Department of Health, suggests phrasing it like this: "I read in the paper that some doctors are reusing syringes. I can't imagine anyone would do that. Do you?"

5. Having surgery? Speak up!

A week or so before surgery, ask your doctor whether you should wash your skin daily with a disinfectant such as chlorhexidine to prepare.

Also, ask whether you should have a nasal or skin swab for MRSA, the superbug that causes many hospital infections. If you've got it, you can be treated with antibiotics.

The day of surgery, if the surgical site needs to be shaved, ask to be clippered, not shaved with a razor, which can create nicks where bacteria thrive.

Also on the day of surgery, if your doctor has ordered IV antibiotics just before surgery, make sure you get them, as they're sometimes forgotten.

One last note: If you or a loved one has a urinary catheter in the hospital, be extra vigilant -- they can become breeding grounds for bacteria. First, ask if one is truly necessary. "If the patient is awake and oriented and alert and can use a bedpan, it may not be needed," says Dr. John Jernigan, a medical epidemiologist at the CDC. If you get one, make sure it comes out ASAP, since the longer it's in, the riskier it becomes.

Ask the same questions about central venous catheters, (also called central lines), another potential host for bacteria. "My brother was in the hospital and needed a central venous catheter for his procedure," Jernigan says.

"The day after surgery, I asked the nurse, 'Are you all still using this? Do you still need it?' And she checked and came back and said, 'We don't need it anymore, we'll take it out.' "

Nahum says it all boils down to this: *Passivity kills*. "People need to start participating instead of just being spectators when it comes to their medical care," she says. "You need to do your due diligence."

BY THE NUMBERS

Food Safety

U.S. food inspectors still rely on the outdated and unproductive practice of inspecting carcasses.

Unless you grow and raise all of your own food, you're dependent on your nation's inspection system for the safety of what you eat. And for residents of the U.S.A., that's not such a comforting thought. A recent report from a group called the Trust for America's Health (TFAH) documents serious deficiencies in the nation's food safety system, including fragmentation of regulation and reliance on outdated inspection practices that don't account for modern bacteria threats such as salmonella and particularly virulent strains of E. coli. Here are some statistics from the report:

- **76 million: The number of Americans who suffer a foodborne illness each year**
- **325,000: The number of Americans who are hospitalized with a foodborne illness each year.**
- **5,000: The number of Americans who die from a foodborne illness each year.**
- **44 billion: The estimated productivity losses incurred by U.S. businesses as a result of foodborne illness per year.**
- **15: The number of federal government agencies that share responsibility for food safety in the U.S.**
- **1: The percentage of imported food that these agencies actually inspect before it enters the U.S.**

- **0: The number of times the U.S. food safety system has undergone major modernization in the past century.**

Source: **THAF, Fixing Food Safety: Protecting America's Food Supply from Farm-to-Fork, http://www.rwjf.org/files/research/20080428tfahfoodsafety.pdf**

PICTURE THIS!

As the weather warms up, you may want to think about installing an air conditioner, whether it be at home or at your place of work. If you decide to take that course of action, please allow these three enterprising gentlemen to demonstrate exactly how not to do it. They may be installing this unit on the first floor, but the presence of a balcony argues otherwise.