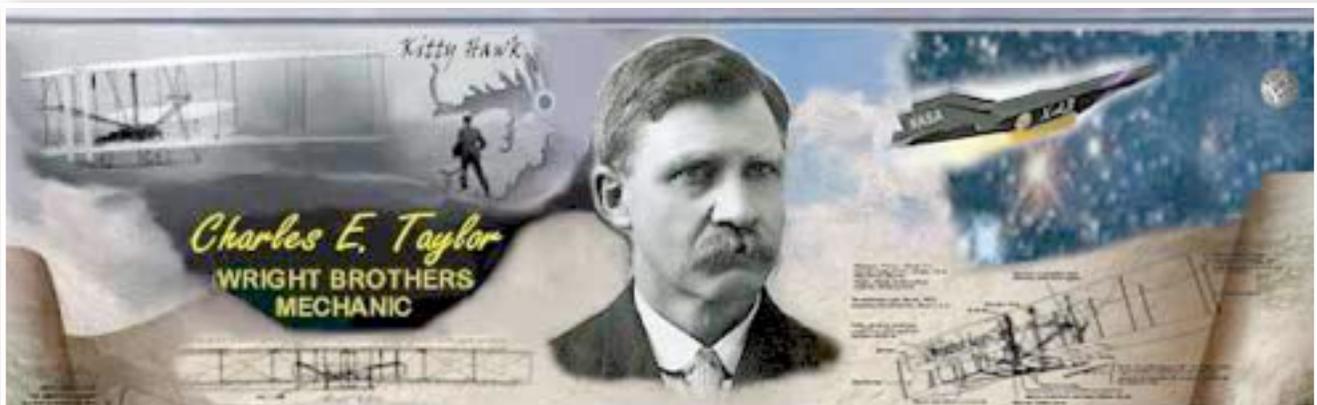


Aviation Human Factors Industry News

Volume VIII. Issue 42, November 16, 2012



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

Hello all,

To subscribe send an email to: rhughes@humanfactorsedu.com

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

★The "B" Nut can be Deadly

★4 workers hospitalized after fall at Miami airport

★Focusing On A Loose 'Beverage Can' In The Cab Of The Truck

★US Airways fined \$354,500 over jet fuel pump

★NTSB Announces Final Rules On Appeals Procedures And Requests Public Comment

★Report: British pilots asleep on the job

★String Of Accidents Challenges Helicopter Pilots

★Business-Jet Crashes Outpace Commercial

★Airlines' Safety Record Hampers Change

★And Much More

The "B" Nut can be Deadly

Maintenance Safety Tip

Notice Number: NOTC4301

All aircraft maintainers have heard or used the term "B" nut. It is the common description of the nut that is used to connect fluid lines and hoses. It is a very simple component; but does a critical job. It provides a reliable seal in plumbing systems and usually results in ease of for AMTs. It is designed to provide years of reliable service. However, "B" nut reliability is only as good as how you treat it. We disconnect and connect them many times during our careers - right?

However, do you "tighten" or "torque" this simple critical

component? No matter how simple this component is, it requires a specific "torque" to keep it reliable in maintaining plumbing system integrity. You may have seen a maintenance record entry where the sign-off stated, "Tightened B nut." Does this mean it was tightened enough to stop a leak, or was it tightened to a specific torque? If you are just tightening the "B" nut, you could be setting the stage for future failure or fracture.

Just get the tools you need to get it done right!

Another "gotcha" is finger tightening then "forgetting" to torque the "B" nut. A high risk of this occurring can be distractions (like telephone calls) and interruptions (like multi-tasking) while on the job.

A good technique to follow is if you connect a "B" nut, finish the job with the proper torque. Otherwise, tag it or write it up so it is not overlooked, especially if you leave the job site or another AMT finishes the job!



Over 10,150 AMTs earned an AMT Award last year. Will you, this year?

4 workers hospitalized after fall at Miami airport

Four workers were hospitalized after they fell from a scissor lift at Miami International Airport Wednesday morning, aviation and fire rescue officials said.

The workers, employees of Commercial Jet, were doing maintenance work on an airplane inside their hangar when they fell, Miami-Dade Aviation spokesman Greg Chin said. All four were taken to a nearby hospital but one of the employees had a more serious injury than the others, Chin said.

Miami-Dade Fire Rescue officials confirmed the injuries but didn't give any other details.



Focusing On A Loose 'Beverage Can' In The Cab Of The Truck

The NTSB has to investigate them all ... but this one is just a bit on the unusual side. A catering truck struck an AirTran B717 in Milwaukee, WI, damaging the airplane and forcing the evacuation everyone on board. The investigation is focusing on a loose "beverage can" in the truck that may have made it difficult for the driver to stop the vehicle. This is preliminary information, subject to change, and may contain errors. Any errors in this report will be corrected when the final report has been completed. NTSB investigators may not have traveled in support of this investigation and used data provided by various sources to prepare this aircraft accident report.



On October 4, 2012, about 2015 central daylight time, a Boeing 717-200, N894AT, was **struck by a catering truck** while it was parked at its gate at General Mitchell International Airport (KMKE), Milwaukee, Wisconsin. There were no injuries to the deplaning 103 passengers and 5 flight crew. The airplane was substantially damaged. The airplane was registered to Wells Fargo Bank Northwest, NA, Salt Lake City, Utah, and by Southwest Airlines, Inc., Dallas, Texas, under the provisions of 14 Code of Federal Regulations Part 121 as a scheduled domestic passenger flight. Visual meteorological conditions prevailed at the time of the accident, and an instrument flight rules flight plan had been filed and closed. The cross-country flight had originated from Hartsfield - Jackson Atlanta International Airport (KATL), Atlanta, Georgia.

Preliminary information indicates the airplane, flight 725, had arrived at Gate C14 and passengers had started deplaning. A catering truck, operated by Aerotek, approached the right front service door. The driver said a **beverage can became lodged between the floor and brake pedal**, preventing him from applying the brake and the truck struck the airplane. Damage was confined to the area of the production splice, a joint where the forward portion of the fuselage is mated to the midsection fuselage.

FMI: www.nts.gov

US Airways fined \$354,500 over jet fuel pump

The Federal Aviation Administration (FAA) is proposing a \$354,500 civil penalty against US Airways, Inc., of Phoenix, for operating a Boeing 757 airliner on 916 revenue flights when it was not in compliance with Federal Aviation Regulations.



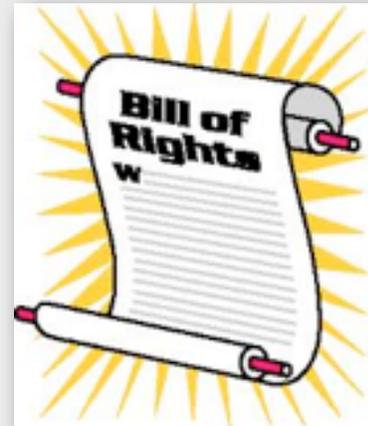
The FAA alleges US Airways removed and replaced a leaking engine fuel pump on the aircraft on Aug. 3, 2010, and US Airways failed to carry out FAA-required tests and inspections before returning the aircraft to revenue service. The noncompliant flights took place between Aug. 3 and Dec 3, 2010.

US Airways, Inc., has 30 days from the receipt of the FAA's enforcement letter to respond to the agency.

NTSB Announces Final Rules On Appeals Procedures And Requests Public Comment

Move Prompted In Part By The 'Pilot's Bill Of Rights'

The NTSB has issued a set of new rules addressing the review of aviation enforcement cases. The changes allow appeals to a federal district court, apply federal rules of evidence and civil procedure to NTSB proceedings and allow parties to move to dismiss a complaint if the FAA fails to disclose its enforcement investigative report. The NTSB, in addition to its accident investigation and safety advocacy work, serves as the "court of appeals" for airmen, mechanics and mariners when they appeal FAA or U.S. Coast Guard certificate actions.



The changes are included in a new final rule and an interim final rule. Although the interim final rule, prompted by the Pilot's Bill of Rights (P.L. 112-53), is effective immediately, the Board is requesting public comment concerning the changes. The 60-day comment period concludes on Dec. 17.

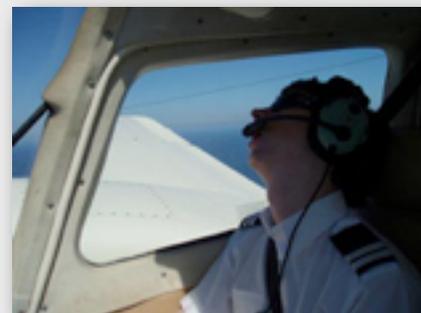
While the interim final rule is being issued as a result of the enactment of P.L. 112-53, the NTSB had been examining its rules of practice and other procedures beginning with an ANPRM published in December 2010 and an NPRM published in February 2012. As a result of that process, the NTSB has also announced it would allow parties to file documents electronically.

FMI: [Final Rule](#)

Report: British pilots asleep on the job

Two pilots working for British airlines fell asleep at the controls during separate flights, [a common problem](#), the British Airlines Pilots Association said.

The incidents were uncovered through a Freedom of Information request submitted to the Civil Aviation Authority by The Sun in Britain.



The authority declined to name the airlines involved in the incidents, saying it would breach confidentiality, The Sun reported.

In one occurrence, the captain left the cockpit momentarily and got no reply from his first officer when he tried to call him on a radio link. When the captain returned, he found the first officer "slumped over the controls," the documents said.

In the second incident, a captain returned to the cockpit to find his first officer was asleep and had to be shaken awake, The Sun reported.

The British Airlines Pilots Association said [43 percent of members polled admitted to sleeping in the cockpit](#). A third of those said they woke to find the other pilot also asleep.

String Of Accidents Challenges Helicopter Pilots

Helicopter pilots need to [take more ownership](#) of a steadily increasing number of accidents, according to the International Helicopter Safety Team (IHST). In the seven-day period between October 10 and October 17 the industry reported four accidents that took the lives of seven people. Two accidents on the same day, October 10, claimed two lives, one in northeastern Pennsylvania and the other in central Louisiana. An October 12 night accident into a wooded area near Fredericksburg, Texas, claimed all three onboard, while five days later, another helicopter crashed and caught fire in Bucks County, Pa.

"As an industry, we need to focus on the expected, easy mission and on [conventional risks](#), such as changes in weather [not just those that appear difficult]," said an IHST statement. "Many pilots are not evaluating the risk when they feel it is a standard, low-risk flight and the consequences of this [mindset](#) are tragic.



One out of every five rotorcraft accidents occurs during routine general aviation/private flying, and another one out of five accidents occurs during instruction flights."

The risk issues of night flying, [weather](#), [fatigue](#) and [stress](#) are magnified for helicopters flying close to the ground.

Business-Jet Crashes Outpace Commercial

The number of accidents involving business jets and turboprops world-wide is [more than five times](#) that of commercial jets this year, highlighting the challenges facing accident-prevention experts in improving safety for private and charter aviation. Through nearly 10 months of 2012, [more than 140 people have died](#) in crashes in eight business jets and 13 commercially operated propeller aircraft, or turboprops, says the Flight Safety Foundation, a nonprofit group.



Only four accidents involving major passenger jets have been recorded world-wide, a record low rate of [one crash per roughly 10 million flights](#) over the period (there were 14 such jet crashes last year). Still, those crashes, which each involved more passengers, killed more than 320 people.

The data, presented at a global aviation-safety conference in Santiago, Chile, this week mark "the first year since there were more business jet accidents than world-wide [passenger] jet accidents," said Jim Burin, the foundation's director of technical programs. The foundation has been compiling the report for 13 years.

Safety experts say the [data mean](#) more effort should be shifted to upgrading training, maintenance and government oversight at the lower end of commercial aviation in order to improve the segment's safety. Those efforts are particularly needed in the developing world, where airports are less advanced and air-traffic control systems are less reliable, experts said.

The ICAO, a United Nations body responsible for overseeing aviation safety, places more emphasis on regularly scheduled jets than smaller flights, said Nancy Graham, a senior official of the International Civil Aviation Organization.

"Perhaps we need to adjust our focus," she said.

Apart from the sheer number of accidents, safety experts increasingly say turboprops, which carry fewer passengers and weigh a fraction of Airbus or Boeing jets, support the vast majority of business activity in parts of the developing world, raising the probability an accident will involve a smaller plane.

Propeller-powered planes often transport employees and material for mining firms, oil drilling operations and other natural-resource companies to remote regions. Traditionally, such flights have been conducted under less local and international scrutiny than those of bigger passenger jets.

Critics say extra attention to turboprops is long overdue.

Compared with jet fleets, "those planes typically have less experienced pilots, their flight simulators are not as advanced and they don't have the same level of automation" or onboard safety protections, according to Dai Whittingham, chief executive of the UK Flight Safety Committee, which helps airlines, pilots and government agencies share safety information.

With crash rates for passenger jets improving dramatically, "the average person automatically assumes the other parts of aviation are equally safe," according to Kevin Hiatt, chief operating officer of the safety committee. But the rise in smaller-plane crashes "sort of crept up on us," he said.

So now the foundation and its supporters "will look deeper into the issue to identify trends and **relevant factors**."

The active fleet of business jets and turboprops together basically equals the roughly 20,000 Western-built jets currently in service worldwide, according to the foundation's updated analysis. Between 2007 and 2011, on average there were nearly 16 passenger jet crashes annually.

With only four jet accidents through this week and slightly more than two months until the end of the year, Mr. Burin said 2012 appears headed to set a new safety standard for jetliners.

Airlines' Safety Record Hampers Change

More than three and a half years have passed since the last airline fatality in the U.S., The Associated Press reported last week, and that record is making it harder for the FAA to impose expensive new safety rules on the industry. Overall, the last 10 years have been the safest time ever for the airlines. "The **extraordinary safety record** that has been achieved in the United States ironically

could be the single biggest reason the FAA isn't able to **act proactively** and ensure safety into the future," Bill Voss, president of the Flight Safety Foundation, told the AP. The FAA started to work on new rules for training airline pilots in 1999, the AP says. The process was revisited after the Colgan crash in 2009, and the new rules are not expected to take effect until 2019. "We're doing rulemaking in a system that is very, very safe," Transportation Secretary Ray



LaHood told the AP. "Sometimes it does get to be difficult to produce the **cost justification** for the kinds of rules that we're promoting." The lack of rulemaking doesn't mean a lack of progress, however. The airline industry and the FAA have been working together to continuously improve pilot training and safety protocols. "There are literally hundreds of people at all the airlines collecting and analyzing data," Margaret Gilligan, FAA's associate administrator for safety, told the AP. "They are working with us voluntarily on all kinds of committees to share that data among themselves because there are things we want an airline to find out and fix for itself." But Tom Haueter, a former head of the NTSB's aviation safety office, **cautioned against complacency**. "I talk to people all the time who say we have this fantastic accident rate and we've cured all these problems," he said. "But I think if we **forget the lessons of the past**, we might have to relive them."

http://hosted.ap.org/dynamic/stories/U/US_VANISHING_AIRLINE_CRASHES?SITE=AP&SECTION=HOME&TEMPLATE=DEFAULT

NASA applies deep-diving text analytics to airline safety

NASA's Aviation Safety Program has been applying a powerful, emerging data tool to the business of making the skies more friendly, using **text analytics** to scan hundreds of thousands of unstructured text reports made by **pilots, mechanics and other workers** to find patterns that may help improve airline safety.



“We’ve been developing and implementing different text mining algorithms for analyzing aviation safety reports as well as other safety-related reports over several years,” Ashok Srivastava, project manager for the System-wide Safety and Assurance Technologies project for the Aviation Safety Program, told GCN. “By doing these kinds of analyses we hope to get a better understanding of what is going on in the aviation system with respect to different safety concerns.”

Airline flights generate a lot of data, but it tends to be scattered in different formats, from maintenance logs to air traffic reports to a plane’s “black box.” When something goes wrong, investigators pore over this data [after](#) the fact to look for the cause. The idea behind NASA’s program is to collect and analyze all that data on a regular basis and identify potential problems [before](#) they occur.

Specifically, the focus is on the reports submitted to the [Aviation Safety Reporting System](#), a NASA program that collects incident reports from pilots, air traffic controllers, technicians and others. “It’s a remarkable database,” Srivastava said.

“If you look at these reports you can find discussions from pilots about certain incidents, you can also see issues that are coming up that are mechanical, or passenger safety concerns. One of the key issues that we are interested in addressing is, why do aviation safety incidents occur? [What are the precursors?](#) What are the drivers to different safety incidents? The technologies are giving us new ways of developing that insight.”

Before Srivastava’s team started applying text analytics, the data was reviewed only by [human analysts](#). And while humans haven’t been taken entirely out of the loop, they can’t catch patterns that occur across and between disparate reports as effectively as text analytic programs.

Text analytics uses algorithms to search for words, phrases and patterns in unstructured text documents, using linguistic and/or statistical techniques to mine data on a large scale.

The team’s initial analysis efforts employed natural language processing (NLP) techniques. “That got us to a certain point,” Srivastava said. “But we started to make a shift toward using more statistical methods for analyzing the data based on machine learning.”

NLP methods involved tagging a lot of words and phrases using [human-built rules](#) that were encoded into the computer system, he said. And then that information is used to analyze the text and determine what type of anomaly it was describing – a runway incursion, a bird strike, etc. The problem is that writing all those rules is very human labor intensive.

“The machine-learning approach is very different,” Srivastava said. “It takes all of the data and a few examples of the way different reports are categorized and then we developed statistical techniques to take documents and predict which category they fell into. So it didn’t require the same degree of rule building as in natural language processing. It reduced the amount of cost involved in analyzing the data because it didn’t require the handcrafted rules.”

Srivastava said the project is not entirely without controversy. “One of the things that we are really interested in doing in the future is analyzing in tandem the text documents with the numerical data that come from the flight data recorder,” he said. “But the carriers don’t let text reports get linked with the flight data recorders. I think there are number of issues. [There are privacy concerns.](#)”

Nevertheless, Srivastava’s team is making a mark. Southwest Airlines, for example, uses NASA’s data in its safety program. “Our technology has been transferred to major carriers in the United States and to a number of agencies, including the Federal Aviation Agency,” he said.

Workarounds - Part 2

The pressure to make schedule often found in [busy maintenance organizations](#) can unfortunately create an environment where workarounds become part of the cultural norms.

As a former air safety investigator, I was often presented with an accident or incident where one of the key elements of the event was the presence of a workaround or deviation to published procedures established by the organization or mandated by the manufacturer. It’s a common problem in all organizations and is rooted in our innate ability to problem solve coupled with resource driven pressures to get the job done better, cheaper, faster. By resource I mean time, money, and labor.



Standard operating procedures

The air carrier SOP (standard operating procedure) was written requiring the mechanic to verify a part's acceptability for installation; which includes assuring the part **was the right one** for the aircraft. But their logic and the "rule of thumb" said that it was acceptable to install because of previously **assumed** installation history.

The root or contributing cause for many incidents or accidents lies in the **failure** of maintenance personnel to follow standard operating procedures. Often these systems contain some kind of double check system such as inspection buy back, ops check read backs, lock out and tag out, etc.

Key departures from maintenance SOP include:

- Failure to perform **an adequate turn over** during a work stoppage or shift change resulting in missing key information;
- Failure to **follow a check list** as directed by the aircraft maintenance manual;
- Use of **improper** tooling, improper tool substitutions — or misuse of tooling;
- **Improper management** of processes and their controls.

The point of maintenance processes and controls are to assure that high levels of safety and workmanship are maintained for the airplane to which they apply. Following them provides the means to avoid hazards as well as reduce the creation of hazards **that are latent**. It does something else that most people fail to realize, but on reflection becomes obvious — it promotes repeatability. If standards are high and followed, the quality will consistently reflect the standards. If a workaround is in place then repeatability of a lesser standard **may become the norm**.

The thing is workarounds are insidious. They are subject to "tolerance creep."

Tolerance creep is the gradual deterioration of a standard or limit by the assumption that previous experience shows that limits are flexible. As each evaluation of the limit is made for the same item or similar items on aircraft elsewhere, further **"judgment calls"** allow the limits to be exceeded based on logical sounding assumptions that promote general consensus.

A good sample of tolerance creep is fuel prices. Once gas got to \$4 a gallon, there was a public outcry. But as the price became the norm, people stopped protesting and have by and large accepted higher fuel prices.

In any organization once personnel have established that something works, even if it violates a standard, **it becomes an accepted norm over time**. Complacency has set in.

To that end latent hazards are not often detectable until an event reveals their presence. These [latent “states”](#) will wait for the right set of circumstances to reveal themselves.

Zero Incident Goals Motivate Risk-Taking, Not Excellence

When excellence in safety is measured by zero failures, a self-limiting organizational viewpoint and very dangerous employee belief are created.

Zero incident programs and goals are the desires of average safety cultures, not excellently performing ones. Organizations that have achieved sustainability of excellent results [in culture and performance define](#), measure, and motivate what they want, rather than what they don't. Is health the absence of visible disease? If you never receive a check-up by a physician, yet you feel good and nothing appears to be wrong, have you reached your goals of health and feel confident you will live a long life with this approach?

To define health as the absence of visible, self-reporting indicators is recognizably dangerous. ["Early detection, early response,"](#) the motto of Dr. Larry Brilliant, who helped eradicate smallpox and frame the thinking that shapes global infectious disease control, is a mantra we should similarly use in safety.

Within the medical community, to respond is positive, to react is negative. If the body responds to a drug, procedure, or intervention, this is positive. When the body reacts to such approaches, this is negative. When we measure success by negative reported outcomes, we are [driving safety culture excellence](#) by reaction, rather than proactive identification and response.

How [we frame our goals](#) is the difference in excellent performance and excellent results; the two are not interchangeable. If the goal is zero incidents/injuries and it is obtained, what is the measure of continuous improvement? Moreover, if an organization obtains excellent results and cannot precisely describe why, the successful results are lucky, not excellent. Whenever results are rewarded, by default, the performance that obtained the results is reinforced. Were the excellent results obtained by excellent performance, or did the group just get a little luckier this year?



An incident is a failure in your systems, programs, and approaches to safety. When the goal, programs, and process are based on zero incidents, this translates as zero failures, thus promoting the mentality: Don't fail. Of course we do not want people to fail, but is this the motivation we truly desire: "Work hard to not fail"? When organizations establish Zero Incidents Injuries, this frames: Safety Excellence = Zero Incidents.

When excellence in safety is measured by zero failures, a self-limiting organizational viewpoint and very dangerous employee belief are created: "If safety means no incidents, **then anything that I do that doesn't result in an incident or get me hurt must be safe.**" When this occurs, risk will be overlooked, complacency will set in, an important and healthy degree of vulnerability of risk will be lost, and organizations will be surprised by an incident that occurs out of nowhere. This will often sound like, "I can't believe that experienced, well-trained employee did that" or "How did we miss that?"

When an organization **is surprised** by results or events, this is an indicator the measurement systems are not properly aligned to capture and motivate both results and performance. If we set goals only based on results and individuals cannot clearly decipher what performance will contribute or deviate from the results, not only are the measurement systems misaligned, but **the behavior within the culture** will be, as well. What do you want in safety? What are you trying to accomplish and why? Is the motivation to achieve the goal based on organizational or individual value? What does success and excellence look like -- not just indicators and activities, but behaviorally, when you get there?

Organizations that achieve excellence set targets such as 10,000 Percent Safe™, a methodology used with clients to measure, motivate, and drive performance and organizational processes towards 100 percent safe, 100 percent of the time. **Safe should be defined as not being at risk, and safety should be defined by what we individually or collectively do to create a risk-free outcome.**

Definitions and terminology drive beliefs, which affect decisions and behaviors at work and away. Is your goal to have zero incidents or successful beliefs and behaviors? Both, I'm sure, but what do your measurements indicate?

Jeppesen, GAEL teaming on fatigue reporting

Jeppesen, a unit of Boeing Flight Services, and Gael, a UK-based compliance management industry leader, have entered into an agreement to provide airlines with a [new automated solution](#) to report crew fatigue. Through the new agreement, Jeppesen's latest version of CrewAlert, an Apple iOS-application for Fatigue Risk Management (FRM), is now able to automatically submit crew fatigue reports directly into Gael's Q-Pulse Safety Management System (SMS). This coordination allows airlines to create safety reports that [aide root cause analysis](#) when working to reduce crew fatigue.



The new solution aligns with International Civil Aviation Organization (ICAO) guidance which states that airline crew fatigue reporting should be easy to access, complete and submit. The new fatigue risk solution also meets an ICAO recommendation to integrate a Fatigue Risk Management System into the normal safety reporting process in an SMS.

“Not only does Jeppesen CrewAlert [simplify the fatigue reporting process](#) compared to filling out legacy paper or electronic forms, but the airline safety team also will receive more detailed, higher quality information,” said Tomas Klemets, head of scheduling safety, Jeppesen Aviation Portfolio Management. “Working with Gael Ltd. has been very rewarding and our combined functionality uniquely [bridges the gap between an FRMS and a SMS](#). All fatigue reports, even with the fatiguing event being pre-modeled using the Boeing Alertness Model, are directly submitted into the normal database, drastically reducing workload for safety departments and enabling a more thorough data analysis.”

The mobile Jeppesen CrewAlert application provides insight into how [sleep science](#) applies to crew schedules. CrewAlert is intended for use by crew schedulers, crew members, government regulators and scientists to determine predicted levels of alertness. CrewAlert allows for data, collected in actual operations, to be fed back into an airlines FRMS to correlate with other pilot data.

Read More On [Fatigue](#) Issues

iPad® in Aviation: Mastering the Human Factors

As pilots, we are very fortunate to be experiencing the advent of the iPad in aviation. Never before in the history of flight has so much information been available in such an accessible medium. If you think about it, it's probably a similar feeling to what pilots experienced when Capt. Jeppesen first produced an airway manual. Valuable, usable, concise information, in an easy to carry package, **designed with the pilot in mind**. And the information was presented in a visually pleasing format that made the complex simple. The iPad has the potential to deliver an even greater experience, but it must conform to your needs and make your tasks easier. Here are some tips from the **human factors** perspective to make the iPad an asset to your piloting instead of a liability.



http://emve.jepdirect.com/HS?a=ENX7CqmJ8xFH8SA9MKJbZIPnGHxKLR7f7PcStGb5lw8W0bBhOG5mpqVsje_HhdA4SIFK

Mark your 2013 Calendar

First Annual Human Factors Recurrent Workshop for Trainers and Instructors a Huge Success!

Myrtle Beach, SC, October 25, 2012

The first annual Human Factors Recurrent Workshop for Trainers and Instructors held on October 24th, 2012 in Myrtle Beach, SC, USA **was a huge success!** Delegates from around the world converged for the one-day event at the beautiful oceanfront Marriott Resort and Spa at Grand Dunes. The focus of the first workshop was, **“How to Effectively Facilitate and Measure the Objectives of Human Factors Training Events.”**



Upon conclusion, all delegates provided very favorable feedback and indicated their interest in attending the next workshop which will occur in Myrtle Beach in October 2013.

TACG President Dr. Bob Baron stated, "I was very encouraged by the turnout and optimism displayed by the attendees. This was a one-of-a kind recurrent HF workshop that **went above and beyond a rehash of basic information**. Instead, the workshop focused on high-level thinking and sharing of ideas that undoubtedly helped them to improve their own courses and facilitation styles. We touched on topics such as:

- Management buy-in and visibility
- Quantifying and evaluating the effects of HF training
- How culture affects HF training
- Return on investment
- Facilitation methods that work (and some that don't)

Due to the great success and positive feedback from this workshop, I am looking forward to an even bigger and better event **next October!** Anyone interested in learning more or reserving a spot for next year's event can visit the event webpage at www.tacgworldwide.com/hfrecurrent.htm"

FAA General Aviation Survey

Help the General Aviation Community by Taking the 2011 General Aviation Survey Today!

The 34th annual General Aviation (GA) and Part 135 Activity Survey is well underway and **still needs your help!** There is one month left before the survey deadline, and we haven't reached our response goal yet. If you were invited to take the survey, please take some time to fill out and submit it by November 30th.

By taking the GA Survey for calendar year 2011, you help the FAA measure the size and activity of the general aviation fleet and better understand how people use general aviation aircraft.



The FAA uses the information collected in this survey to assess the impact of general aviation activities on the National Airspace System and determine the need for increased traffic facilities and services. It also allows the FAA to [track the success of its safety initiatives](#), [identify areas for improvement](#), [focus its resources](#), and better serve the GA community.

To take the survey online, please visit our website at www.aviationsurvey.org. The information provided will be used only for statistical purposes and will not be published or released in any form that would reveal specific information reported by an individually identifiable respondent.

To learn more about the General Aviation and Part 135 Activity Survey, visit our FAQ site at www.aviationsurvey.org/faqs. For any questions, please contact us toll-free at [888.672.4493](tel:888.672.4493) or by email at InfoAviationSurvey@faa.gov. For the latest survey updates, follow the FAA on [Facebook](#) and [Twitter](#) (@FAANews).

National Sleep Foundation Launches New Inside Your Bedroom Website

The National Sleep Foundation is pleased to announce the launch of its new “[Inside Your Bedroom, Use Your Senses!](#)” website. It is the first site to use [sleep science](#) and the five senses to help people create their best individual sleep environment. “This site includes fun, practical information to help people their bedrooms into a sanctuary for sleep,” says David Cloud, CEO of the National Foundation. “We believe everyone can benefit from better sleep and this site provides [easy tips and links](#) to more in-depth research to help people improve their sleep environments. It also gives guidance for when more help is needed.” The National Sleep Foundation will continue to add new, updated information to the website in the coming months. Visit bedroom.sleepfoundation.org to see, hear, touch, smell, and taste how you can improve your bedroom and your sleep!



<http://bedroom.sleepfoundation.org/>

DHS contractor allegedly fixed an airplane with paper clips

Jerry Edward Kuwata, formerly an executive at an airplane repair company with government contracts, pleaded guilty to "recklessly endangering the safety of aircraft," the Justice Department announced.

Kuwata, a former executive with WECO Aerospace Systems Inc., concealed facts about repairs from customers and did not ensure that repairs were done according to Federal Aviation Administration regulations, said U.S Attorney Benjamin Wagner of the Eastern District of California. WECO's clients included the Homeland Security Department and the City of Los Angeles.



"This conduct recklessly endangered the safety of aircraft that used the parts repaired by WECO," Wagner said.

Airplane repair stations are required to use component maintenance manuals -- guides developed by aircraft manufacturers and approved by FAA -- to direct technicians through sanctioned repair procedures. Wagner said Kuwata "conspired with others to conceal facts," did not adhere to the proper CMMs specified by the manufacturers and falsely told customers that the repairs had been completed to federal regulations.

Kuwata and several others were indicted in September 2011 on charges of fraudulent repairs. In one instance, WECO employees allegedly used paper clips instead of certified parts to fix an aircraft component and then told the customer that the repair was properly completed.

"The indictment alleges that these defendants knowingly cut corners in repairing aircraft parts and concealed the fact that they were not complying with FAA regulations," Wagner said in September 2011.

Two others have pleaded guilty in the case and charges remain against four more co-defendants.

Though the actual sentencing will be done at a later date, Wagner said Kuwata faces a maximum sentence of 20 years in prison, a \$250,000 fine and three years of supervised released.

