

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

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

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Looking Forward to Your Next Accident

By Bob Baron, Ph.D

The Aviation Consulting Group

A Safety Management System (SMS) is a **holistic program** intended to identify and mitigate various safety risks within operators' organizational and operating environments. This is accomplished through **reactive, proactive, and predictive** methods. Reactive refers to the things (accidents, incidents, occurrences) that have already happened. It is unfortunate that these events happened to begin with but on the flip side they typically provide us with some of the most detailed and useful information, through a thorough investigation into root cause(s).

In other words, it is easier to quantify the event, and as a result that makes it easier to present the case to management for action. This is **reactive safety**, and although it can provide excellent information, it doesn't do much to prevent the accident or incident from happening in the first place. I call this "**look back**" safety. Unfortunately, many companies still rely extensively on "look back safety" as an accident prevention method.

One of the benefits of SMS is that it promotes today's paradigm shift towards **proactive and predictive safety**. Proactive and predictive measures are not intended to replace reactive measures, but instead to complement them (there will always be events and thus there will always be reactive responses). However, much more emphasis is placed on preventing those events with the use of proactive and predictive tools. I call this "**look forward safety**" because we are trying to prevent events from happening in the first place by identifying and addressing the various links in the chain that might be joining together before the event takes place. A proactive safety example is the use of hazard reporting forms by employees. Predictive safety examples include having a Line Operations Safety Audit (LOSA) or Flight Data Monitoring (FDM) program.



Many times when I work with clients I ask one simple question; what will be the cause of your next accident? After a few moments of awkward gaze I start to get answers. “Runway excursion”, “loss of control inflight,” “controlled flight into terrain,” etc., etc. Then I ask what will be the contributing factors that will lead to that accident? “Fatigue,” “lack of training,” “management complacency,” etc., etc. Then I say to them, “congratulations, you have just ‘looked forward’ to your next accident, now how are you going to prevent it?” [Welcome to the world of proactive safety!](#)

Dr. Bob Baron is the President and Chief Consultant of The Aviation Consulting Group (TACG). His specializations include Human Factors, SMS, CRM, and LOSA. He consults with, and provides training to, hundreds of aviation organizations on a worldwide basis. Please visit the TACG website for more information. www.tacgworldwide.com

FAA Proposes \$110,000 Civil Penalty Against Air Evac EMS

Alleges Chin Bubble Improperly Installed On Bell 206 Helicopter

The FAA has proposed a \$110,000 civil penalty against Air Evac EMS Inc., of West Plains, MO for operating a Bell BHT 206 helicopter that was not in compliance with Federal Aviation Regulations. The FAA alleges a company mechanic installed a chin bubble window on the aircraft [without following the manufacturer’s instructions, and then failed to document the installation in the aircraft’s maintenance logbook.](#) The window is located



at the front of the helicopter, near the pilot’s feet, and allows the pilot to see below and forward of the helicopter. As a result of the improper installation, the aircraft was not in compliance with Federal Aviation Regulations.

The company, which provides air medical services, returned the aircraft to service and flew it on eight passenger-carrying flights. On Sept. 4, 2012, after only 7.3 flight hours, the [chin window fell off during cruise flight,](#) resulting in a precautionary landing.

The FAA alleges Air Evac operated the aircraft in a careless manner that endangered the lives of people on the aircraft and on the ground.

Air Evac has been in communication with the FAA about this matter.

NTSB Announces Safety Study on Drug Use in Aviation

The National Transportation Safety Board announced that investigators are completing work on a study of drug use trends in aviation.

Acting Chairman Christopher A. Hart had the following to say in testimony before the House Subcommittee on Government Operations on the federal government's response to marijuana legalization as it pertains to transportation policy: "In

aviation, our investigators sometimes see evidence of drug use by pilots involved in accidents. [So we decided it was time to look at this issue more in depth.](#) In September, we will meet to discuss drug use in aviation by examining toxicology testing results conducted on fatally injured pilots."The study hopes to describe the prevalence of drug use by aviation pilots over time, compare the prevalence of pilot drug use with that of other populations, and evaluate the need for safety improvements related to pilots' use of any drug.



<http://www.nts.gov/news/2014/140731b.html>

NS Mayport Remembers Victims of USS Forrestal Fire

The Naval Station Mayport First Class Petty Officer Association (FCPOA) held a Navy History presentation to mark [the 47th anniversary of the devastating events](#) on board aircraft carrier USS Forrestal (CVA 59) at the base chapel July 31.

On July 29, 1967, while operating off the coast of Vietnam in the Tonkin Gulf, [an accidental firing](#) of a Zuni rocket from an F-4 Phantom

struck an armed A-4 Skyhawk causing one of the worst losses of life in naval history. One hundred thirty-four crew members lost their lives and 67 were seriously injured. The damage to Forrestal totaled more than \$70 million. The guest speaker for the event was former USS Forrestal crewmember, USN (Retired) Gunners Mate 1st Class Richard Company, who served aboard the aircraft carrier from 1984-1992. He stated that those who lost their lives that day will always be membered in the rich history of the ship.

“The leadership made sure everyone was aware of the sacrifice these members made to help save the ship and other shipmates” Company said. [“We learned the importance of fire fighting safety and the leadership always backed us up and gave us the training we needed.”](#)

Today, the US Navy commonly refers to the fire aboard Forrestal when teaching damage control and ammunition safety.

The navy [circulated the lessons](#) which the men of Forrestal re-learned at such cost, throughout the fleet, and the flight deck film of the flight operations, subsequently entitled [“Learn or Burn”](#), became mandatory viewing for fire fighting trainees for years.

The Farrier Fire Fighting School Learning Site in Norfolk is named for Chief Aviation Boatswain’s Mate Gerald W. Farrier, the Sailor who died in the initial explosion in an attempt to extinguish the fire with a single PKP extinguisher. According to Company, there is a reminder on the Forrestal of what Farrier and others sacrificed for their country.



“Every day when you walk aboard the ship, there is a plaque with the names of all those that died that fateful day,” he said. [“We learned how important safety is toward weapon handling. We don’t want this to happen again.”](#)

All new navy recruits are required to view a training video titled, Trial by Fire: A Carrier Fights for Life produced from footage of the fire and damage control efforts, both successful and unsuccessful. On the one hand there were damage control teams spraying fire fighting foam on the deck to contain the flames, which was the correct procedure, while on the other hand, crewmen on the other side of the deck sprayed seawater, washing away the foam and worsening the situation by washing burning fuel through the hole in the flight deck into the decks below; the burning fuel was not easily extinguished, and was spread by water.

Due to the first bomb blast, [which killed nearly all of the specially trained firefighters](#) on the ship, the remaining crew, who had no formal firefighting training, was forced to improvise. In response, a “wash down” system, which floods the flight deck with foam or water, was incorporated into all carriers. Many other fire safety improvements also stemmed from this incident, including making sure [everyone receives basic damage control training](#) during basic training and during your INDOC period when reporting to a ship.

“If a fire happens at sea and the people who primarily fight fires, like those in my rate go down, you only have you, the water and your shipmates to save the ship,” said Damage Controlman 1st Class (SW/AW) Jessica Kreps. “It doesn’t matter what rate you are or what rank you are, everyone is a fire fighter at sea.”

FAA proposes \$12m fine against Southwest for maintenance lapses

The US Federal Aviation Administration (FAA) has proposed a \$12 million fine against Southwest Airlines for violating regulations in three instances related to maintenance work on its Boeing 737s. The airline had conducted repairs beginning in 2006 on 44 aircraft to prevent potential cracking of the aluminum fuselage skins. Everett, Washington-based MRO firm Aviation Technical Services (ATS) was contracted to perform the work.



"Investigators determined that ATS [failed to follow proper procedures](#) for replacing the fuselage skins on these aircraft. FAA investigators also determined that ATS [failed to follow required procedures for placing the airplanes on jacks and stabilizing them](#). All of the work was done under the supervision of Southwest Airlines, which was responsible for ensuring that procedures were properly followed," says the agency.

It adds that the airline had returned the aircraft to service while the aircraft were not in compliance with federal aviation regulations, and had operated "numerous flights" in 2009. The agency says it subsequently approved the repairs when the airline provided proper documentation.

The FAA alleges that ATS workers had applied sealant under the new fuselage skin panels [but did not install fasteners in all of the rivet holes for the sealant to be effective](#). Such an omission could have resulted in gaps between the skin and the fuselage surface, which could have led to moisture penetrating the skin and to corrosion.

ATS workers also failed to properly place the aircraft on jacks while the work was being performed. "If a plane is shored improperly during skin replacement, the [airframe could shift](#) and lead to subsequent problems with the new skin," says the agency.

In addition, the FAA alleges that the airline [failed to properly install a ground wire on water drain masts](#) on two 737s in response to a FAA airworthiness directive concerning lightning strikes on these parts. The aircraft were each operated on more than 20 passenger flights after the airline became aware of the problem.

The airline has 30 days from the receipt of the FAA's civil penalty letter to respond, says the FAA.

In response to the FAA's proposed penalty, Southwest tells Flightglobal that the FAA letter "concerns repair issues that were addressed several years ago."

"Having fully resolved the repair issues some time ago, none of the items raised in the FAA letter affect aircraft currently being operated by Southwest Airlines," it adds. "Safety is paramount and we always strive for full compliance with established and approved processes and procedures."

The airline will respond to the FAA's allegations in accordance with procedures, it says.

Factors That Led To Risk Of Collision For An Aircraft Landing At Toronto's Lester B. Pearson Airport In March 2013

In its investigation report (A13O0045) released today, the Transportation Safety Board of Canada (TSB) determined that a number of factors contributed to an [unattended maintenance van crossing the active runway](#) while an aircraft was landing at the Toronto/Lester B. Pearson International Airport on 11 March 2013. There were no injuries. A Sunwing Airlines aircraft maintenance technician was in a van parked near the nose of one of the company's aircraft. The technician exited the van to perform various duties outside the aircraft and then boarded it to check the cockpit. [Meanwhile](#), the van had rolled to and crossed the active arrival runway as an aircraft prepared to land. Air traffic control noticed a ground radar target as the driverless van crossed the runway, and instructed the Air Canada Embraer 190 to pull up and go around. [Despite two calls to go around](#), the Air Canada flight continued its approach, flew over the van at a height of approximately 35 feet and landed.



The investigation found that the van rolled across the active arrival runway because it was [left unattended with the engine running and the drive gear engaged](#). The first air traffic control instruction to the Embraer's flight crew to go around [was masked](#) by the sound of the ground proximity warning system in the cockpit, and therefore not heard by the flight crew. The second go-around instruction went unnoticed by the flight crew because [it was truncated](#) and the crew did not hear the aircraft call sign. Without supporting visual cues, the crew did not interpret the second call as applying to them.

Following the occurrence, the Greater Toronto Airports Authority (GTAA) issued directives to the Toronto Pearson aviation community reiterating the prohibition against leaving vehicles idling and unsecured on the airside.

The GTAA also published and disseminated information [on the luminosity requirements for vehicle roof beacons](#) and did spot checks to inspect beacons and require inoperative or inadequate beacons to be repaired or replaced. Sunwing Airlines reported to Transport Canada that it has inspected all of its airside vehicles and ensured that their roof beacons meet specified luminosity standards.

Risk of collisions on runways is a TSB Watchlist issue. [Watch the video!](#)

Report: Jet hit unlisted pole in fatal Ga. crash

A private jet hit a utility pole [that wasn't listed on aeronautical charts](#) before running into trees and bursting into flames last February, killing a Georgia vascular surgeon and four colleagues, federal investigators said in a report released Wednesday.

National Transportation Safety Board investigators say the plane with Vein Guys medical practice employees aboard hit the [unlighted pole](#) at the Thomson-McDuffie County Airport near Augusta the night of Feb. 20, 2013. The plane's six seats were found scattered among the fiery wreckage and were detached from the floor of the aircraft, according to the report.

The plane's left wing hit the pole as it was lifting off after a failed landing attempt, NTSB investigators said. The pilot aborted the landing after a warning light for the Beechcraft 390 Premier jet's anti-skid system illuminated.

Georgia Power built the pole in 1989, [but didn't notify the Federal Aviation Administration](#), and the obstruction wasn't listed on aeronautical charts, according to the NTSB report. The pole supplied power to a nearby textile plant.

"The pole and its involvement with airspace at the airport is currently under review by the FAA. The FAA is conducting further study on the pole in question and a final determination has not been made," said Georgia Power spokeswoman Carol Boatright.



Georgia Department of Transportation inspections in 2010 and 2012 found that the airport [met minimum state safety requirements, but didn't meet federal requirements](#) for precision and visual approaches, according to the NTSB report. Airport officials couldn't immediately be reached for comment.

Dr. Steven Roth, 48, who was killed in the crash, routinely traveled between the medical practice's satellite clinics in Atlanta, Nashville, Tennessee, and Raleigh, North Carolina.

Four members of Roth's traveling medical team also died. Roth and his colleagues treated patients for varicose and spider veins, and other vascular diseases affecting the legs.

The plane's South Carolina-based pilot and co-pilot both survived but were seriously injured, according to the report.

The NTSB plans to release a probable cause report on the crash later.

Asiana refutes Japan's report on its passenger injuries in 2012

Asiana Airlines Airbus A330-300 jet.

Asiana Airlines Inc., South Korea's No. 2 full-service flag carrier, said Monday that it refuted findings by Japan's transportation board that recently claimed its pilots were at fault for causing passenger injuries on a flight from Hawaii to Incheon International Airport (IIA) in 2012. The company's stance comes after the Japan Transport Safety Board (JTBSB) alleged pilots of Asiana flight OZ231 [ignored warnings by en-route air traffic controllers](#) that they should alter course to avoid cumulonimbus cloud formations that can cause severe turbulence and lightning strikes.



The Japanese authorities said warnings were issued to the South Korean pilots, [but these were ignored](#), resulting in the injury of three passengers on board the Airbus A330-300 jet. It also said the Asiana pilots [had not turned on their weather radar](#), which would have alerted them to the presence of severe turbulence that caused other planes in the area to make detours.

The plane carrying 221 people, including a crew of 14, was cruising at an altitude of 12.2 kilometers when it was rocked by severe turbulence at 3:17 p.m. on Aug. 21, 2012, over Shimane Prefecture in southwestern Japan.

In response, Asiana said the pilots, who testified after the accident, reported getting no prior warnings from regional controllers. The airline pointed out that its pilots are not required to turn on their onboard weather radar all the time. The radar can give a better picture of weather conditions ahead for pilots.

The airline said it sent its views back to JTSB through South Korea's transportation ministry.

The transportation ministry, meanwhile, said it will examine details of the accident before making a ruling.

If the pilots are found to have been at fault, Asiana can expect a fine or be penalized with suspended flights for a set number of days.

The company has recently been slapped with a fine and flight suspension after one of its Boeing B767-300s experienced engine trouble en-route to Saipan from IIA in April. The pilots of flight OZ603 [did not head for the nearest airport in accordance with set flight safety manuals](#), and flew the crippled plane for several hours to its destination. The plane carrying 253 people landed on a single engine at Saipan International Airport.

Boeing Forecasts Rising Demand for Commercial Pilots and Technicians

Boeing is forecasting [continued strong growth in demand](#) for commercial aviation pilots and maintenance technicians as the global fleet expands over the next 20 years.

Boeing's 2014 Pilot and Technician Outlook, released recently at EAA AirVenture Oshkosh, projects that between 2014 and 2033, the world's aviation system will require:

- 533,000 new commercial airline pilots
- 584,000 new commercial airline maintenance technicians

"The challenge of meeting the global demand for airline professionals cannot be solved by one company or in one region of the world," said Sherry Carbary, vice president, Boeing Flight Services. "This is a [global issue](#) that can only be solved by all of the parties involved—airlines, aircraft and training equipment manufacturers, training delivery organizations, regulatory agencies and educational institutions around the world." The 2014 outlook projects continued increases in pilot demand, which is up approximately 7 percent compared to 2013; and in maintenance



training, which increased just over 5 percent. Pilot demand in the Asia Pacific region now comprises 41 percent of the world's need, and the Middle East region saw significant growth since last year's outlook due to increased airline capacity and orders for wide-body models which require more crew members.

Overall, the global demand is driven by steadily increasing airplane deliveries, particularly wide-body airplanes, and represents a global requirement for about 27,000 new pilots and 29,000 new technicians annually.

[Projected demand for new pilots and technicians by global region:](#)

- Asia Pacific – 216,000 pilots and 224,000 technicians
- Europe – 94,000 pilots and 102,000 technicians
- North America – 88,000 pilots and 109,000 technicians
- Latin America – 45,000 pilots and 44,000 technicians
- Middle East – 55,000 pilots and 62,000 technicians
- Africa – 17,000 pilots and 19,000 technicians
- Russia and CIS – 18,000 pilots and 24,000 technicians

Random checks catch 99 tipsy Indian pilots since 2011

Random Indian preflight safety checks have caught 99 tipsy pilots since 2011, the national aviation minister told parliament on Monday.

The revelation could fuel questions about [airline discipline](#) and whether safety procedures in India's fast-growing industry need to be tightened further.

“Since 2011 a total of 99 pilots, including the 10 (so far this year), have been grounded for testing positive in preflight medical examination for alcohol consumption,” aviation minister G.M. Siddeshwara told parliament.

The minister did not divulge the names of the airlines involved or any other details, according to the report from the Press Trust of India news agency.

The Times of India newspaper earlier this year reported that statistics from the Director General of Civil Aviation showed a [gradual rise every year](#) in the number of pilots with alcohol in their bloodstream during preflight tests. India has a checkered past when it comes to implementing aviation safety rules.

Critics say that Indian airlines which have been expanding rapidly to meet rising demand while [operating on razor-thin profit margins](#), are facing a tough challenge to meet safety regulations.

In 2011, the airline sector was shaken by a scandal over a number of unqualified Indian pilots flying on fake licenses.

In March, an Indian pilot and flight crew were suspended for putting aviation safety in jeopardy when they performed a Bollywood dance high in the air.

The U.S. Federal Aviation Administration (FAA) stripped the country of its top safety rating in January, citing a lack of safety oversight.

It downgraded India’s aviation safety rating to category two from category one, putting it in the company of such countries as Zimbabwe, Bangladesh and Indonesia.



UPS Commits 20 Million Volunteer Hours by 2020

Global shipping giant UPS and the UPS Foundation have announced a [company-wide commitment](#) of twenty million hours of voluntarism and community service by the end of 2020.

Since 2011, UPS employees around the world have logged 5.3 million hours of volunteer and community service.



The new commitment represents a 12 percent increase in that number by the company and its employees. Going forward, the company will build on its past efforts in the areas of community development, education, and the environment, with nonprofits around the globe receiving volunteer assistance valued at more than \$460 million by 2020.

"Voluntarism has always been an integral part of our company culture," said UPS CEO-elect David Abney. "Jim Casey [one of the company's founders] continually advocated for employees to give back to the communities in which they live and work."

ALPA Honors Capt. Don Wykoff for Role in Developing New Flight Crew Rest Rules

The Air Line Pilots Association, Int'l (ALPA) president Capt. Lee Moak will honor Delta Air Lines Capt. Don Wykoff for his tremendous leadership role in developing new flight- and duty-time rules for commercial aviation. Capt. Moak will present the prestigious award during ALPA's 60th Air Safety Forum, took place August 4-7 in Washington, D.C. The Air Safety Forum is a week-long discussion of current safety and security aviation issues, of which flight- and duty-time rules (Federal Aviation Regulations, Part 117) have long been an agenda topic. "It is most fitting that during a week of intense focus on the top safety and security issues of our industry that we recognize Capt. Wykoff and his individual [accomplishments in bettering the entire piloting profession](#)," Moak said. "Through various leadership roles with the Association and aviation industry groups, he has helped accomplish what others have been trying to do for more than 60 years--establishing new pilot rest rules that improve the safety of air travel worldwide."



Capt. Wykoff's efforts to bring key stakeholders to consensus updating an archaic flight regulation led to the Federal Aviation Administration [issuing science-based](#) Part 117 flight limitations regulations on Jan. 4, 2012. The agency implemented these regulations for passenger airlines two years later, replacing outdated rules that had been in effect prior to the introduction of jet aircraft to commercial aviation.

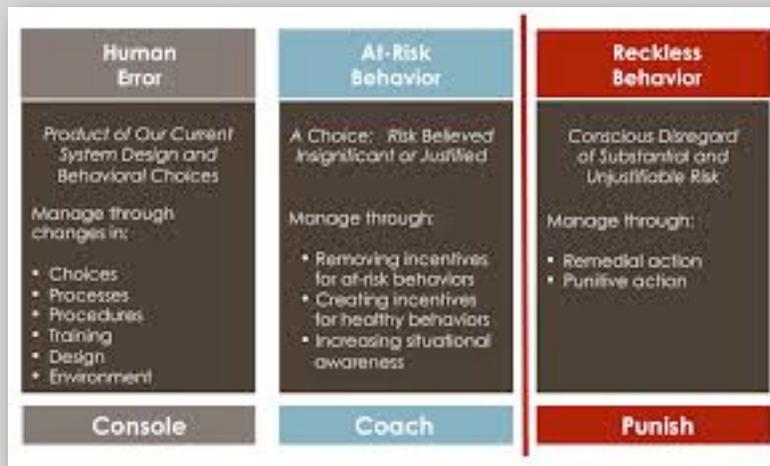
"For the first time in the United States, these rules address a pilot's [circadian rhythm](#), [duty limits](#), and on-board rest facilities; they provide education for pilots to address [fatigue mitigation](#) and a clear path to implementing Fatigue Risk Management Systems," said Moak. "They also set a standard for other aviation regulators to emulate worldwide, and ALPA intends to share these best practices with the global aviation community--including our Canadian members. We also will not rest until these rules apply to all commercial airline pilots, including those who fly cargo."

Capt. Wykoff chairs ALPA's Flight Time/Duty Time Committee (FTDT) and co-chaired the FAA Flight and Duty Time Limitations and Rest Requirements Aviation Rulemaking Committee (ARC). Under his leadership, the ARC developed recommendations for a modern, science-based set of flight, duty, and rest regulations, and ALPA adopted a new policy on flight-time and duty-time limits and minimum rest requirements.

The U.S. Congress has also recognized the value of the process and application of universal scientific principles. Lawmakers are developing legislation to ensure that the work of the ARC [applies to all pilots](#). Regulators specifically designed Part 117 to cover all operations, without differentiating among international, domestic, or supplemental operations, and with no distinction between cargo and non-cargo operations. Cargo pilots are flying the same routes, in the same airspace, and use the same equipment as other pilots.

The enigma called "just culture"

The frequency of aviation accidents and incidents has greatly reduced due to technological advances. However, [the human factor is indispensable](#), and as a result, there will always be errors, slips and mistakes. This implies that accidents and incidents cannot be completely eliminated.



A case in point is the near miss at the Barcelona-El Prat airport on July 5, 2014. With humans being at the forefront of aviation, the industry has come up with a concept called “just culture,” to identify, discuss and understand human errors with a view to finding ways to improve processes, systems and enhance safety without punishing individuals. This concept is central to safety risk management in aviation organizations where risks are identified, assessed and controlled. There are several publications on this subject, but for purposes of this article we will restrict ourselves to analysis of “just culture” as defined in Ugandan aviation literature.

Neither the Civil Aviation Authority (CAA) Act, nor the regulations made there under define “just culture.” However, according to the CAA Safety Management Systems Manual for Air Navigation Services (June 2012 issue), “Just culture” is “an important aspect of safety culture that ensures that while staff will be held accountable for their actions, they will at all times be treated fairly and with respect.” It further states, “While a non-punitive environment is fundamental for a good reporting culture, all staff must know what is acceptable and what acceptable behavior is. Negligence or deliberate violations will not be tolerated in this organization, even in our non-punitive environment. Our “just culture” recognizes that, in certain circumstances, there may be a need for punitive action and management will define the line between acceptable and unacceptable actions or activities.”

This definition highlights four key ingredients:

- **A non-punitive environment good for a reporting culture:**

This is how it is supposed to work; an incident occurs, information about the same is reported by the employee to supervisors or investigators. An investigation is conducted on the basis that no punitive action shall be taken against the employee and that the investigation findings shall be used to prevent further accidents/incidents thus enhancing safety.

The assumption here is existence of trust on both sides. This is an illusion. There can be no guarantee in any organization that volunteering information will not work against an employee who may be “held accountable” by way of suspension, demotion, dismissal or even prosecution before, during or after the investigation. In any case, the employee does not determine whether or not punitive action should be taken and may hold back vital information due to FEAR. This is because whether or not to take punitive action is at the discretion of management.

- **All staff must know what is acceptable and what acceptable behavior is:**

Some might consider risky what is considered safe to others, but all within the parameters of normal operating procedures. For example, in relation to the El-Prat incident, the Spanish Air Navigation Service Provider stated that the Boeing

plane could have continued to land without any danger, that the separation between the two aircraft was sufficient, and that the Airbus aircraft would have cleared its path. According to the BBC news website, “Officials have denied passengers were in danger at any point” (<http://www.bbc.com/news/world-europe-28195337>). However, the same incident has been described as “a heart stopping moment” by reporters (<http://www.news.com.au/travel/travel-updates/two-passenger-jets-in-near-...>)

It may be difficult to determine “acceptability” where there are divergent views like in the EI-Prat incident. This is likely to put the organization at crossroads. An act/omission should not be deemed unacceptable simply because some other person or group holds a contrary view.

Where acceptable/unacceptable behavior is not clearly defined, or is border line, management may have to come up with a definition after the incident, taking the aviator employee by surprise.

- **Negligence and deliberate violations will not be tolerated in this organization:**

One can only be found negligent at common law when; (a) A legal duty exists, (b) There has been breach of that duty, (c) There is consequential injury/damage/loss as a result of the breach.

Proving negligence in Courts of Law requires adducing and evaluating evidence on facts, law, custom/usage, circumstances, acceptable practice, the reasonableness test, and analyzing causation and remoteness factors. This is a complicated process that Courts have mastered with guidance of Counsel. It requires time, which may not be available to a disciplinary panel, constituted by lay people, and tasked to make a decision within a period limited by statute. Besides, Courts of law may overturn a finding of negligence by the disciplinary panel, and such a reversal is likely to dent the image and question the objectivity and competence of the organization’s disciplinary process.

Whether or not an act or omission amounts to negligence or a deliberate violation is also subject to discussion. An honest mistake, for instance, might be interpreted to be negligent or a deliberate violation. This depends on the composition and attitude of the disciplinary Committee at the material time.

Just like “acceptability” above, it may be difficult to determine negligent acts/omissions. An employee should not be found negligent if he followed a procedure accepted and used by some aviators but held in contempt by another group of aviators whose opinion differs.

Once again, the employees do not determine whether their acts were negligent/deliberate violations. **This is left to management.**

- **Management determines what is acceptable or unacceptable:**

This last ingredient arms management with a giant double-edged-sword. It means management may come up with offenses and punishments for the same at its convenience, even after the fact. This is untenable. What is or is not acceptable should be clearly laid out in employment contracts/operations manuals/ human resource guidelines to avoid employees being taken by surprise, a tool that could be used unfairly and arbitrarily by management.

There is no guarantee that management shall always be fair, balanced and objective. Discretion will certainly be abused to the employee's detriment. This erodes "fairness and treatment with respect" that is a component of "just culture."

"Just culture" as defined above is based on assumption, excessively empowers management, is vague, difficult to understand/enforce and is unlikely to achieve its intended objective of safety risk management and enhancing safety [in the Ugandan context](#).

Nearly Two-Thirds Fall Asleep with TV On

According to a new national consumer study, nearly two-thirds (61%) of Americans fall asleep with the TV on. (Perhaps even more worrisome: LG Electronics USA, which commissioned the survey, says the survey also reveals "Americans have redefined their relationships with television, seeing their TV less as an entertainment device and [more as a companion](#).)



Keeping in mind that television and other electronics frequently have a negative effect on sleep, [here are some other survey findings](#) you may find interesting: 22% of Americans admit to watching or listening to the TV while they are intimate with their partners.

- More than a third of Americans (38%) turn their televisions on as soon as they wake up.
- Nearly half (45%) of all Americans switch their televisions on within 15 minutes of arriving home.

- For some (35%), their relationship with their TV is so strong they'd rather watch the same show at the same time as family members or roommates, but in a separate room.
- The majority of people (55%) talk to the TV during programs and sporting events.
- Even with the ability to pause live TV, 37% of people admit to leaving the door open while in the bathroom so they can keep watching.
- A quarter of respondents (26%) leave their TVs on for their pets when they step out.
- Multi-taskers love TV for background noise and leave it on while doing chores (73%), cooking (72%), and even while working (58%).

<http://www.sleepreviewmag.com/2014/03/children-sleep-better-rules-limit-electronics>

Aviation Legend Mac Job Dies

Mac Job in 2008 at the 70th anniversary commemoration of the Kyeema crash.

Aviation safety expert and writer Macarthur "Mac" Job OAM has died, aged 88, after a battle with cancer. Job was most well known for his books on aviation accidents, as editor of the [Aviation Safety Digest](#) and as the person who rediscovered the crash site of the DC-2 *Kyeema* on the side of Mount Dandenong.



He began his career in Ceduna, SA, flying De Havilland Dragons and Percival Proctors for the Anglican Bush Church Aid Society, before moving into fish spotting operations in both Port Lincoln and Merimbula.

In 1964, Mac was appointed to the Air Safety Investigation Branch of the Department of Civil Aviation, which began his long association with air safety and publications. He would later write several books including *Air Crash*, the four-volume series *Air Disaster, Disaster in the Dandenongs* about the crash of the *Kyeema*, and *Into Oblivion - the Southern Cloud Enigma*.

He also edited the aviation magazine *Aircraft* and was a Director of the Missionary Aviation Fellowship.

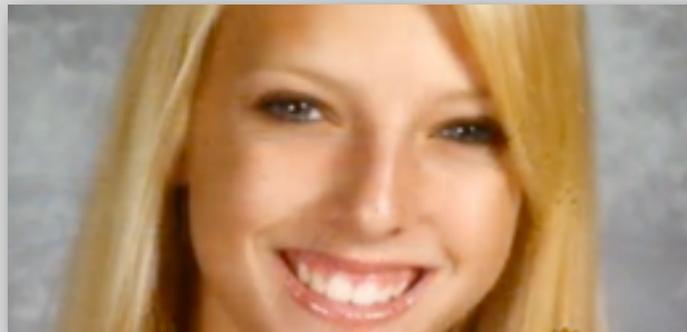
Mac's expertise was drawn on for the TV series *Black Box*, and in 2003, he was awarded an OAM for services to aviation safety.

It was Mac Job's determination that unearthed the forgotten site of the *Kyeema* crash in the 1970s. The ANA DC-2 overshot Essendon Airport and crashed into Mount Dandenong in 1938. The incident resulted in the government establishing a civilian aviation agency. Previously the military had control of all aviation in Australia.

Read a more detailed biography of Macarthur Job on the [Civil Aviation Historical Society website](#).

Inspiration

Parents mourn daughter's death by living her bucket list



July 27, 2014, 10:00 AM|A "bucket list" of things you want to do before you die can be filled if you live long enough. When 21-year-old Kristina Chesterman's parents found her list after she was killed by an [alleged drunk driver](#) while riding her bike, they knew exactly what to do. Steve Hartman reports.

<http://www.cbsnews.com/videos/parents-mourn-daughters-death-by-living-her-bucket-list/>