Aviation Human Factors Industry News

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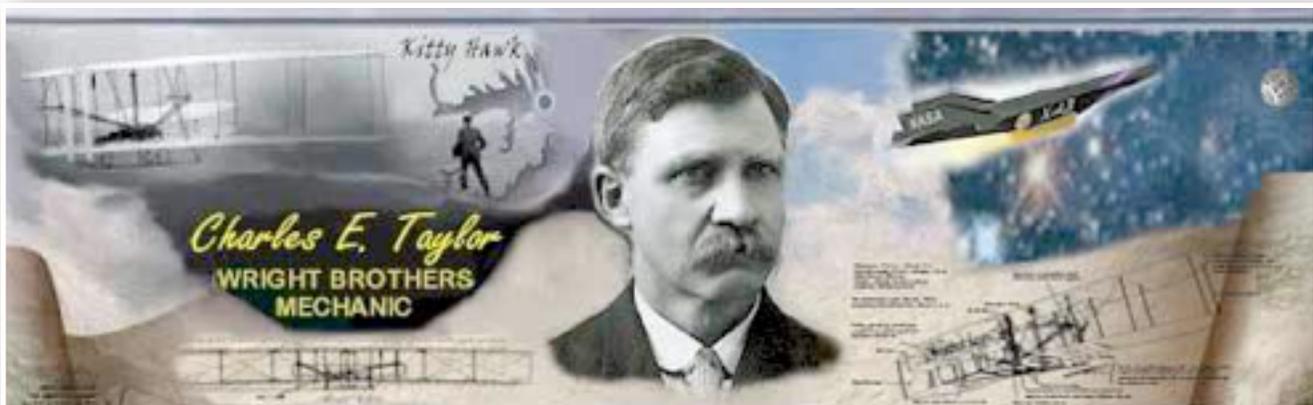
From the sands of Kitty Hawk, the tradition lives on.

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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★**FAA, FCC Investigating Misuse of 'Mayday' Frequency**

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EasyJet A320 damaged after chocks prematurely removed

Investigators have found that undetected release of the parking brake and premature removal of chocks led to an EasyJet Airbus A320's suffering damage as it rolled backwards at London Gatwick.The crew had already carried out cockpit preparation checks, which included checking that the parking brake was on.

Maintenance personnel subsequently probed a braking system defect, which had occurred on the previous sector, and this required the parking brake to be off.

But there was "no requirement" to put the parking brake back on once the task was completed, says the UK's Air Accidents Investigation Branch, and the crew was left "unaware" that it had been released.

The A320 (G-EZTM) was chocked at the time but, after a tug was attached for pushback, the chocks were removed – in breach of the operator's procedures which required chocks to remain in place until all ground equipment was clear of the aircraft. Forward boarding stairs were still in position at the time.

Investigators state that the tug driver discovered that the tug's radio was not functioning and – without communicating with the aircraft crew – disconnected the tug with a view to using a different, serviceable vehicle.

This released the unchocked aircraft and it rolled backwards, sustaining damage to its forward left-hand exit door as well as its fuselage as it struck the stairs. The crew halted the movement with footbrakes.

None of the 168 occupants was injured during the event, which occurred on 26 March this year. The operator's engineering division subsequently reviewed the maintenance task with a view to making recommendations to Airbus, while the ground-handling company has retrained personnel in chocking procedures.

FAA, FCC Investigating Misuse of 'Mayday' Frequency

The FAA and Federal Communications Commission (FCC) Enforcement Bureau are investigating the misuse of the frequency 121.5 MHz, according to the National Business Aviation Association (NBAA). Commonly known as the "Mayday" frequency, it is dedicated for use in emergency and distress situations.An FAA report on the nonemergency use of 121.5 MHz led to the first FCC Enforcement Advisory of the year, NBAA said. The advisory emphasized that the FCC Enforcement Bureau "will aggressively enforce the rules related to aviation radio operations," according to the association.

FCC rules prohibit false distress and emergency messages, as well as "all superfluous communications," NBAA said. It continued that this includes obscene, profane or indecent messages; general calls not addressed to a specific station; routine messages; radio tests; and recorded audio such as music.

For air-to-air communication, NBAA said pilots should use 122.750 MHz.

AIN's The Human Factor Episode 02: Flying into a Thunderstorm, Part 2

In the second episode of **AIN**'s *The Human Factor*, we pick up with Tim Valentine just after flying his SR22 into the back of a thunderstorm. This is part 2 of Tim's story. If you have not yet listened to Part 1, please do so before continuing. As he deals with radio and flight instrument failures and violent turbulence, we follow along as Tim relives the decisions that got him safely back on the ground.

In this episode we will hear from:

- Tim Valentine—pilot of the SR22
- Brian Lloyd—flight instructor and member of SAFE (The Society of Aviation and Flight Educators)

Topics in this episode will cover:

- Precipitation static or P-static
- Instrument failures
- Cirrus parachute systemFear management
- Determining cloud tops

AIN's The Human Factor: Tales from the Flight Deck

Flying into a Thunderstorm, Part 2

Download

NTSB Aviation Incident Data Summary (69K)

NTSB Aviation Incident Final Report (129K)

FlightAware Flight Track Log N715CD (277K)

NEVER OUT OF REACH

The paperwork from an official accident inquiry included an investigator's note with this observation about the pilot involved: **"No Wings Program or safety seminar participation."**

A pilot's recent experience, including documented training such as a flight review or equivalent, or other safety-related activities, may come in for examination after a mishap.

To look at it in a more encouraging light, a pilot who participates in formal or informal safety education, whether through structured programs, online courses, or events put on by a flying club, can expect some credit for the effort.

For that kind of pilot, mishaps are known to be less probable, so any initiative to make aviation ever safer will be most effective if it seeks out pilots who have disconnected from regular efforts to raise their safety consciousness. What areas get pilots in trouble the most? The AOPA Air Safety Institute provided its annual look at that question on Aug. 23, when it released the *26th Joseph T. Nall Report*, a review of general aviation accidents for 2014, the most recent year for which complete data are available.

The answer: landings, takeoffs and climbs, low-altitude maneuvering, and fuel mismanagement. No surprises there.

Also announced was an effort you can participate in to get more pilots involved in safety-related activities by urging the so-far "unreachable" members of the aviation community back to safety through the "Find one, bring one" approach.

As a student pilot preparing for a checkride, right now you are one of the most safety-conscious aviators out there, your head crammed with V-speeds and emergency procedures, and your carefully prepared practice flights saturated with stall avoidance, go-arounds, and see-and-avoid techniques.

How does a pilot drift from that level of mindfulness to "unreachable"?

Gradually, in most cases, fueled unwittingly, as accident reports and Aviation Safety Reporting System filings attest, by lack of current information, and piloting skills rusted from inactivity.
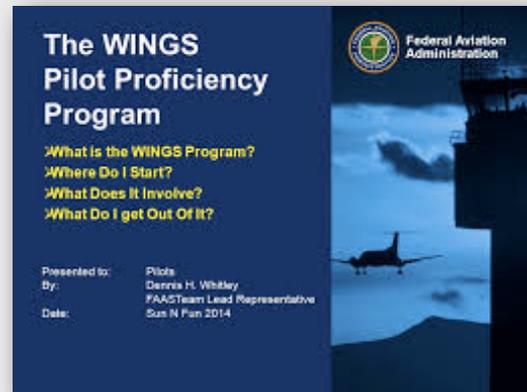
In a few cases, pilots become unreachable through overconfidence or defiance—but even they enjoy a cup of coffee on the house, so invite one along next time you watch a safety video, attend a local safety session, or drop in at a safety seminar at an **AOPA Fly-In** like those scheduled Sept. 8 and 9 in Norman, Oklahoma, or Oct. 6 and 7 in Groton, Connecticut.

Then make a pact with your pilot pal to never drift out of safety's reach.

https://www.aopa.org/news-and-media/all-news/2017/august/23/low-accident-rate-maintained-as-ga-activity-grows

https://asrs.arc.nasa.gov/

https://www.aopa.org/news-and-media/all-news/2017/january/pilot/membership-news-and-notes-january

Manchester Airport Disaster – 22nd August 1985

August 22 marks the 32nd anniversary of the Manchester Air Disaster. 55 people died when a 737 burst into flames while taking off from Manchester Airport. We look at the legacy of Flight KT28M 32-years-on.

For most holiday makers, the 22nd August 1985 started like many other. Looking forward to their holidays they would have arrived at Manchester Airport in jovial spirits ready for their flight to Corfu.131 passengers and six crew boarded a British Airtours Boeing 737-236 registration G-BGJL.

The aircraft was named River Orrin after a famous fishing river in the highlands. Just after 7 am, the aircraft prepared to depart Manchester Airport beginning its takeoff roll on Runway 24.

At 07:13 BST (GMT +1) a loud bang was heard as the aircraft accelerated and the captain, assuming a tire burst, aborted the takeoff by engaging the thrust reversers and the first officer, who was flying the aircraft, engaged the brakes.

During the aborted takeoff, fire alarms sounded in the cockpit, this coincided with air traffic control stating that *"there's a lot of fire."* and as the aircraft came to a halt turning off the main runway, the controller suggested evacuating passengers from the starboard (right) side as the port (left) engine was well alight. The airport fire service was called although they had already dispatched after seeing the incident for themselves.

The aircraft turned off of runway 24 onto taxiway link Delta and came to a halt and the evacuation began. Unfortunately, by turning this way it put the prevailing wind onto the port side of the aircraft effectively blowing the flames onto the fuselage. This, combined with delays in the evacuation caused by design flaws in the emergency slides, led to fire penetrating the cabin whilst passengers were still onboard the aircraft.Toxic smoke from burning materials such as seats and fittings filled the cabin resulting in the deaths of 53 passengers and 2 crew, the cause of death was mainly smoke inhalation.

The **Air Accident Investigations Branch (AAIB) investigated the accident** and concluded that a combustor can on the port engine ruptured, and a section of the can was ejected forcibly into an underwing fuel tank access panel. That panel was fractured, which allowed fuel to spill onto hot combustion gases from the engine. The resulting fire developed catastrophically, primarily due to the orientation of the aircraft and the fire to the wind.

The AAIB went on to say *"the major cause of the fatalities was rapid incapacitation due to the inhalation of the dense toxic/irritant smoke atmosphere within the cabin, aggravated by evacuation delays caused by a forward right door malfunction and restricted access to the exits."*

The accident was described as a watershed moment for British aviation.

As a result of the accident, the Cranfield Institute did a large amount of research into the evacuation of aircraft in emergencies and combustible materials.

Their findings led to the redesign of seating around emergency exits and galley areas to aid in a more rapid evacuation along. Materials used in the cabin must now be able to resist fire for significant periods and not give off toxic fumes.

One controversial measure that came from the research was the use of smoke hoods. Overwhelming evidence suggested that smoke hoods would have saved multiple lives in the accident however they were deemed impractical and too expensive to equip across a whole aircraft. Modern aircraft do carry smoke hoods for cabin crew use.

The Air Accident Investigations Branch made a total of 31 safety recommendations as a result of the including:

- In the event of a fire, procedures to be developed to enable the crew to position an aircraft with the fire downwind of the fuselage
- Fire extinguishing techniques inside passengers cabins to be reviewed to deal with internal fires
- Aircraft cabin materials to be fire resistant, including seat covers, wall and ceiling panels
- Onboard water spray/mist fire extinguishing systems to be developed as a matter of urgency
- Experienced cabin crew should be distributed throughout the cabin

In recent years there have been a number of significant engine fires on takeoff, notably a **British Airways**777 in **Las Vegas** in 2015. The port engine of G-VIIO burst into flames on take off and when the aircraft was brought to a halt, fire lapped against the fuselage. All 170 passengers and crew safely evacuated before fire penetrated the cabin and perhaps all of them owe a debt to the work carried out by the Cranfield Institute.

On the 30th anniversary of the Manchester Air Disaster in 2015, both British Airways (British Airtours was part of **British Airways**) and Manchester Airport apologized to the survivors and victims families. British Airways said the apology was "for their loss" and the "memories they have had to live with over the past 30 years".

https://youtu.be/kwHPQT65LjY

https://www.gov.uk/aaib-reports/8-1988-boeing-737-236-g-bgjl-22-august-1985

Aviation Accident Rates Improve, but Pilot Errors Persist

AOPA's Air Safety Institute (ASI) is encouraged that its most recent version of the Joseph T. Nall Report showed positive results from an industry-wide concerted effort to whittle away at aviation accident rates. The effort appears to have traction, with total accidents dipping to 1,163 in 2014. However, the report also highlights continual issues with pilot-related errors and personal flying. A subsequent "Scorecard" detailing initial data of 2015 and 2016 shows mixed results.The Air Safety Institute yesterday released its 26th edition of the Nall report reviewing data for 2014—the most recent year with "reasonably complete data"—finding the number of general aviation accidents dropped below the 1,185 accidents in 2013. The report traces to the most complete year of data to dig into causal trends.

"The significant improvements and historically low accident rates revealed in last year's report proved not to be a one-time statistical anomaly," said ASI executive director Richard McSpadden in a publisher's note in the report. "Across the general aviation community, we can take pride that our collaborative efforts appear to be having a positive, sustained impact."

The drop in total accidents comes in spite of 1.7 percent increase in overall general aviation flight activity. This pick-up in flight activity reverses a decade-long decline, ASI noted. But those improvements were not even among all flying categories, with commercial fixed-wing and non-commercial helicopter activity increasing by 5 percent and 21 percent, respectively, and non-commercial fixed-wing and commercial helicopter each sliding by less than one-half of one-percent.

The number of non-commercial fixed-wing accidents decreased by nine to 952, keeping the accident rate stable at 5.78 per 100,000 hours. But the fatal accident rate for that flying category pushed up 18 percent, to 1.19 per 100,000 hours.

Non-commercial helicopter accidents increased from 105 to 108, but involved six fewer fatal accidents. With the increase in flight activity, the accident rate declined 15 percent overall to 6.28 per 100,000 hours, and the fatal accident rate dropped 42 percent to 0.81 per 100,000 hours.

Commercial fixed-wing accidents dropped 16 percent to 68, marking a new low of 2.0 per 100,000 hours. The commercial helicopter accident rate remained stable at 0.32 per 100,000 hours.

The Scorecard, detailing the initial results of 2015 and 2016, traced a 5 percent increase in flight time of non-commercial fixed-wing aircraft in 2015, with just a 1 percent increase in accidents, providing an improvement in the accident rate for the category to 5.53 per 100,000 hours. Also, the fatal accident rate in 2015 dropped to 1.12 per 100,000 hours with two fewer fatal accidents. In 2016 the number of accidents involving non-commercial fixed-wing aircraft increased 3 percent to 991, but fatal accidents dropped significantly from 194 in 2015 to 156.

The commercial fixed-wing accident rate trended up in 2015 to 2.33 per 100,000 hours, but the fatal rate dropped from 0.32 to 0.24.

McSpadden noted that overall the trends show "troubling and stubborn" accident categories, particularly with the discrepancy between pilot-related and other types of accident causes, as well as the disparity between personal and commercial flying.

Pilot-related mishaps account for 75 percent of all accidents. "The overwhelming majority of these accidents are avoidable, so if we can convince more pilots to access safety information, we can drive the accident rate even lower and save lives," he said.

AOPA is taking a multi-pronged approach to addressing this, including encouraging operators to become more involved in type clubs and striving to reach the "unreachables" by encouraging increased involvement in safety programs.

"I'm a big believer in the value of type clubs," he said, noting, "They make you smarter on your airplane, make you smarter on the maintenance," and have expertise and mentors accessible. ASI has been working with type club leaders to help expand safety efforts.

As for safety programs, McSpadden expressed concern that they typically "preach to the choir" with people who already employ best practices attending. AOPA has begun a "find one, bring one" campaign to encourage pilots to bring other pilots who don't obtain safety information regularly. He notes studies suggest that about half of pilot community actively seek out safety information.

AOPA also is encouraging pilots to focus training and safety areas on problem areas associated with accidents: landings; takeoff and climbs; low-altitude maneuvering; and fuel management.

http://download.aopa.org/advocacy/0822_Nall_Report.pdf

El Faro: NTSB Releases Human Factors Report

The National Transportation Safety Board released a Human Performance Factual Report earlier this month as part of its investigation into the sinking of the *El Faro,* citing leadership, training and working hours issues on board.

The *El Faro* sank near the Bahamas in October 2015 en route from Jacksonville to Puerto Rico during Hurricane Joaquin.Captain Michael Davidson, similar to the other officers, normally worked a 10-week rotation, having 10 weeks off after working for 10 weeks on the ship.

He started a work rotation on May 5, 2015, and left the ship, as scheduled, on July 14. His relief resigned just three weeks later, and the captain was asked to return to *El Faro* earlier than anticipated. On August 11, four weeks into his vacation, he returned to work on *El Faro*.

El Faro's officers had employment contracts with TOTE through AMO. They were expected to work 12 hours a day while on the vessel under their contract. Actual work hours for the accident voyage were not available to investigators. However, during the two-week period from August 24 to September 6, 2015, the average workday was approximately 13 hours for *El Faro*'s officers. For the next 2-week period leading up to the accident voyage, from September 7 through September 20, the work hours were 12.5 hours.

The report documented several reports of fatigue among the *El Faro*'s crew in the weeks leading up to the sinking. According to testimony, the chief engineer had told his wife that he was exhausted from extra maintenance work, and had described his last rotation as the worst he had been on in terms of maintenance issues. Two friends of the second mate told investigators that she complained about fatigue from her watch schedule and the additional work required at sea. In the hours before the sinking, the *El Faro*'s VDR picked up a conversation in which she told her watch AB that she took ZzzQuil (a sleep aid with the same active ingredient as Benadryl) to help her rest.

The captain's voyage plan has been widely discussed given the presence of the hurricane. Investigators found no evidence that users of weather forecasting system on *El Faro* had any formal training with the system. Testimony from deck officers indicated that there was on-the-job training, and a user's manual and quick reference guide were readily available for use on the vessel.

The company did not issue alerts or email communications about Hurricane Joaquin before or during the fatal voyage. During interviews, TOTE managers repeatedly stressed that the captain could make any and all decisions related to the vessel's operation. They also stated that the captain would approve the voyage plan unilaterally and make all voyage-related decisions without the concurrence of shoreside management.

According to shipowner TOTE, the captain was the primary nautical expert: "There is no one in the company that formally provides oversight for nautical.

We depend on the captains to take on that role." However, company emails also indicate that some managers saw the *El Faro* captain as a "stateroom captain," with one voicing "dwindling confidence" in him. The captain had been advised around May 12 by the director of labor relations that he was not selected to work on TOTE's new LNG ships.

The day after the vessel got under way, the captain reported that he had been monitoring Hurricane Joaquin "tracking erratically" for the better part of a week. In an email to shoreside management, he stated that he had previously adjusted his course to a more southeasterly direction to account for Joaquin, and that he anticipated passing approximately 65 nautical miles to the south of the eye of the storm.

The National Transportation Safety Board released a transcript of the bridge audio recording from the *El Faro*'s final voyage in December last year. For the last few minutes of the recording, after the captain had ordered the crew to abandon ship, he attempted to help the helmsman to get out of the bridge; the AB called for a line or a ladder, but neither were at hand. Both men were within range of the bridge microphones until the end.

The NTSB Human Performance Factual Report is available here.

http://maritime-executive.com/article/ntsb-releases-transcript-of-el-faro-bridge-audio

Developing The Skill Of Failure

Do you know how to fail? This might seem like a strange question, but think about it. Most people don't know how to fail.

The failure rate in any activity is in direct correlation to your familiarity with that activity. If the activity is fairly routine, and you are familiar with it, there is a high probability for correctness.

If on the other hand, you are working in a new area, if you are looking to be original or creative, you are going to make a lot of mistakes, and be wrong a lot.

What rules or beliefs do you carry around in your mind about mistakes and failure? Most of us have developed a rather defensive mentality about failure that suggests that we should not fail in public. As a result, we don't work at failing. Thomas Watson, the man who started IBM, had a very interesting belief about failure. He believed that the way people become successful was by doubling their failure rate.
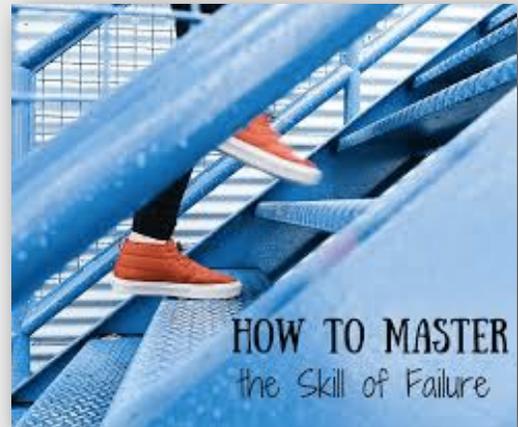
This leads to a very powerful question. How do you define failure? Too often, people define failure in such a way that it is almost impossible for them to succeed.

If they don't achieve what they want, when they want it and exactly the way they want it, they believe they have failed.

On the other hand, the innovators, the people who are creative, define failure in such a way that it is practically impossible for them to fail. They understand that when they work at developing new ideas or skills, they will be opening the door for more mistakes and failures. But, they don't look at failure like everybody else. They define failure as a condition that happens only when they don't learn something. As long as they have learned something from an experience, they haven't failed. They believe that you can't learn from something you haven't experienced.

This is a very resourceful and empowering way to define failure. With the many challenges life throws your way, your ability to define failure as the absence of learning, positions you to strengthen your "risk muscles" and experiment with new ideas and new approaches. This is true whether you are individual or an organization. A very powerful question that should be continually asked as you move into new areas is, "What can I learn from this experience"? This question focuses the powers of your mind in a positive, resourceful direction. It challenges you to think of the benefits from an experience that, initially, may have seemed a failure. It forces you to look deeper into the experience to come up with something that you can learn from and use as a building block for future growth.

Many people and organizations operate based on sets of rules and regulations that they have developed over time. These rules and regulations, when they were first developed were based on reasons that made sense at that time. But, things change. Unfortunately, those rules and regulations you have, the more frustrations and difficulties you will have dealing with the challenges of life and change.

To effectively deal with change and growth, you will want to examine your definition and your rules about failure. Why not accept the belief that there is no failure, there is only feedback. We all have a right to fail, as long as that failure does not severely hurt others or us. When the opportunity to fail is taken away, the opportunity to learn is denied, and with it, the opportunity to grow and to contribute. What do you think?

Doing Something is Better Than Doing Nothing…Or is It?

There is an old saying, "Doing something is better than doing nothing." However, doing "something" isn't always the best or correct thing to do. Circumstances are situational and require different levels of action. When it comes to aviation safety, lives are at stake, and we can't afford to do "something" just for the sake of doing it. Safety Managers frequently ask what's the acceptable way to manage all the hazards that have been reported. Managing numerous hazards that get reported, as part of an organization's Employee Reporting Process, can be overwhelming. Often the Safety Manager has a primary job, such as flying, and finding enough time to do both is a challenge.

Applying the concept of "doing something is better than doing nothing" isn't always the answer. Doing a "little something" on each reported event can provide some temporary relief to the workload, but doesn't do much to impact the safety of an operation. Another downside surfaces when team members begin to realize that not much happens when they file reports. Eventually, they stop doing it.

Simple Rules Ensure That You're Doing the Right Thing

One alternative when faced with managing multiple safety reports is to apply simple rules. A few simple rules can ensure that you're doing the right thing rather than just "something." Here's how it works.

Simple rules are shortcut strategies that save time and energy by simplifying the way we process information. They are not universal rules, but instead tailored to the specific situation and the person using them. All of us use simple rules throughout our daily lives. If we didn't, our brains would be overloaded by the complexities of our world. For example, you may decide to only check your email three times a day. This simple rule can help manage your workload and reduce your stress level. Simple rules have four common characteristics, according to Donald Sull, the author of *Simple Rules…How to thrive in a complex world*.

1. Simple Rules apply to a specific activity or decision, such as managing safety reports.
2. Simple Rules are tailored to the particular person using them instead of one-size-fits-all rules that apply to everyone, such as the Safety Manager.
3. Simple Rules are most effective when they apply to critical activities and decisions that represent bottlenecks to accomplishing an important goal, such as hazard identification within an aviation organization.
4. Simple Rules give concrete guidance without being overly prescriptive. It provides a way to do things better.

Simple Rules Are Always Tailored to the Specific Situation

Given that simple rules are always tailored to the specific situation, when managing safety reports try establishing a few rules in these three areas:
- Boundaries
- Prioritizing
- Stopping
-

Boundaries

When there is an overwhelming number of safety reports/hazards, boundary rules provide a quick way to screen for the most significant events/hazards. Boundary rules help to select which events/hazards to pursue, and which can wait until later. *For example: Move a hazard with a medium-to-high risk to the Hazard Risk Register for further action/investigation.*

Prioritizing

Prioritizing rules helps to rank a group of hazards competing for attention. In the medical community this is referred to as "triage." It allows the most critical patients to be treated first. In aviation, assessing the hazards with the greatest urgency is a good way to begin the process of risk management.
For example: Hazards with both the highest probability and severity are handled within 48 hours.

Stopping

Stopping rules helps to manage the amount of time and resources devoted to each situation. In our everyday life, knowing when to stop eating helps to manage our calorie intake and is way to avoid weight gain. When managing hazards, knowing when to end an investigation or stop monitoring a hazard can also be accomplished by a stopping rule.
For example: A hazard resolution no longer requires monitoring when there have been zero reported events in a 12-month period.

Simple Rules Can Calm the Stress of Managing Safety

Although it is necessary to respond to each and every safety report, the level of action can be most effective by creating a few simple rules. Simple rules can calm the stress of managing safety in an ever-changing and complex environment. It can make the role of Safety Manager achievable amongst other competing responsibilities.

As you know, communication is key to a strong safety culture. Sharing those rules and even documenting them in your Safety Management System manual is as important as using them. When everyone on the team is aware of the rules, they know that you, as their Safety Manager, are making the best decisions and not just doing "something."

SleepRate and The Sleep Council Call on Employers to Sign Up for a Global Sleep Fix Challenge

SleepRate, a company that helps improve sleep for better health, announced to employers its "Global Sleep Fix" challenge.

During the promotion, people can download the SleepRate app for free and use it for 12 months. They will receive a personalized sleep evaluation report, provided that sleep is tracked for a minimum of 3 nights within a 7-day period.Global Sleep Fix will launch on September 5 and run through to October 3.

Anda Baharav, MD, founder and chief scientist of SleepRate, says in a release, "Many employers have woken up to the fact that the best way to address issues such as absenteeism and productivity in the work place is by investing in programs that improve health and wellbeing, offering perks such as subsidized gym membership or offering emotional counseling. However, the importance of good quality sleep is often missed.

"There are simple changes we can make to help our sleep, from keeping more regular bed-time and waking hours to understanding triggers that lead to poor quality sleep. Employers need to take sleep as seriously as the health problems of their employees, and ensure they are doing what they can to support their staff."

Baharav has collaborated with Stanford University's Cognitive Behavioral Therapy for Insomnia to develop a sleep app SleepRate, based on protocols and content licensed from Stanford University, to help everyone get a better night's sleep.

Lisa Artis of The Sleep Council, says, "It is widely recognized that lack of sleep can affect employee productivity and wellbeing. In today's modern life there are even more distractions, from social media and games on our phones last thing at night to the pull of watching the next pre-recorded Game of Thrones episode, as we can't wait to find out what happens next. We don't really think about the long-term consequences. Here at The Sleep Council we are fully behind the Global Sleep Fix Challenge, supporting our Sleeptember initiative. We would encourage employers to join Global Sleep Fix and everyone to get involved to get a better night's sleep. Who doesn't want to sleep better?"

Britney Blair, PsyD, Stanford University School of Medicine, says, "For years we have known how important sleep is for our health, wellbeing, and overall productivity, but sadly millions of people around the world continue to get insufficient or poor-quality sleep. The team at SleepRate is committed to changing this frightening reality. I am hopeful many employers recognize the importance of sleep for their employees health and productivity and support their staff by signing up to Global Sleep Fix to encourage getting a better night's sleep.

How Can Employers Get Involved in the Global Sleep Fix Challenge?

- Download the posters and company materials

- Top Tips compendium that can be used on your workplace intranet site

- Distribute via email news about the launch of Global Sleep Fix on September 5 (template email provided) to their employees

- Set up your own challenge either between teams in the workplace or even some of your main competitors for fun

- Track improvements in your company's sleep

Working directly with the human resources departments, SleepRate aims to drive awareness around the importance of quality sleep and work place satisfaction and performance.

To get your workplace involved, visit www.globalsleepfix.com/enterprise and enter a workplace email, following which you will receive a free business kit.

TED: Ideas Worth Spreading

The secret to living longer may be your social life

The Italian island of Sardinia has more than six times as many centenarians as the mainland and ten times as many as North America. Why?

According to psychologist Susan Pinker, it's not a sunny disposition or a low-fat, gluten-free diet that keeps the islanders healthy -- it's their emphasis on close personal relationships and face-to-face interactions. Learn more about super longevity as Pinker explains what it takes to live to 100 and beyond.

What reduces
your chances of
dying the most?
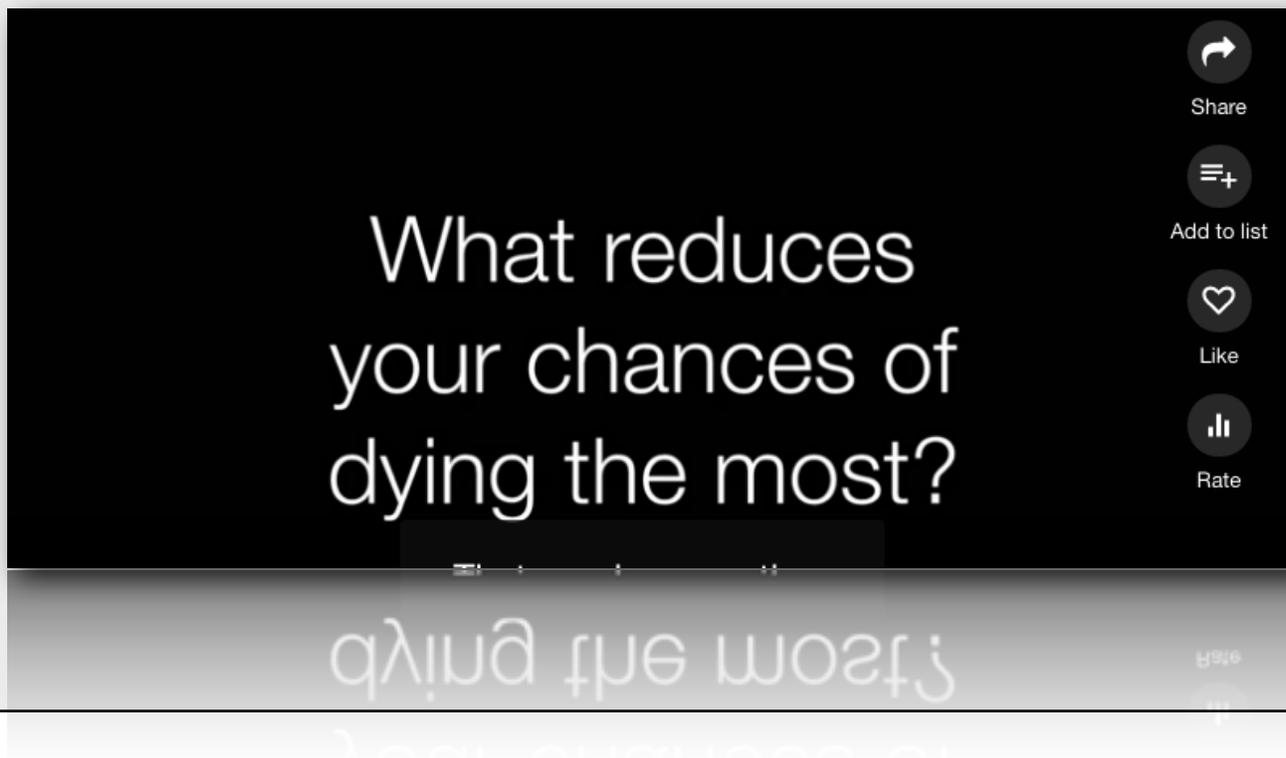
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