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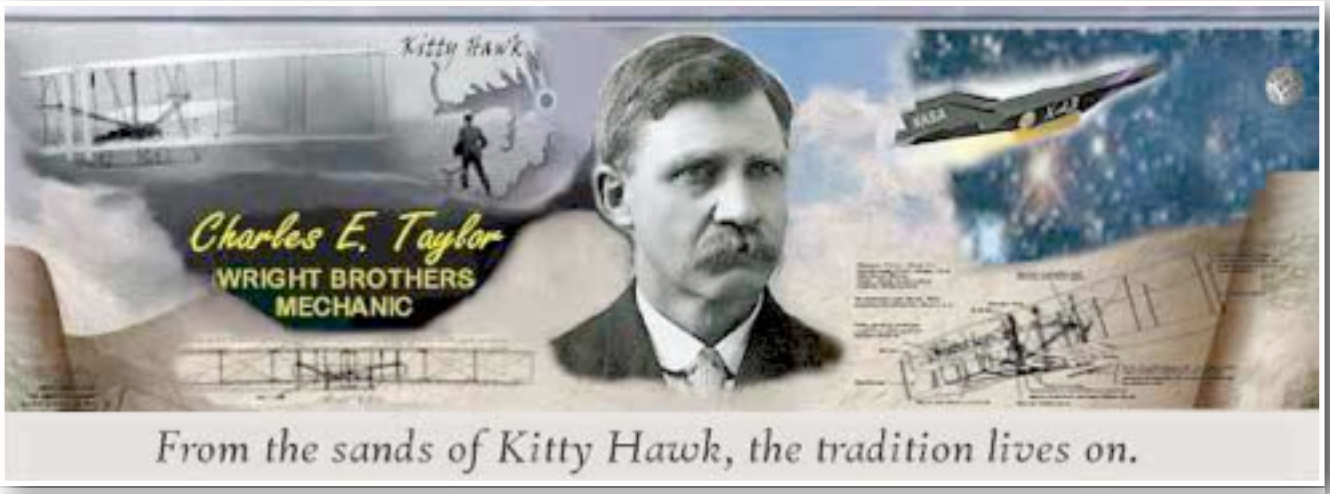


Hello all,

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:

System Safety Services -

Home of the "Father"

of the Dirty Dozen -

Gordon Dupont

Please view our Christmas Message

http://www.system-safety.com/ (scroll down when page opens)

22 YEARS AGO; AA Flight 965, 20 DEC 1995, Cali, Colombia

22 Years ago on 20 December 1995 an American Airlines Boeing 757 crashed into a mountain while approaching Cali, Colombia; killing 160 out of 164 occupants

Narrative:

At about 18:34 EST, American Airlines Flight 965 took off from Miami for a flight to Cali. At 21:34, while descending to FL200, the crew contacted Cali Approach. The aircraft was 63nm out of Cali VOR (which is 8nm South of the airport)) at the time. Cali cleared the flight for a direct Cali VOR approach and report at Tulua VOR. Followed one minute later by a clearance for a straight in VOR DME approach to runway 19 (the Rozo 1 arrival). The crew then tried to select the Rozo NDB (Non Directional Beacon) on the Flight Management Computer (FMC).

Because their Jeppesen approach plates showed 'R' as the code for Rozo, the crew selected this option. But 'R' in the FMC database meant Romeo. Romeo is a navaid 150nm from Rozo, but has the same frequency. The aircraft had just passed Tulua VOR when it started a turn to the left (towards Romeo). This turn caused some confusion in the cockpit since Rozo 1 was to be a straight in approach. 87 Seconds after commencing the turn, the crew activated Heading Select (HDG SEL), which disengaged LNAV and started a right turn. The left turn brought the B757 over mountainous terrain, so a Ground Proximity (GPWS) warning sounded. With increased engine power and nose-up the crew tried to climb. The spoilers were still activated however. The stick shaker then activated and the aircraft crashed into a mountain at about 8900 feet (Cali field elevation being 3153 feet).

Probable Cause:

PROBABLE CAUSE: "Aeronautica Civil determines that the probable causes of this accident were:
1. The flight crew's failure to adequately plan and execute the approach to runway 19 at SKCL and their inadequate use of automation;
2. Failure of the flight crew to discontinue the approach into Cali, despite numerous cues alerting them of the inadvisability of continuing the approach;
3. The lack of situational awareness of the flight crew regarding vertical navigation, proximity to terrain, and the relative location of critical radio aids;
4. Failure of the flight crew to revert to basic radio navigation at the time when the FMS-assisted navigation became confusing and demanded an excessive workload in a critical phase of the flight.
Contributing to the cause of the accident were:
1. The flight crew's ongoing efforts to expedite their approach and landing in order to avoid potential delays;
2. The flight crew's execution of the GPWS escape maneuver while the speed brakes remained deployed;
3. FMS logic that dropped all intermediate fixes from the display(s) in the event of execution of a direct routing;
4. FMS-generated navigational information that used a different naming convention from that published in navigational charts."

Ryanair culture ‘gone very miserable’, says airline executive

Chief operations officer tells pilots there was a culture where issues raised by staff were not addressed

The culture and tone of working at Ryanair “has gone very miserable . . . even in our head office,” chief operations officer Peter Bellew told pilots recently.

“I do think we can fix it,” Mr Bellew said, in a recording of a speech made to pilots that was obtained by *Independent.ie*.
Mr Bellew returned to Ryanair from his role as chief executive of Malaysia Airlines, replacing Michael Hickey, who resigned from Ryanair following the controversy in September where the airline cancelled a large number of flights due to rostering problems with pilots.

Speaking privately to pilots recently he said: “It seems that there was a culture that people who knew there was a problem . . . that they were not listened to, or they were actively discouraged from even raising the issue.”

Mr Bellew was critical of the airline’s current relationship with staff and said “basic, basic things that had been operated here for many years just were thrown in the basement”.

Mr Bellew previously worked at the carrier as the flight operations director, and a large part of his new brief will be to improve the relationship between pilots and management.

Human Error Blamed for CH-53 Window That Fell on Playground: Probe

A window that fell from a flying CH-53E Super Stallion and landed on an Okinawa playground, injuring a young boy, had not been properly secured, a Marine Corps investigation found.The announcement comes four days after the Dec. 13 incident that caused some local furor.

The 17-pound window fell near where about 60 children were participating in physical education on the sports field of Daini Futenma Elementary School, according to reports.

"A thorough inquiry determined that the incident was caused by human error," 1st Marine Aircraft Wing officials said in a statement released Sunday. "The window in question is designed to be removed in order to assist pilot egress in an emergency situation. The appropriate procedures for ensuring the window was secured were not correctly followed."

Following the incident, the Corps is conducting a full-court press on training, according to the announcement. All Okinawa-based CH-53E aircraft have been inspected, with a focus on the windows, to ensure there are no mechanical or structural problems.

Aviation personnel have gotten retraining on proper window installation procedures, and maintenance crews have reviewed aircraft maintenance procedures, including those specific to the helicopter windows.

Routine maintenance days and safety meetings, as well as regular inspections and upkeep, will continue to ensure the aircraft remain safe for flight, according to the release.

"1st MAW has taken comprehensive actions to ensure the safety of all Okinawa-based CH-53 aircraft, the aircrew that fly in them, and our broader community," officials said.

"This incident is regrettable, and we again apologize for the anxiety it has caused the community," 1st MAW officials said of the window incident. "We strive to be good members of the Okinawan community and to ensure the safety of both our personnel and our community in which we live and serve."

Navy Probe Missed Key Factors in Pilot Oxygen System Failures

The Navy missed a series of key factors in its investigation into the causes behind a rash of midair, oxygen-related failures in F/A-18s, which led to the deaths of at least four pilots, a NASA team concluded in a recently released report.

The 258-page report, which is slated to be the focus of an upcoming House Armed Services Committee sub-panel hearing, signals the Navy has plenty of work to do to create safer flying conditions for its pilots.The findings raised an alarm for at least one key lawmaker Thursday.

"I know that hundreds of dedicated people in the Navy are working very hard to address this problem but the report points out that we have a long way to go and that in some areas we can do much better," said Rep. Niki Tsongas, D-Mass., who helped spearhead the push for the study. "I am hopeful that the Navy will carefully examine the findings of this report and act on them as quickly as possible."

Tsongas is the ranking Democrat for the House Armed Services subcommittee on Tactical Air and Land Forces, which plans to hold a hearing on the matter in January.

The chairman of the panel, Rep. Mike Turner, R-Ohio, agreed that much work remains after reading the report, which was delivered to his committee last week.

"There is no doubt this remains a complex problem to solve that requires a well-coordinated 'systems approach' to include all factors such as the aircraft, the pilot, and the environment," Turner said. "These incidents have a direct effect on overall readiness. These episodes affect the confidence of our pilots and their ability to perform, because it is not just these events occurring, it is also the anxiety of these events occurring in succession."

In an April hearing, Adm. John Richardson, chief of naval operations, said the Navy had already made plenty of ground on addressing fixes.

"We've improved training" for pilots and others, Richardson testified. "And we're making sure that we are listening and they all feel like they can be talking to leadership so we understand where their anxieties and concerns are."

The NASA report is the result of a provision in the 2017 National Defense Authorization Act directing an independent review be conducted of recurring "physiological episodes" for Navy pilots. In turn, the Navy asked NASA's assistance, which began investigating the problem in March.

A physiological episode, which entails pilot impairment as the result of a lack of oxygen or other contributing factors, can involve decompression sickness, disorientation, hypoxia, cognitive impairment, inability to read or interpret data and instrumentation, numbness and pain, among other factors, the report states. The episodes, also known as PEs, can have deadly consequences, with incidents of some pilots passing out mid-flight, leading to a fatal crash.

In June, the Navy said in a review that four pilot deaths were tied to oxygen system failures in the cockpits of F/A-18 Hornets. The review had said reports of oxygen failures in the Hornets had increased from 57 in 2012 to 125 in 2016. By June 2017, the figure had already reached 52.

"While the Navy has introduced a number of corrective actions to address what was believed to be the primary causes of these events, PEs are still occurring," according to the report from the NASA's Engineering and Safety Center.

The Navy focused on aircraft fixes, instead of its pilots and crew, missing critical factors in its probe, the NASA team found.

The physiological episodes "do not happen to planes, they happen to people," the NASA team said in the report.

"For a long time the Navy made the assumption that the (physiological episode) resulted from a defect in one or more components of the aircraft" and the aircraft would be taken out of service, the report states. "No serious attention was paid to the interface of the human and the machine, or how they function during flight."

The Navy fixes included changes to the aircraft, such as relocating the cabin pressure gauge to make it more visible when pilots wear night-vision goggles, updated maintenance and operating procedures, and improved cabin pressure diagnostic testing equipment. By 2012, a new system was introduced to track aircrafts with a history of oxygen problems.

Still, the NASA team also discovered lingering concerns regarding the design and specifications of the F/A-18 aircraft related to aircrew life support, Tsongas said.

"It places particular attention on the aircraft's oxygen generation and cabin pressure systems, raising significant questions regarding both," she said.

The NASA team also found the Navy's medical community hasn't been involved enough in the probe, Tsongas added.

"The report examines internal Navy organizational challenges that may be making it much harder to address the PE issue," she said. "The report focuses attention on the need for the Navy's medical community to be more tied into the Navy's ongoing lines of effort."

The report also raised concerns about a breakdown in leadership trust among pilots, which the report contends is critical in light of pilots being asked to take on risky tasks. In April, more than 100 Navy pilot instructors for the T-45, which has also seen oxygen failures, refused to fly in protest of the slow pace of Navy fixes on oxygen failures.

"There has been a breakdown of trust in leadership within the pilot community," the report stated. "This has been precipitated by the failure to find a definitive cause for the PEs, the implementation of 'fixes' that do not appear to work ... and the belief that Navy leadership is not doing enough to resolve the issue."

AIN's The Human Factor, Episode 09: Flying Under the Influence, Part 1

Passengers put their lives in the hands of their flight crews when they step onto an airplane. But what if pilots violate the trust passengers bestow? In 1990, Lyle Prouse was the first pilot arrested for being drunk in the cockpit when he attempted to fly Northwest Airlines Flight 650 from Fargo, North Dakota, to Minneapolis.

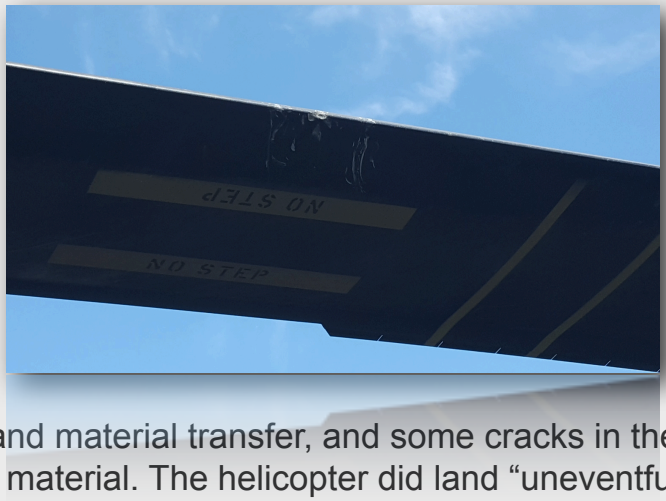
Today, a pilot is pulled from a flight for being too intoxicated to fly about once a month, according to experts.In this episode of **AIN**'s *The Human Factor*, multiple pilots tell their stories of dealing with addiction while in the cockpit and explain how their actions affected their careers. This episode also explores how the FAA, pilot unions, and companies have worked together to create the Human Intervention Motivation Study (HIMS) Program to help addicted pilots return to the cockpit.

Listen to the podcast.

NTSB: Drone/Black Hawk Probably Collided Due to Drone Pilot's Lack of Safety, Regulation Knowledge

A privately owned/operated unmanned aircraft system (UAS) collided with a U.S. Army Sikorsky UH-60M Sept. 21 on Hoffman Island, New York, outside New York City. The NTSB's final report, released Thursday, said probable cause was that the operator flew the drone beyond line of sight, unable to see the helicopter.

According to the final report, the UH-60 was flying in Class G airspace some 300 feet above mean sea level (operating over the ocean) when it collided with a hobby drone — a DJI Phantom 4.



The aircraft sustained minor damage; a 1.5-inch dent on the leading edge of one of the main rotor blades with various scratches and material transfer, and some cracks in the composite fairing and window frame material. The helicopter did land “uneventfully,” the report said. The drone was destroyed; some parts were “lodged in the helicopter.” According to the NTSB, the helicopter’s pilot saw the drone before impact and tried to avoid the drone; there was not enough time to do so successfully. On board the UH-60 was two pilots and two crew chiefs. The pilot in command had 1,570 hours on the UH-60. This was the crew’s first experience with UAS.The NTSB said the drone pilot did not hold an FAA remote pilot certificate and didn’t need to. Hobby/recreational pilots are expected to comply with Part 101 (Part 107 applies to commercial operations). Part 101 includes maintaining visual contact with the drone at all times and not interfering with manned aircraft. At the time of the collision, two temporary flight restrictions (TFR) were in effect for the area, authorizing the Army aircraft and prohibiting the drone. However, the drone operator was unaware. According to the report, the pilot solely relied on the DJI GO4 app for airspace awareness. The app does have a TFR function, but the function was not active at the time of the incident. (The NTSB report added that the only way to fully comply with FAA airspace restrictions is to check FAA TFR information at the time of flight.)

The collision occurred two minutes before the end of civil twilight. At the time of the collision, the drone pilot did not have visual contact with his aircraft or the helicopter. He had hit the “return-to-home” button on his control tablet, and the drone was making its way back to the operator when it collided with the helicopter. The NTSB said that even though recreational drones can fly at night under certain conditions, the drone pilot answered authority questions in a way that the NTSB assumed he was likely unaware of best practices and guidelines for night operations.

According to the report, all the drone pilot knew about regulations and guidelines was to “stay away from airports,” and that he should fly below 400 feet. However, he relied on the app to tell him if he was allowed to fly and had no knowledge of TFRs.

The drone pilot was unaware of the collision until he was contacted by the NTSB. According to the report, he had just assumed the drone malfunctioned and fell into the ocean.

According to the final report:

“The National Transportation Safety Board determines the probable cause(s) of this incident to be:

The failure of the [small drone] pilot to see and avoid the helicopter due to his intentional flight beyond visual line of sight. Contributing to the incident was the [small drone] pilot's incomplete knowledge of the regulations and safe operating practices.”

https://app.ntsb.gov/pdfgenerator/ReportGeneratorFile.ashx?EventID=20170922X54600&AKey=1&RType=Final&IType=IA

NTSB: Captain's failure to avoid hurricane a key cause of El Faro sinking

The National Transportation Safety Board (NTSB) has determined that the probable cause of the sinking of El Faro and the subsequent loss of life was the captain's insufficient action to avoid Hurricane Joaquin, his failure to use the most current weather information, and his late decision to muster the crew.

"We may never understand why the captain failed to heed his crew's concerns about sailing into the path of a hurricane, or why he refused to chart a safer course away from such dangerous weather," said NTSB Chairman Robert L. Sumwalt. "But we know all too well the devastating consequences of those decisions."

The 790-foot, cargo vessel, S.S. El Faro, en route from Jacksonville, Florida, to San Juan, Puerto Rico, sank Oct. 1, 2015, in the Atlantic Ocean during Hurricane Joaquin, taking the lives of all 33 aboard.

Contributing to the sinking was ineffective bridge resource management on board El Faro, which included the captain's failure to adequately consider officers' suggestions. Also contributing to the sinking was the inadequacy of both vessel owner TOTE's oversight and its safety management system. Further contributing factors to the loss of El Faro were flooding in a cargo hold from an undetected open watertight scuttle and damaged seawater piping; loss of propulsion due to low lube oil pressure to the main engine resulting from a sustained list; and subsequent downflooding through unsecured ventilation closures to the cargo holds.

Also contributing to the loss of the vessel was the lack of an approved damage control plan that would have assisted the crew in recognizing the severity of the vessel's condition and in responding to the emergency. Contributing to the loss of life was the lack of appropriate survival craft for the conditions.

As a result of the 26-month long investigation, the NTSB made 29 recommendations to the U.S. Coast Guard, two to the Federal Communications Commission, one to the National Ocean and Atmospheric Administration, nine to the International Association of Classification Societies, one to the American Bureau of Shipping, one to Furuno Electric Company and 10 to TOTE Services.

The complete accident report will be available in several weeks. The executive summary, including the findings, probable cause and safety recommendations is available

http://bit.ly/2nWVpnH

Don’t Limit Yourself To One Instructor

Within the aviation community, no two pilots are alike. Each has strengths and weaknesses, good and not-so-good techniques, and their own combination of skills, experience, and instinct. Which pilot is better? To quote Gordo Cooper in The Right Stuff, “Who’s the best pilot you ever saw? Well, you’re looking at him!” pretty much answers that question.

No two instructors are exactly the same either. Each has different strengths and weaknesses that highlight the diversity of their own flying and instructing experiences, and that’s exactly why it’s important to vary the instructors with whom you train. It’s important to glean the valuable lessons that only training with a variety of instructors can bring to you. Even the FAA agrees that pilot diversity is important with a primary focus on experience that is directly relevant to the needs and goals of the training pilot. A diverse instructor cadre helps to validate that you are getting the best training you can and ensures robust skills development.

Flying with instructors who have a wide experience base also broadens your horizons to the different types of aviation that exist. Each instructor brings a wealth of experience specific to his or her background. You may fly with a former military pilot who has a determined intensity after consistently returning to an aircraft carrier in the middle of the night after combat missions. Maybe you are learning from an Alaskan bush pilot who truly understands what it means to hug the mountains in low visibility, extremely low temperatures, and high elevation. Either would work, along with myriad others who have unique experiences in aviation.

If your instructor comes from a military background, they developed their skills in an environment of very strict discipline. They learned early that not only can their life depend on doing things a specific way, but that squadron mates' lives – or the lives of troops on the ground – may hang in the balance as well. Of course not everyone needs to train in this type of environment, but having an instructor with a military background can definitely complement your training.

But, maybe this type of intensity is not right for you and you would prefer the experience of someone who has released jumpers out the back of an airplane? There's an instructor out there who can teach you to be on your line, on altitude, on time, to flip the light to green, bring the flaps all the way down, and crack the throttle back to on speed for those tumbling out of your airplane. And then, that instructor can teach you to race the jumpers (safely, of course) to the ground to get the next load.

Maybe instead you have your eyes set on flying for the airlines or a sweet corporate gig taking the C-codes all around the globe. Maybe your passion is teaching new young aviators for a living, or maybe even working for the FAA as an inspector! There are so many different types of instructors out there. Every one of them has a story, and (if they are a good instructor!) a commitment to impart what they know to every student. "The most important questions to ask when choosing an instructor are not the ones you ask the instructor; they're the ones you ask yourself after an introductory meeting or demo flight with the potential instructor."2 If you are not getting what you need from your current training environment, something has to change.

Another significant point is that even the worst instructor can give you new insight. There are instructors who, through poor example, showed you what not to do with an airplane. You may have said to yourself, "I will never respond to my students or other pilots the way that instructor did." There are lessons to be learned from every instructor out there; hopefully most of them are good ones!

So, don't limit yourself to just one instructor. Fly with different people, in different airplanes, in different environments. Get your glider rating! Learn to fly a seaplane or get upset prevention and recovery training. Always push yourself to learn something from every instructor with whom you fly. Experience is an excellent teacher, but it doesn't always have to be your own personal experience.

Learn from the wealth of experience that a diverse instructor cadre brings. That experience might just save your life.

No Floats, Life Rafts on Crashed Mi-8

The Accident Investigation Board of Norway (AIBN) has issued its preliminary report on the October 26 crash of a Russian-registered Mil Mi-8AMT that crashed offshore near Barentsburg on October 26 that killed all eight aboard. The wreckage was recovered from a depth of 686 feet 1.1 nm off the coastline northeast of Kapp Heer on November 4 and transported to Stavanger.

Despite the harsh maritime climate in which it was operating, the accident helicopter was not equipped with flotation devices, life rafts, or survival suits, the AIBN found. Life jackets apparently were not used and all but one was recovered from beneath the helicopter's seats. The remaining life jacket was found on the seabed separate from the wreckage along with the only body recovered to date. No bodies were found inside the helicopter, and the AIBN said it had “reason to believe that all persons on board evacuated the helicopter before it sunk.”

The cockpit voice recorder (CVR), flight data recorder (FDR) and GPS units were recovered with the wreckage and analyzed. Only one of the two GPS units contained data from the last flight. The FDR was severely damaged and its memory unit was missing and not recovered. Neither the FDR nor the CVR were equipped with underwater locator beacons.

Preliminary CVR analysis indicates that the crew did not note any anomalies before impact and did not make any unusual communications with air traffic control and last communicated with ATC five miles out from intended landing at Barentsburg and was declared missing 24 minutes later.

Rescue helicopters arrived on scene 42 minutes after that. Wreckage analysis suggests that the helicopter struck the water relatively flat, tail low. Visibility in the area at the time of the accident was reported as poor.

Florida Pilot, Mechanic Face Federal Fraud Charges

A Florida pilot and an aircraft maintenance technician were arraigned in U.S. District Court last month by the Department of Transportation's Office of the Inspector General on charges of conspiracy to commit aircraft parts fraud. According to the allegations, in June 2012, the mechanic, James Michael Schiller, completed an inspection on a twin-engine aircraft and found it to be non-airworthy.

He subsequently removed the serviceable components from the aircraft, which was reported to the FAA as totally "destroyed or scrapped" and was therefore deregistered. At a later date, Ulpiano Luis Amy, the co-defendant, obtained engines and propellers from a crashed airplane and supplied them to Schiller, who then installed them on the supposedly destroyed aircraft. Schiller is accused of hiding these actions by failing to record the installations in the aircraft's logbook, as is mandated by FAA regulations. The complaint states that Amy then submitted false documents to the FAA certifying the airworthiness of the aircraft, with the plan to sell it to an unsuspecting buyer. Among the documents submitted was a bill of sale in which he is accused of forging the seller's signature, which carries an additional count of falsely registering an aircraft with the FAA.

Crew lapse allowed A319 to enter runaway descent

Investigators have found that an EasyJet Switzerland crew inadvertently allowed an Airbus A319 to descend at excessive speed, before a sudden sidestick input threw several cabin crew to the floor.

One cabin crew member sustained a serious injury during the 20 July 2014 incident.

The A319, bound for Basel, had been cleared to descend to 24,000ft and had been operating in 'open descent' mode, which idles the engines and uses pitch to priorities a target airspeed - in this case M0.76. Swiss investigation authority SUST says the aircraft accelerated to 315kt and was further cleared to descend to 18,000ft.

While the descent mode was switched to 'vertical speed', with a setting of 2,500ft/min, the target speed remained at M0.76. As the aircraft descended the engine thrust increased in order to achieve this target.

The airspeed reached 345kt, close to the maximum operating speed of 350kt, as the A319 approached clouds at around 20,000ft.

SUST says the captain had been "pre-occupied" by the presence of the cloud formation, and the first officer - concerned about the possibility of exceeding speed limits in turbulence - called for a speed check.

Although the captain reduced the target speed to M0.54, the aircraft momentarily reached 349kt. The captain disengaged the autopilot, says the inquiry, and "instinctively and abruptly" pulled on the sidestick.

The overspeed warning sounded and the A319's pitch transitioned from 2.5° nose-down to 2° nose-up, subjecting the aircraft to a force of 2.33g.

While the passengers were unaffected, three of the four cabin crew were thrown to the floor during this maneuver, one of whom suffered a serious ankle injury.

The captain proceeded to enter several changes to the target speed before it was fixed at 275kt and the aircraft continued its descent normally.

SUST says the A319 (HB-JZQ) was undamaged.

Investigators could not identify any "extraordinary factors" which might have increased the pilots' workload during the descent. The inquiry cites inappropriate management of the descent mode, and has attributed the late detection of the proximity to maximum operating limits to a "lack of diligence" in visually monitoring crucial flight parameters.

Qatar Airways A321 damaged by fire during maintenance

A Qatar Airways Airbus A321 has been badly damaged by fire during maintenance at the airline's home hub at Hamad International Airport, Doha.

According to the *Aviation Herald* accident reporting website, the aircraft—believed to be A7-AIB —"sustained substantial damage and possibly needs to be written off."Pictures on social media show extensive damage to the top of the fuselage, which was burned through at several points. The interior also appears to have sustained substantial damage.

In a statement, the airline acknowledged the incident: "At 0650 on 8 December 2017, a Qatar Airways Airbus A321 aircraft positioned at a remote stand experienced a fire while under maintenance at Hamad International Airport (HIA).

The fire inside the cabin was promptly contained and extinguished. While there was some damage to the aircraft, there were no injuries. A full investigation is being conducted by the local authorities to establish the cause. Traffic at HIA was not affected."

If the aircraft's identity was confirmed as A7-AIB, it was built in 2010 and was powered by IAE V2500 engines.

New SAFO Addresses Collision Risk During Runway Crossing

This week the FAA issued a Safety Alert for Operators (SAFO 17012) which serves to warn pilots of high-risk category A or B runway incursions and potential collisions in the first two-thirds of an active runway. This was based on data collected from Airport Surface Detection Equipment, Model X (ASDE-X) from FY14-FY16. Among the SAFO's recommended pilot actions are to: actively listen to ATC; remain clear of the runway hold lines unless you are certain you have received a clearance to cross the runway, line up and wait, or takeoff; and ensure there is no aircraft that could overfly your aircraft and that the runway is completely clear before entering it for takeoff.

Pilots and vehicle operators should familiarize themselves with this SAFO (found here https://go.usa.gov/xnnYT), as well as review and comply with *Best Practices for Airfield Safety – Pilots* at https://go.usa.gov/xnnYc, and *FAA Runway Safety Best Practices Guide to Operations and Communications* at https://go.usa.gov/xnnY3.

Dallas Love Field Addresses Bird Strikes With High Tech

City Council May Spend $1.2 Million On Detection System

The number of bird strikes at Dallas Love Field is on the rise, so the city council is considering a high-tech solution that would detect birds as much as five miles from the airport. So far in 2017, there have been more than 150 bird strikes at Love Field, according to airport statistics.

The Dallas Morning News reports that the high number of incidents is what has prompted the city council to consider to $1.2 million investment in a bird detection system from a company called Pharovision. The system uses optical and infrared sensors to detect and track birds up to five miles from the airport, according to the company. When birds are detected, airport officials and air traffic controllers are alerted to the potential danger.

Along with the initial investment would come a $550,000 bill for an extended warranty and ongoing maintenance, according to the report. The cost would be paid from the airport's operating funds.

The Pharovision system would also detect drones operating illegally within five miles of Love Field.

FMI: Original Repot, www.birdstrikecontrol.com/pharovision/index.php/payloads/interceptor

This Underrated Employee Benefit Is Helping American Workers Recharge

In today's work culture, we are always connected to our work and commitments, leading many employees to burn out at faster rates. American employees seem to think the solution to this problem is to take a sabbatical.

"Although sabbaticals are strongly associated with employees in academia and college faculty members, the term also extends to a period of paid leave from work, which can be used to acquire new skills, travel, training or rest," stated a press release about the study conducted by eDreams.While the term may need to evolve with the times, workers today are taking sabbaticals where possible and more companies are making it part of their policy to send an employee on sabbatical after a set time frame working for the company, usually five years.

Europeans Are Better At Balance And Americans Are Overworked

"On average, U.S. workers receive half the paid vacation time (10-12 days) that Europeans are entitled to by their employers (20-25 days), so it comes as no surprise that almost two thirds (63%) say they don't have an adequate amount of paid time off," states the eDreams press release. "As a result, 59% of Americans claim that they are overworked and don't have a good work-life-balance."

Each European country is different, but what is abundantly clear is that employee and labor laws in the United States are severely lacking compared to the rest of the world. Whether it's parental leave rights, job protection or time off, American employees are often left with little by way of trust or guarantee from their employer or government.

Americans Think Sabbaticals Are The Solution

“Three quarters (75%) of employed Americans say they would like to take an extended break, with over half (53%) citing the opportunity to escape the stress of working life as a contributing reason (higher than EU average of 49%),” according to the eDreams press release.

While American work policies are being touted as evolving to meet the current workforce, the statistics are saying otherwise. American workers want to take an extended break from work in the form of a sabbatical. Flexible work situations such as cutting out early from work for a vacation or working from home, while more common in the US than other countries, are not providing the relief workers are looking for.

Despite flexible work policies at many companies in America, employees and millennials in particular are burnt out from the overuse of technology. Their phone never leaves their side and, by default, work never stops either.

“The first thing I did while on sabbatical was purchase a generic wall calendar,” said Kira Karbocus, Head of Finance and Operations at Fingerpaint Marketing, an advertising agency. “My life for the last five years was run by Outlook. Even time with my family had to be scheduled. I then set two rules to live by: limit my screen time (cell phone, TV, and computer) and go to bed each night physically tired instead of mentally tired.”

Karbocus was not alone in the need to unplug on sabbatical. Many sabbatical users report being more productive and energized when they return to work after unplugging for a time.

“While the outcomes of sabbaticals are often meaningful, there are ancillary benefits to ‘turning off’ for a time,” said Michelle Hayward, CEO of Bluedog Design, a growth and innovation consultancy. “Laurel Hanson, 12-year Bluedog veteran and designer of two Bluedog 'Baticals, shared that prior to a sabbatical, she experienced that feeling of being constantly behind due to the constancy of always-on media. To have the space to step away and quiet the noise quickly silenced that feeling and made her feel more willing to re-approach the everyday again with fresh energy.”

Companies Offering Sabbaticals Are On The Rise

“According to a 2015 survey by the Society for Human Resource Management, 13% of companies offer an unpaid sabbatical, while only 5% percent of companies offer paid sabbaticals,” said Ed Mitzen, Founder of Fingerpaint Marketing, an advertising agency.

https://www.edreamsodigeo.com/wp-content/uploads/sites/19/2017/09/Sabbaticals-U.S.-14SEP17.pdf

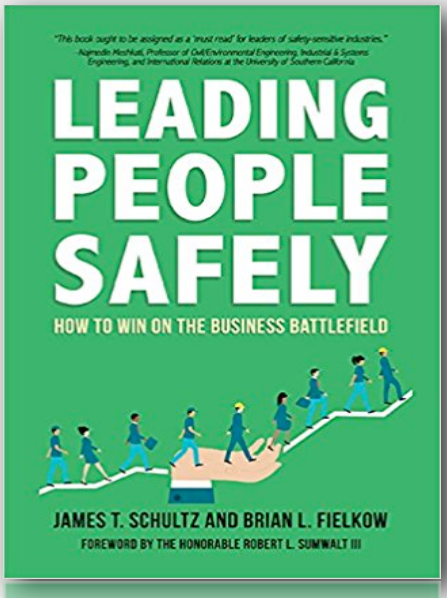
https://www.shrm.org/hr-today/trends-and-forecasting/research-and-surveys/Documents/2016-Paid-Leave-in-the-Workplace.pdf

https://www.shrm.org/hr-today/trends-and-forecasting/research-and-surveys/Documents/2015-Employee-Benefits.pdf

Book Review: Leading People Safely: How to Win on the Business Battlefield

by James T. Schultz (Author), Brian L. Fielkow (Author), Foreword by Honorable Robert L. Sumwalt III (Author)

SAFETY IS THE CORNERSTONE for excellent operations, but it is often marginalized and relegated to dense handbooks that are ignored by employees. James T. Schultz and Brian L. Fielkow instead offer a straightforward how-to guide for maximizing organizational performance through safety leadership. They demonstrate why safety must be a core value engrained into the rhythms of every task. Jim and Brian show how to bring people and process together in full alignment to provide a definitive competitive advantage.



Leading People Safely is packed with succinct, savvy know-how for implementing a culture of safety, punctuated with easy-to-skim lists and text boxes, and uses on-the-ground examples supplied from Jim and Brian's combined seventy-plus years of experience.

Applicable for businesses of any size or industry, Leading People Safely is a must read for leaders looking to create a safe and successful business with a healthy corporate culture.

Hardcover: 214 pages

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