Case Study Comment 3
by Captain Ed Pooley

We probably all recognise this type of Operator. They always have classic aeroplanes which if not leased cheaply would remain parked in the desert until scrapped for not a lot. We may know or have guessed that these aeroplanes are often crewed by almost-retired Captains over 60 years old accompanied by much younger First Officers with aspirations of a proper job. Meanwhile, these youngsters have little effect on their Captain's traditional approach to command ("I'm in charge") especially on a Classic 747 where there's likely to be an equally geriatric flight engineer with as much time on type and (consequently) almost as much 'authority' over the First Officer as the Captain. Examples of the genre are to be found more often outside Europe – such as the annual Haaj pilgrimage flights to Mecca and Medina. But as this sort of business is typically a long haul business model now that we have a proliferation of LCCs doing short haul, they sometimes have one end of the journey here, as in this story.

The attitude of the Captain to an unserviceable transponder doesn't surprise me much – although I'd expect the other one to have been available as a substitute whereas we are left to assume that it was defective already. Neither am I surprised by the reliance on SSR with no primary - although I did wonder if the airspace involved had been properly notified as a transponder mandatory zone….

The fact that there was defective safety equipment and that a cabin crew who had experience of something better felt moved to try and expose the fact didn't surprise me either. And as for the ease with which a non-specialist journalist can "have the wool pulled over has eyes" about safety issues, again no surprise. In fact this media problem actually works both ways – not only are real safety issues not appreciated for what they are, occurrences that aren't really about safety are often presented as though they are!

And what about the west sector team? They were certainly rather slow to spread the word that they thought the transponder on the old 747 may have failed? Definitely a poor response in SSR-only airspace – but had the controllers been properly prepared for the withdrawal of primary radar?

So where is there a chance to act to stop the next incident like this? Well quite possibly at the ANSP, but I am going to opt for the Flight Operation involved and specifically pick on the Regulator that issued an AOC to the airline involved. Such an act requires oversight of the holder **in proportion to the assessment of risk**.

A RECOMMENDATION

The Regulator which has responsibility for the AOC holder involved must recognise that their oversight effort cannot be based on fleet size and that this type of operation will need a lot more watching than many if an acceptable level of safety is to be maintained. Of course, I hope that the Regulation of operators like this one is provided by agencies which understand that their responsibilities extend beyond collecting the money. Unfortunately as with shipping on the high seas, outside of Europe, not all Regulators are equally competent…

could be strengthened to ensure this was a regulatory requirement. ANSPs have to balance safety with costs and they may decide not to operate primary radar if States do not require it.

I would be looking at how to bring about improvements in the safety culture, in particular improving communications between controllers, supervisors and managers, and seek to improve the balance between safety and capacity.

For this scenario, the recommendation would be to evaluate the feasibility, then develop and implement the ACT-FASST tool, including provision of user training in the use and limitations of such a tool.

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