Case Study Comment 5
by Mike Edwards

What happened next…

At the centre
Stan could not understand what had happened, there was no aircraft near X-line 123. It must be a spurious TCAS Alert, or maybe one of those new Stealth fighters that they were not supposed to know about, he thought. He had calmed down and was now just annoyed that he would now probably have to waste his break time, trying to enter a Safety Report into the new electronic safety database. To complete his increasingly bad morning, when the aircraft called the TCAS, he had been reading about how his team, Tottenham, had been beaten 0-3 at home yesterday. So much for that new manager!

On the flight deck of X-line 123
After they had followed the RA and returned to their cleared level, Paul turned to Dirk and asked "What the xxxx was that?". "I don't know, but it was big" said Dirk. "Do you think we should ask ATC about it?" asked Paul. "No, best not, he seemed a bit shocked. We'll leave them alone" replied Dirk.

In the cabin of X-line 123
The pilot came on the PA and apologised for the sudden descent and climb. Apparently they were avoiding turbulence or something. Brent was snoring and Sid was drifting in and out of sleep, dreaming about eating herring and marmalade sandwiches.

At the centre
An assistant alerted the Supervisor that he was wanted back in the operations room. "Now what?" he sighed as he heaved his considerable bulk out of his comfy chair. Three people were standing around the Supervisor's position looking at a flashing red light. "What's that?" asked one. " Ah.. that's….. new" said the Supervisor, painfully aware of how inadequate that sounded and dreading the next question about what it was for, and knowing that he did not have the answer. There had been a briefing sheet lying on the desk when he came on duty this morning, but he had not got round to reading it yet.

Stan rescued him by calling him over. He quickly explained about the TCAS alert, trying to keep it low key. "Okay, not to worry, just fill in a safety report on your break" said the Supervisor, failing to see Stan's whole body language drop.

The Supervisor went back to the desk and read the briefing sheet about the red light. "Ye Gods, which idiot approved this?" and then immediately knew which idiot it would be. He went upstairs and knocked on the door of the idiot. The idiot smiled in the vacant way that idiots do. The Supervisor put the briefing sheet on the desk and asked when had it been approved. "At the usual Project Board meeting a couple of weeks ago" said the idiot. The Supervisor just stared at him, so the idiot went on "Bert was involved.. oh no..he was on leave, but Sven from Ops was there…ah…well no actually he had called in sick that day…anyway it can only be a help to the controllers in the unlikely event of a radar failure, so it has to be a good thing, doesn't it". "Was a Hazard Analysis done?" asked the Supervisor. "It's in hand, now that Sven is back, I am going to ask him to

do one today" grinned the idiot, satisfied with another job well done.

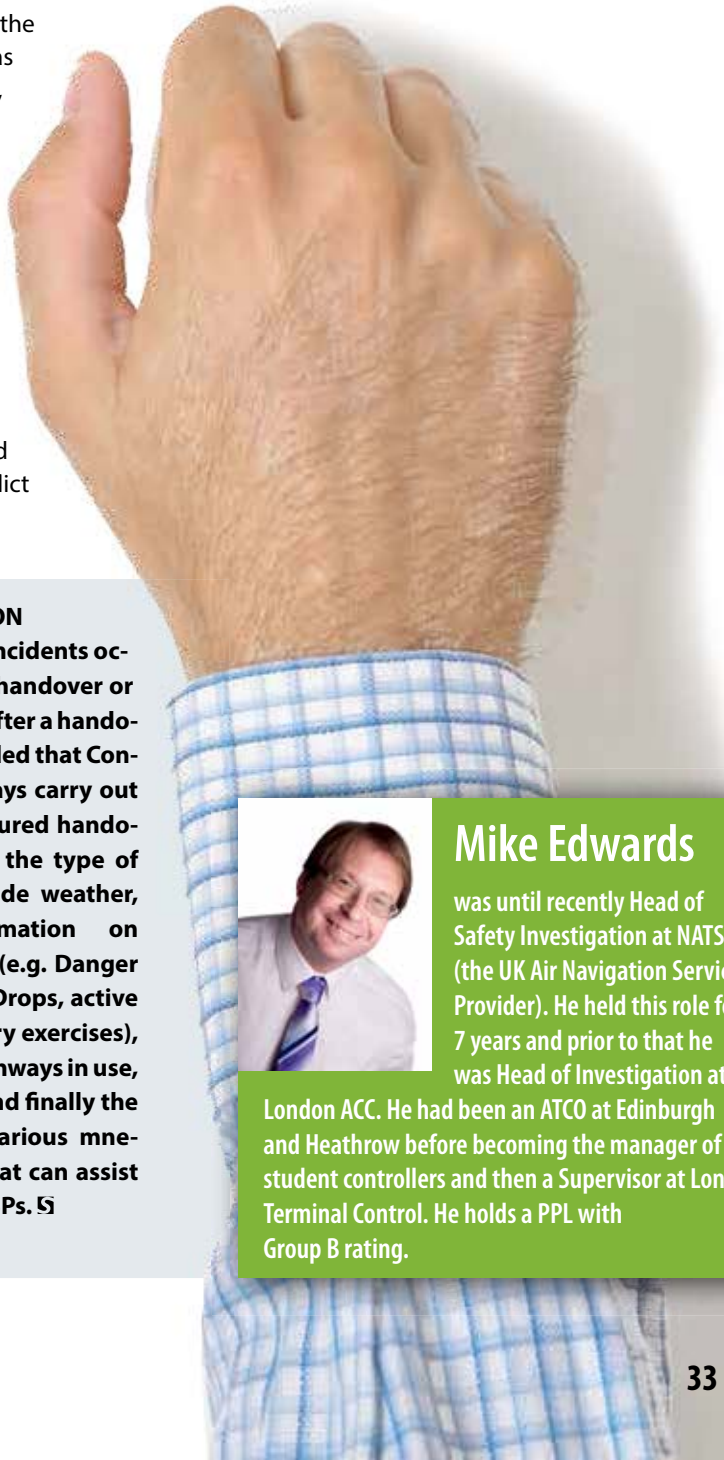
Conclusions

The new software build had been introduced into the live environment without any operational expert advice, hazard analysis or pre-operational briefing material for supervisors and controllers. It was fundamentally flawed in design, functionality and implementation. Its operation was based on the Supervisor's desk being manned 24/7, which was clearly not the mode of operation, whether officially or not. The controllers, who were the ones that needed to know first and immediately were not to be given any information. The way that this unit or ANSP runs projects needs a complete overhaul.

The incident itself was initiated by Ann, who cleared X-line 123 to route direct to BABLA, which is in an adjacent sector, without the prior approval of the controller responsible for that sector. This type of non-conformance has been identified as one of the principal contributing factors in the current EUROCONTROL's study of Top 5 Operational Safety Issues, one of which is 'Conflict involving adjacent sectors'.

The second factor in the causality chain was that Ann did intend to co-ordinate the direct routing with Stan on the adjacent sector, but forgot to carry out the planned action, after being distracted by the arrival of Alexander for a handover.

The next factor in the chain was that there was no actual handover, other than Alexander declaring that he had the picture. If a properly-structured handover had taken place, the position of X-line 123 and the direct routing that still needed to be co-ordinated, would have been included and the potential conflict removed.



A RECOMMENDATION

A large number of incidents occur either during a handover or within 10 minutes after a handover. It is recommended that Controllers should always carry out a formal and structured handover. Depending on the type of unit, this can include weather, equipment, information on non-standard stuff (e.g. Danger Area activity, para Drops, active gliding sites, military exercises), flow restrictions, runways in use, pressure settings and finally the traffic. There are various mnemonics available that can assist controllers and ANSPs.

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