

The role of aviation safety information in accident prevention

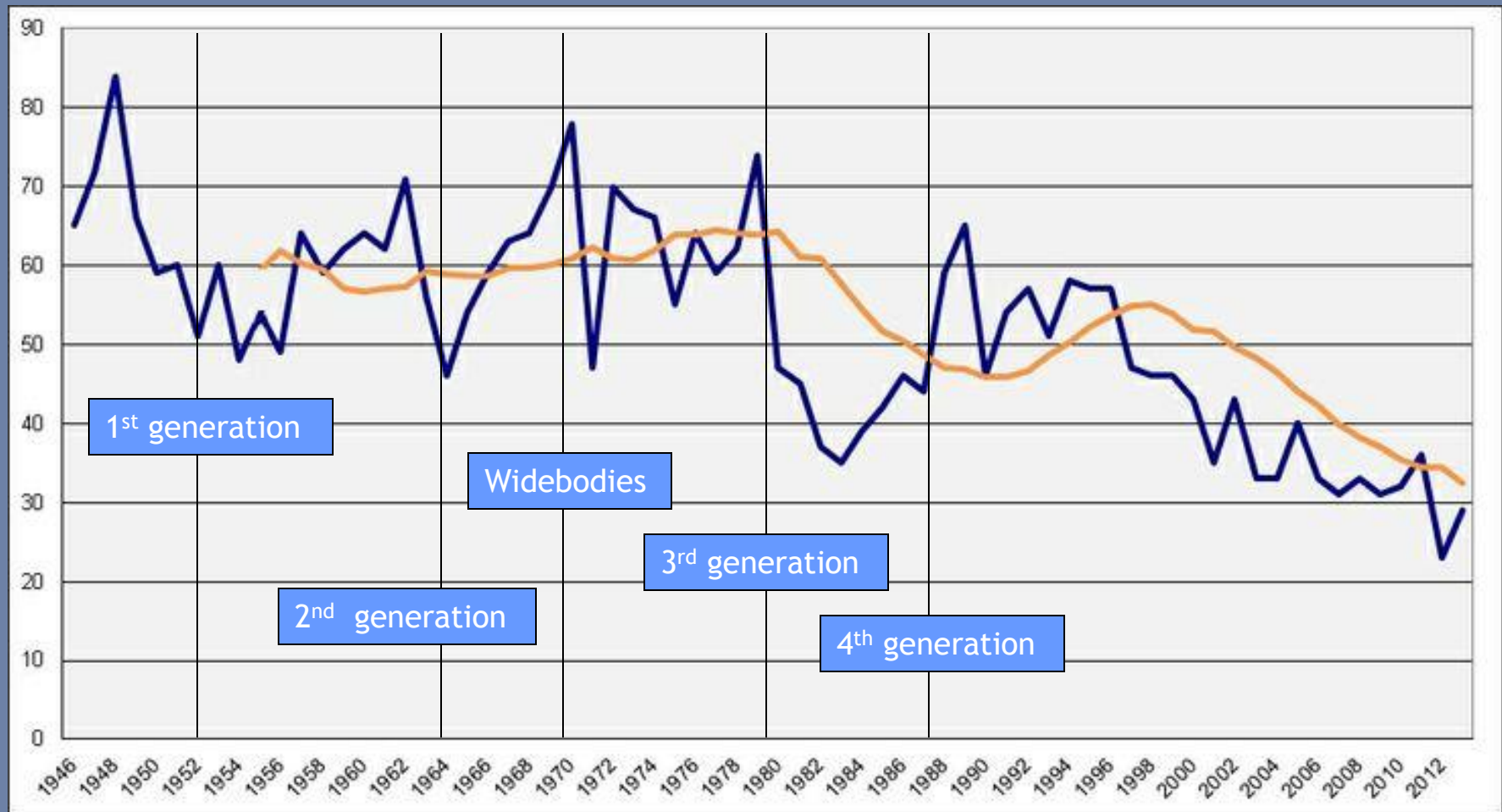
Contents

- How safe is aviation in this day and age?
- Aviation safety information and accident prevention
- Challenges in aviation safety information

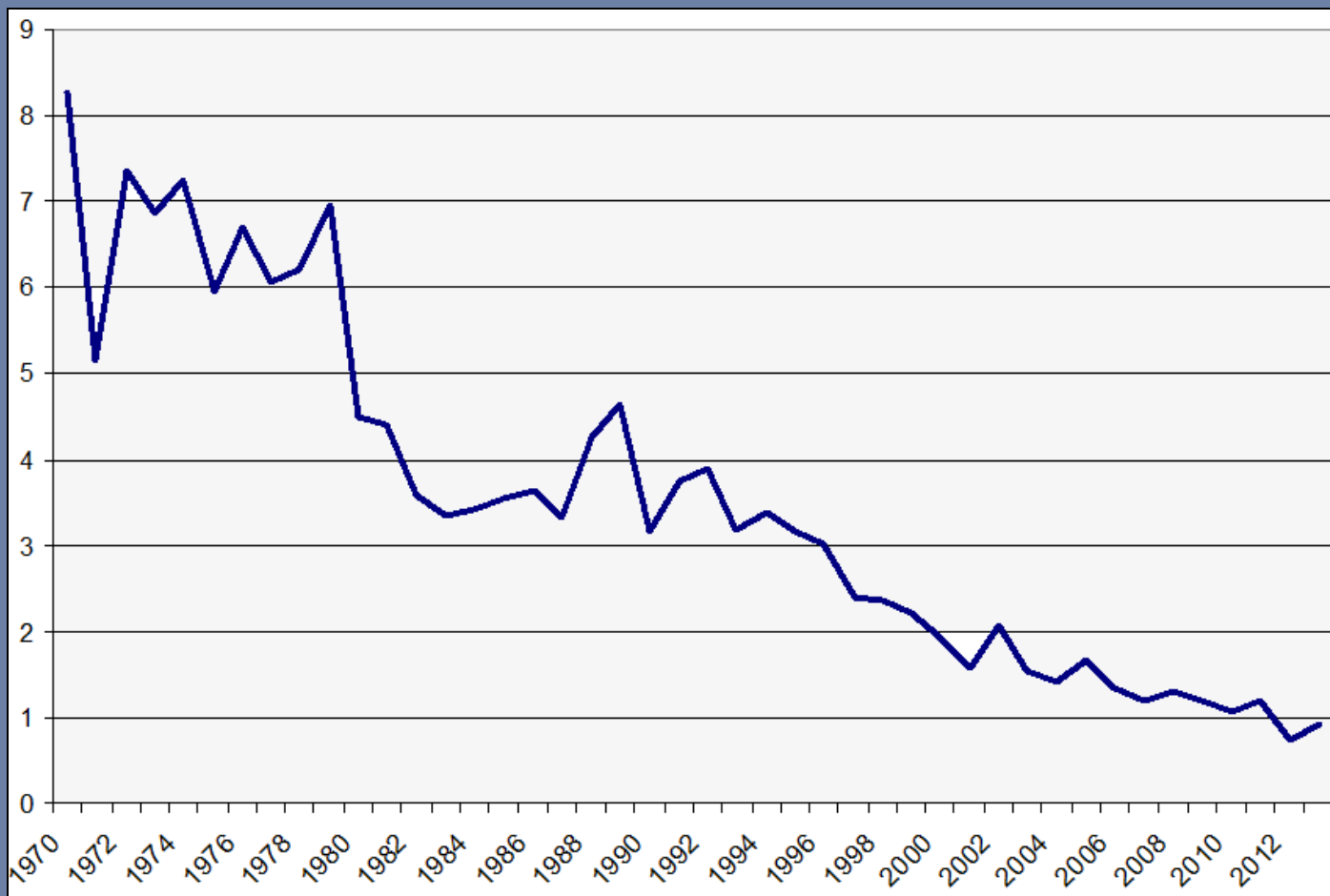
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Fatal airliner accidents and moving ten-year average



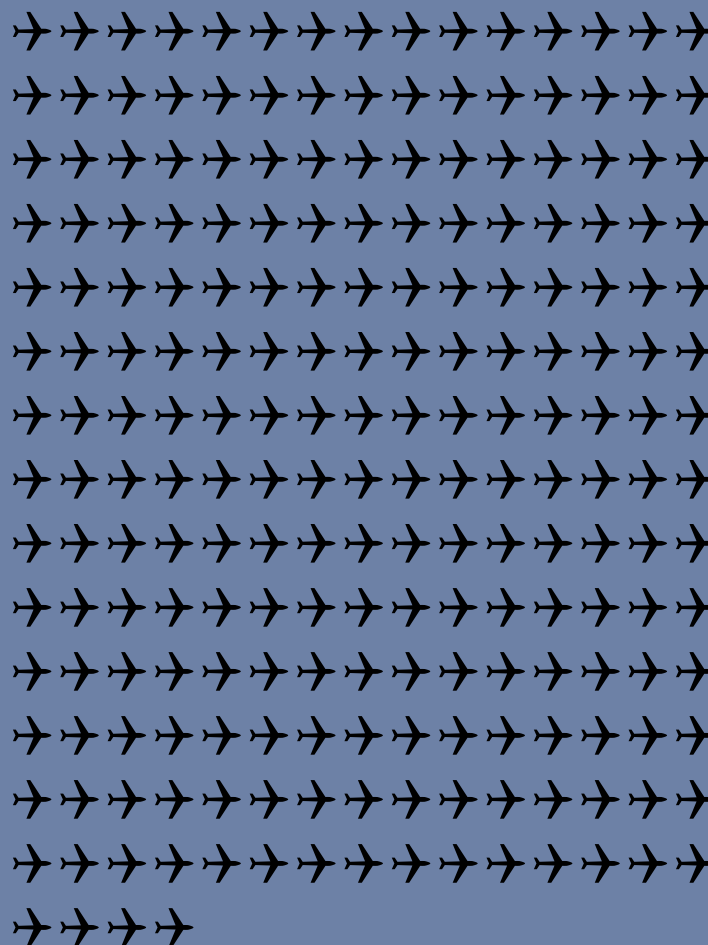
Fatal airliner accidents per 1,000,000 departures



2013 - at 1973 accident rate

6446 fatalities

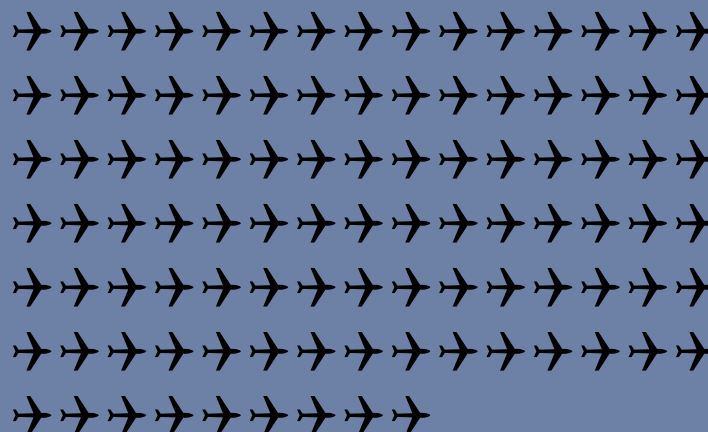
214 accidents



2013 - at 1993 accident rate

2225 fatalities

99 accidents



2013

265 fatalities

29 accidents



16 Passenger

8 Cargo

4 Ferry

1 Training

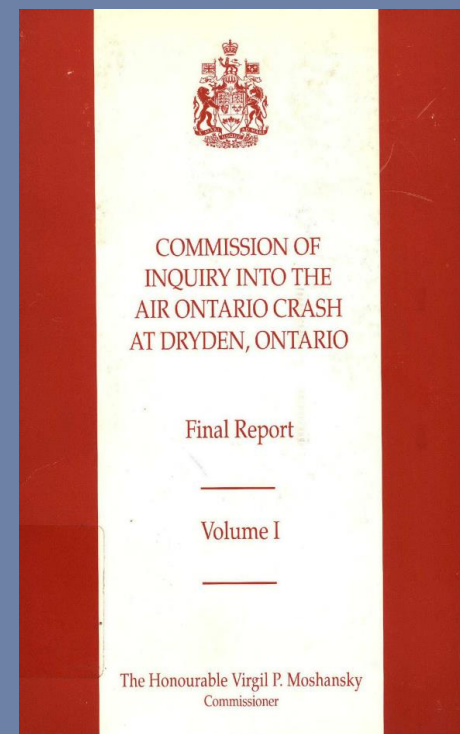
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Safety information

March 1989

- Fokker F-28
- Dryden, Ontario, Canada
- 24 dead



Safety information

March 1992

- Fokker F-28
- New York-La Guardia
- 27 dead



1990 de-icing report was not sent to USA

BY GRAHAM WARWICK
IN ATLANTA

A report on an Air Ontario Fokker F.28 accident in 1989 in circumstances similar to those of the 22 March loss of a USAir F.28 was not sent to the US Federal Aviation Administration, as is accepted practice.

The "special nature" of the investigation — by a Commission of Inquiry rather than the

Canadian Aviation Safety Board — is blamed for the departure from procedure.

The Canadian judge who led the Commission investigating the accident at Dryden, Ontario, criticised USAir sharply for apparently ignoring the December 1990 interim report's recommendations on de-icing. It has emerged since that no copies of the report were forwarded to any US agency or airline.

FLIGHT INTERNATIONAL 8 - 14 April, 1992

Safety information

Accident

Accident. An occurrence associated with the operation of an aircraft which takes place between the time any person boards the aircraft with the intention of flight until such time as all such persons have disembarked, in which:

- a) a person is fatally or seriously injured as a result of:
 - being in the aircraft, or
 - direct contact with any part of the aircraft, including parts which have become detached from the aircraft, or
 - direct exposure to jet blast,

except when the injuries are from natural causes, self-inflicted or inflicted by other persons, or when the injuries are to stowaways hiding outside the areas normally available to the passengers and crew; or

- b) the aircraft sustains damage or structural failure which:
 - adversely affects the structural strength, performance or flight characteristics of the aircraft, and
 - would normally require major repair or replacement of the affected component,

except for engine failure or damage, when the damage is limited to the engine, its cowlings or accessories; or for damage limited to propellers, wing tips, antennas, tires, brakes, fairings, small dents or puncture holes in the aircraft skin; or

- c) the aircraft is missing or is completely inaccessible.

Incident

Incident. An occurrence, other than an accident, associated with the operation of an aircraft which affects or could affect the safety of operation.

Note.— The types of incidents which are of main interest to the International Civil Aviation Organization for accident prevention studies are listed in the Accident/Incident Reporting Manual (Doc 9156).

Occurrences

Incident reporting systems

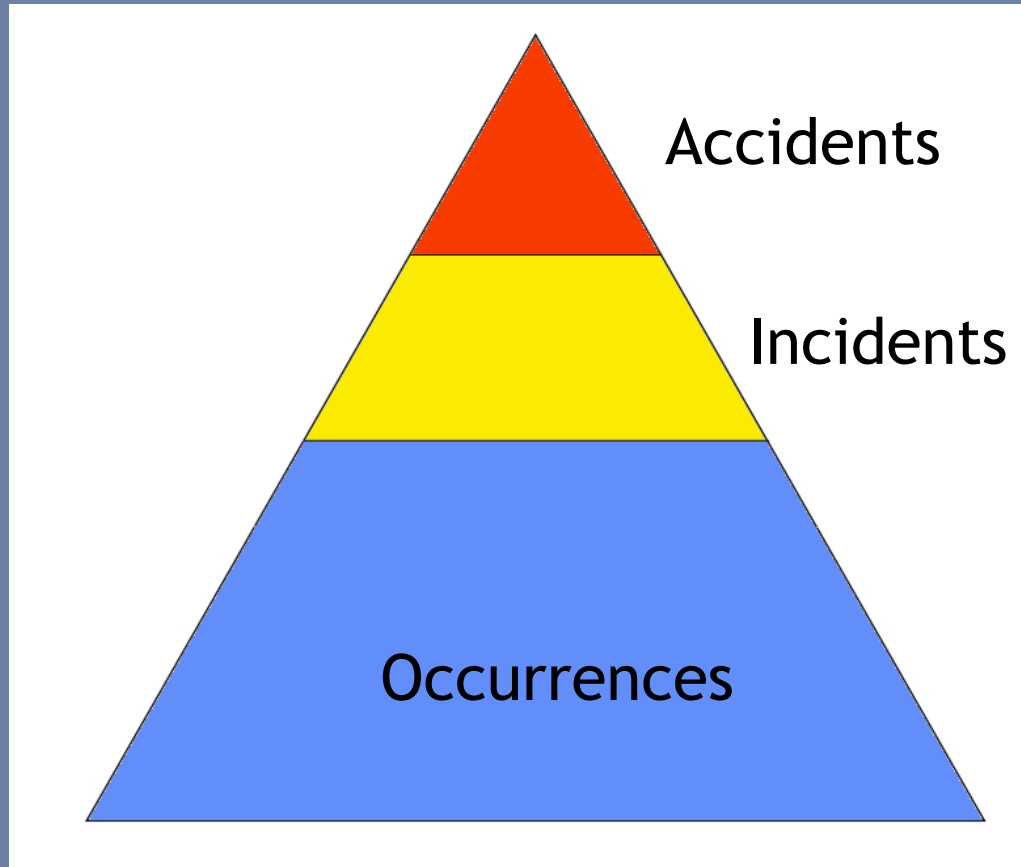
8.1 A State shall establish a mandatory incident reporting system to facilitate collection of information on actual or potential safety deficiencies.

8.2 **Recommendation.—** *A State should establish a voluntary incident reporting system to facilitate the collection of information that may not be captured by a mandatory incident reporting system.*

8.3 A voluntary incident reporting system shall be non-punitive and afford protection to the sources of the information.

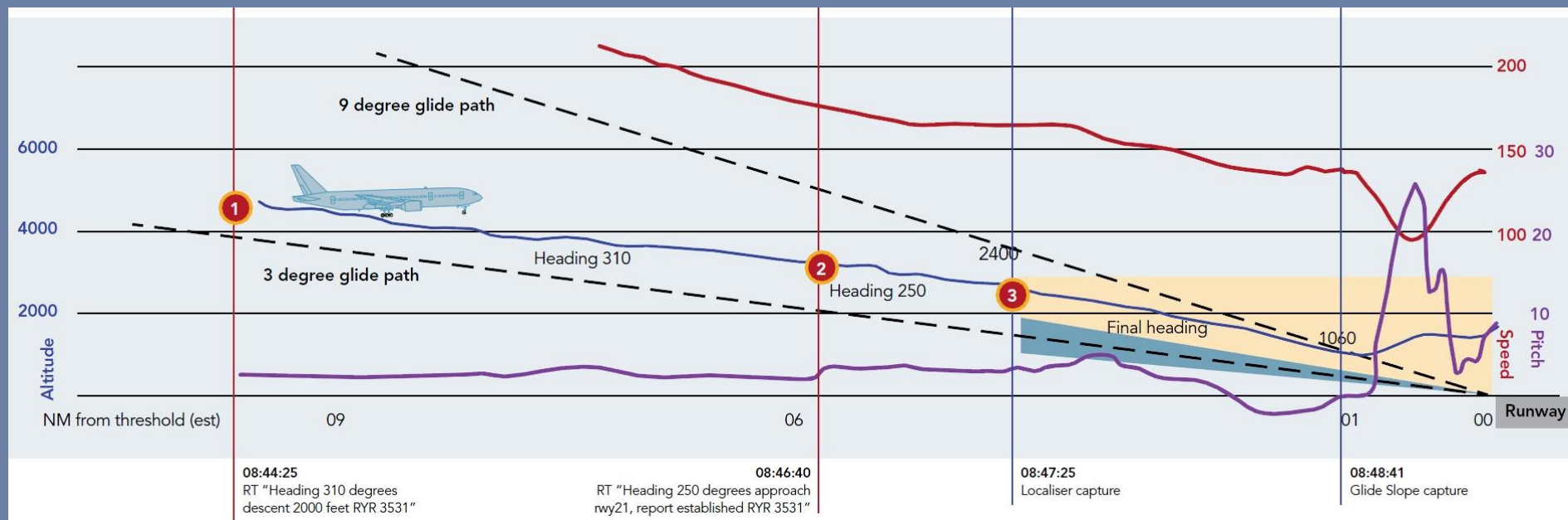
ICAO Annex 13

Safety information



Heinrich Pyramid

False glideslope report



False glideslope report

BEA
 Bureau d'Enquêtes et d'Analyses
 pour la sécurité de l'aviation civile
 www.bea.aero

Approach above glide path increase in pitch

Aircraft	Air
Date and time	13
Operator	Air
Place	Or
Type of flight	Int
Persons on board	Ca Cc
Consequences and damage	Nc

This is a courtesy translation by the BEA as the translation may be, the original is

HISTORY OF FLIGHT

Note: the history of flight has been drawn from air navigation services' radar data and from the aircraft cockpit voice recorder (CVR) notified to the BEA.

The crew took off from Bamako (Mali) for Paris Charles de Gaulle (CDG) a visibility procedure (LVP) was in full precision approach.

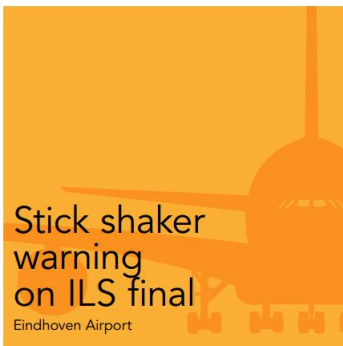
The aeroplane was stable at FL90 a Autopilot 1 was engaged in HDG mode. The speed was stable at 250 crew was in contact with CDG approach.

At 04 h 40 min 20, the controller cleared the aeroplane, stable at FL90, to descend to FL60. They selected autopilot mode changed to OP DES (LOC*) and then the LOC mode engaged and was 17.5 NM from the threshold controller requested that a speed of speed was about 250 kt. The crew The controller apologised for his 3,000 ft to intercept the 08R ILS.

The crew selected 220 kt and 3,000 ft. The OP DES mode remained active. The aeroplane speed and rate of descent decreased⁽¹⁾ which resulted in increasing the deviation from the glide path. The crew extended the airbrakes. When the aeroplane speed reached the target speed of 220 kt, the rate of descent increased again to a value of -1,840 ft/min⁽²⁾.

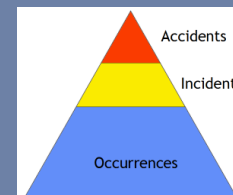
⁽¹⁾In OP DES mode, the decrease in speed has priority over the acquisition of altitude.

⁽²⁾At that moment, there was a 10 kt head wind. The rate of descent for a glide path of 3° at the aeroplane's speed is about 1,100 ft/min.



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5 Recommendations
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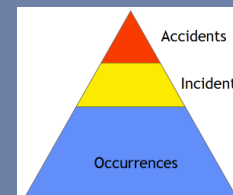
False glideslope report

A narrative search was performed on the ASRS database with the key words: 'False Glide Slope', 'False Glideslope' and 'False GS'. The result was 57 occurrences related to False Glide slopes. These occurrences were analysed further.


Example ASRS report number 1054754

Boeing 737-300, 20 December 2012, altitude 3,000 feet

This event occurred during approach to Runway 28L. The ceiling was approximately 1,500 ft MSL, requiring ATC vectors to the approach. There was other traffic in the area and we were vectored to final behind them. ATC had slowed us to 150 KIAS, which, in our type of aircraft, requires landing gear down, and flaps 15. This is a high amount of drag to have, especially in level flight. I was the pilot flying. I was given an intercept heading to join the localizer, and cleared for the approach. The autopilot was engaged, and I armed the VOR/LOC mode. It was clear that the localizer was going to capture at about the same time as the Glide Slope was intercepted. As soon as the FMA changed VOR/LOC to green (captured), I selected the approach function, and the Glide Slope indication went to green (captured) almost immediately. The Glide Slope indicator then trended downward, showing that we were getting high on the desired path. The autopilot, instead of pitching down to follow the Glide



False glideslope report

 **SAFETY ALERT**

Date: November 18, 2013

UNEXPECTED AUTOPILOT BEHAVIOUR ON ILS APPROACH

Potential severe pitch-up upset when intercepting the instrument landing system (ILS) glide slope from above, which can lead to (approach to) stall conditions.

The particulars

- Different types of Instrument Landing System (ILS) glide slope systems are used worldwide. Signal characteristics in the area above the (standard) 3 degree glide slope are system dependent.
- Similar glide slope capture logic in automatic flight control systems (autopilot) is used for the majority of aircraft types currently in service worldwide.
- While intercepting the ILS glide slope signal from above the 3 degree flight path with the automatic flight control system engaged, the aircraft can capture a false glide slope resulting in an unexpected rapid pitch-up command (automation surprise).

Preliminary investigative findings

The Dutch Safety Board is investigating a severe and sudden pitch-up upset during an ILS approach to Eindhoven Airport in 2013. The airspeed dropped rapidly to a near stall situation (stick shaker). The crew carried out a go-around. During the investigation the Board has become aware of similar events. Analysis revealed that the common factor linking these events is the ILS antenna type; M-array (Capture effect) ILS antenna. The M-array ILS antenna type is used around the world, including at major airports and military air bases in the Netherlands.

Regulations mandate that ILS systems be periodically checked with a Flight Inspection in order to be certified for operational use. The Flight Inspection focuses exclusively on the 3 degree glide slope area. The signal characteristics in the area above the 3 degree glide slope were examined as part of the Dutch Safety Board's investigation. Flight tests were conducted to measure the M-array antenna signal and determine the 'glide slope field' characteristics above the 3 degree glide path while established on the localizer.

- 3 -

6 RECOMMENDATIONS

Based on the findings and conclusions the Dutch Safety Board made the following recommendations.

The Dutch Safety Board made the following recommendations to the regulators involved with the manufacturing of transport category aircraft; European Aviation Safety Agency (Europe), Federal Aviation Administration (USA), Agência Nacional de Aviação Civil (Brasil), Civil Aviation Administration of China, Federal Air Transport Agency (Russian Federation), Japan Civil Aviation Bureau, and Transport Canada.

1. Information and awareness

Ensure that the established False Glide Slope characteristics and the possible associated consequences for aircraft are made widely known and are modified accordingly in the published manuals and training material used in the aviation sector. This specifically refers to:

- a. the area above and below the published or nominated ILS Glide Path;
- b. the absence of warnings in the cockpit when flying with the automatic flight systems engaged in the area above the published or nominal ILS Glide Path.

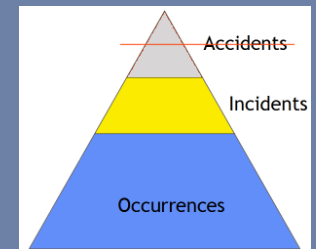
2. Short term measures

Ensure with oversight that aviation operators, manufacturers, and Air Navigation Service Providers take mitigating actions to prevent pitch-up upsets due to aircraft exposure to False Glide Slope Reversal as a result of flying with the automatic flight systems engaged in the area above the published or nominated ILS Glide Path. This can be achieved by means of:

- a. operational measures;
 - raising the interception of the ILS Glide Slope from below to a Standard, or in the event of an interception from above,
 - developing additional operating procedures.
- b. technical measures;
 - automated on-board systems when in use should not cause a pitch-up upset, at least not without a preceding clearly recognizable warning and with ample time for flight crew intervention.

3. Long term measures

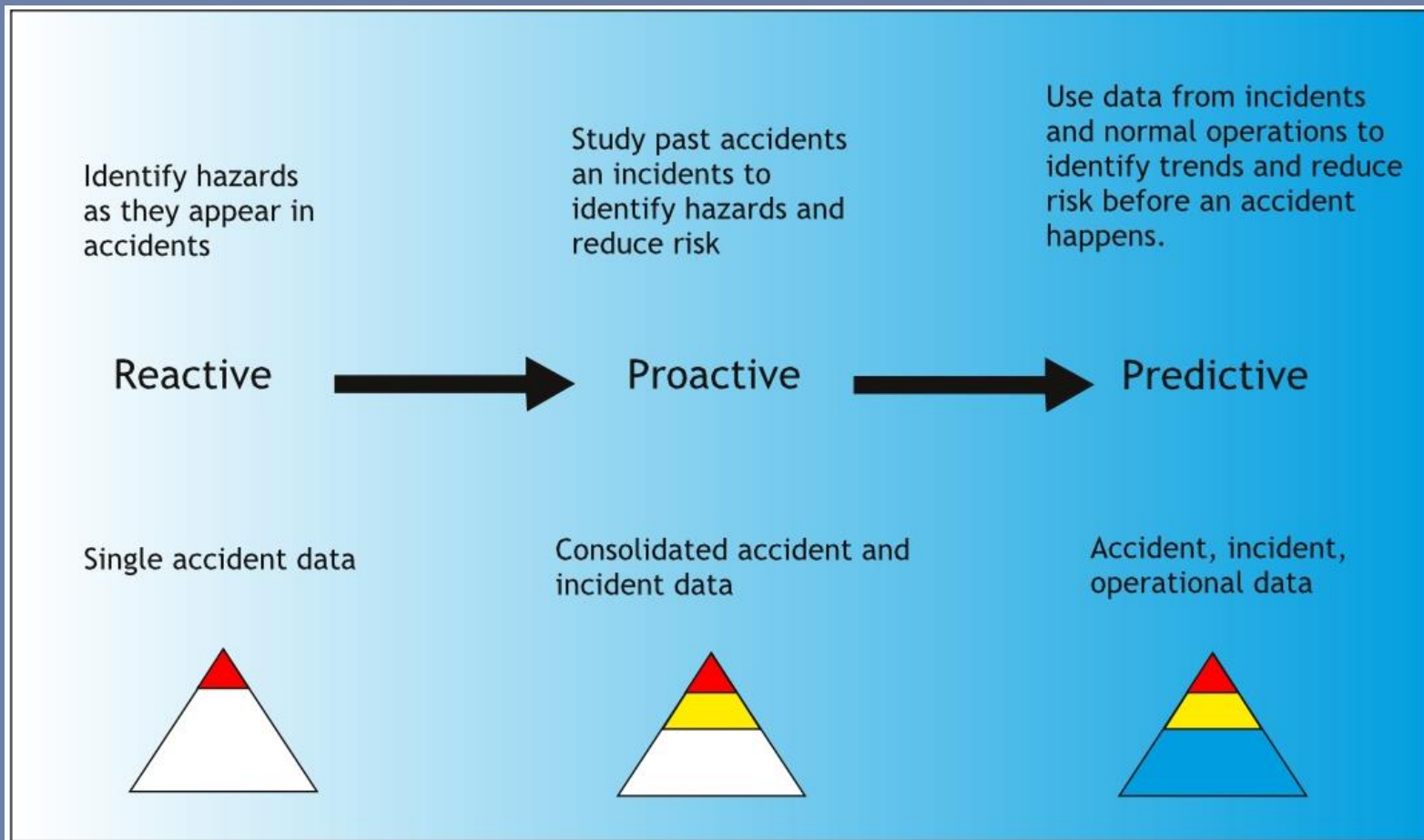
Stimulate that aircraft manufacturers in the long term develop new landing systems to accommodate new approaches for aircraft with automatic flight systems engaged and ensure that airports are equipped with these landing systems.



Contents

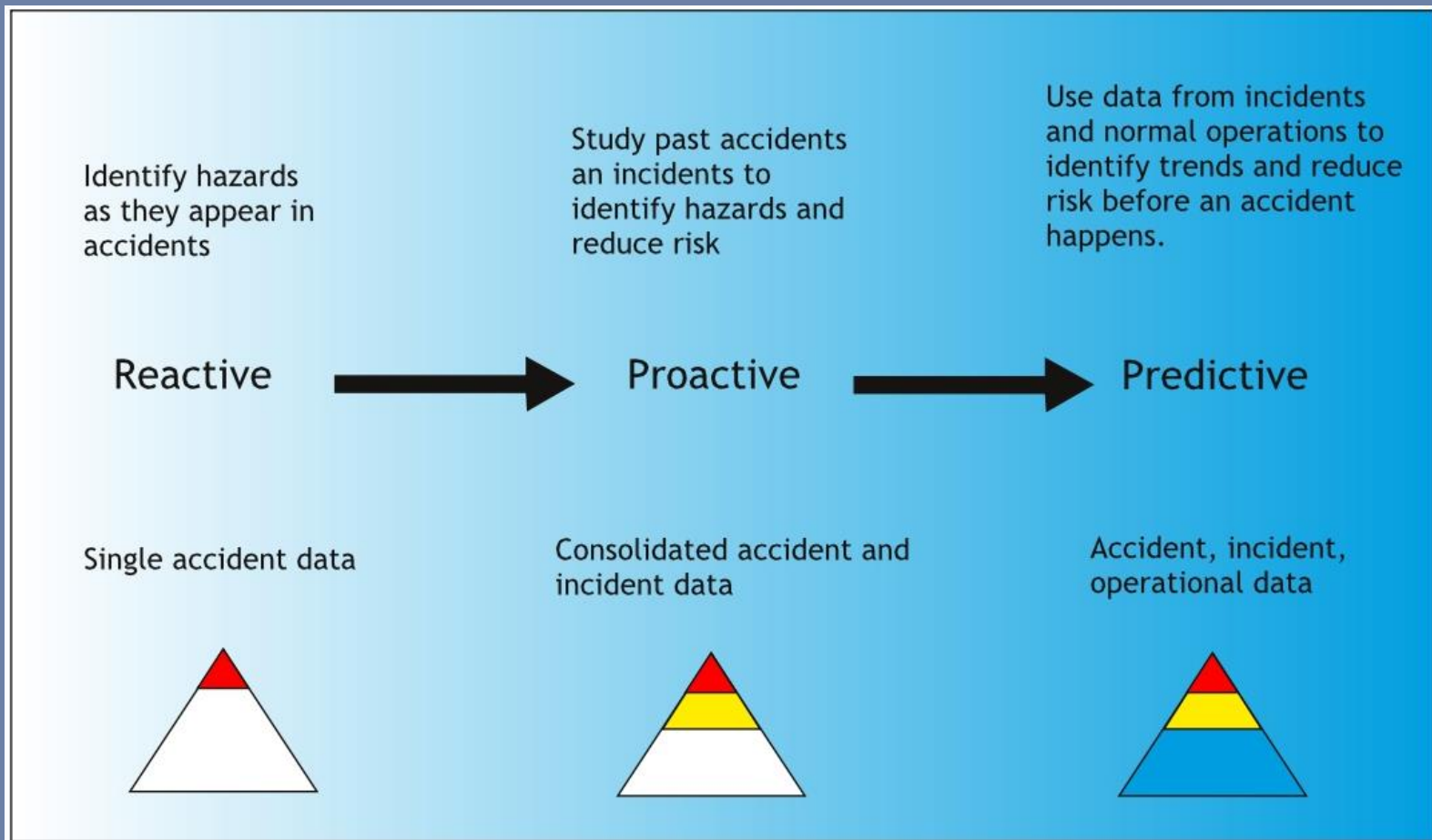
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- Challenges in aviation safety information

Challenges



Spectrum of Safety model (adapted) from J. Burin, FSF

Challenge 1 - use of data available



database
ker F-28

Challenge 2 - data entry

Quality of data entry

8 found

8 records meet your search criteria.

A docket of supporting materials may exist for factual and probable cause reports. Please contact Records Management Division. Dockets are not available for preliminary reports.

[Accident Database & Synopses](#) [Download XML](#) [Download Delimited Text](#)

Current Synopsis	PDF Report(s) (Published)	Event Date	Location	Make/Model	Regist. Number	NTSB No.	Event Severity	Type of Air Carrier Operation and Carrier Name (Doing Business As)
Foreign	Factual (04/29/2004)	1/9/2003	Chachapoyas, Peru	Fokker F-28 MK 1000		FTW03RA083	Fatal(46)	
Probable Cause	Probable Cause (06/30/2004)	3/6/2002	Dallas, TX	Fokker F-28 MK-100	N1425A	FTW02LA088	Nonfatal	
Probable Cause	Factual (11/25/1998)	5/13/1998	FT. WAYNE, IN	Fokker F-28 MK100	N1400H	CHI98LA154	Nonfatal	(DBA: AMERICAN AIRLINES)
Probable Cause	Probable Cause (07/02/1999)							
Probable Cause	Factual (04/06/1995)	11/23/1994	EVANSVILLE, IN	FOKKER F-28-4000	N479AU	CHI95IA045	Incident	
Probable Cause	Probable Cause (05/16/1995)							
Probable Cause	Factual (08/26/1994)	1/26/1993	DETROIT, MI	FOKKER F-28 MK 1000	N452US	CHI93IA078	Incident	USAIR (DBA: USAIR)
Probable Cause	Probable Cause (09/05/1991)	8/19/1989	VERO BEACH, FL	FOKKER F-28 MK4000	N489US	MIA89LA228	Nonfatal	USAIR (DBA: USAIR)
Probable Cause	Factual (07/10/1989)	10/3/1987	BALTIMORE, MD	FOKKER F-28-MK-1000	N288N	BFO88IA001	Incident	
Probable Cause	Factual (02/06/1995)	10/24/1985	FLUSHING, NY	FOKKER F-28	N510	NYC86IA019A	Incident	EMPIRE AIRLINES, INC.
Probable Cause	Probable Cause (02/06/1995)							

NOTES:

- On Jan. 8, 2001, dynamic access to the accident data repository was implemented. Static files are no longer available.
- On Oct. 2, 2001, minor cases which do not fall under the definition of "accident" or "incident" were removed from the database; these entries were previously identified with "SA" in the accident number.
- On Sept. 18, 2002, data from 1962-1982 were added to the aviation accident information. The format and type of data contained in the earlier briefs may differ from later reports.

** - Do not use these fields as selection parameters if your date range includes pre-1982 dates, as they did not exist prior to 1982 and their use may falsely limit the data returned.

[Aviation Page](#) | [Switch to Monthly Lists](#)

NTSB online database
 Search: Fokker F-28

Challenge 2 - data entry

Quality of data entry

41 found

41 records meet your search criteria.

A number of supporting materials may exist for factual and probable cause reports. Please contact Records Management Division. Dockets are not available for preliminary reports.

Accident Database & Synopses [Download XML](#) [Download Delimited Text](#)

Current Synopsis	PDF Report(s) (Published)	Event Date	Location	Make/Model	Regist. Number	NTSB No.	Event Severity	Type of Air Carrier Operation and Carrier Name (Doing Business As)
Foreign		7/1/2010	Warsaw, Poland	FOKKER F28		ENG11WA010	Incident	
Foreign		5/4/2010	Bogota, Colombia	Fokker F28		DCA10WA058	Incident	
Foreign		9/22/2008	Quito, Ecuador	Fokker F28-4000		MIA08WA200	Nonfatal	
Probable Cause	Factual (11/18/2004)	9/4/2003	Flushing, NY	Fokker F-28 Mk 0100	N1450A	NYC03FA190	Nonfatal	
	Probable Cause (01/24/2005)							
Foreign		1/17/2003	Quito, Ecuador	Fokker F28		FTW03RA085	Nonfatal	
Foreign		1/9/2003	Chachapoyas, Peru	Fokker F-28 MK 1000		FTW03RA083	Fatal(46)	
Probable Cause	Factual (07/30/2003)	9/5/2002	Minneapolis, MN	Fokker 100	N1473K	CHI02IA270	Incident	
	Probable Cause (09/30/2003)							
Probable Cause	Factual (04/29/2004)	3/6/2002	Dallas, TX	Fokker F-28 MK-100	N1425A	FTW02LA088	Nonfatal	
	Probable Cause (06/30/2004)							
Probable Cause	Factual (06/12/2003)	10/3/2001	DFW Airport, TX	Fokker F28 Mk 0100	N1448A	FTW02FA003	Nonfatal	
	Probable Cause (08/26/2003)							
Foreign		9/15/2001	Belo Horizonte, Brazil	Fokker F28 Mk 100		ENG01RA010	Incident	
Foreign		7/16/2001	TULCAN, Ecuador	Fokker F28		WAS01RA016	Nonfatal	
Probable Cause	Factual (08/19/2003)	5/23/2001	DFW Airport, TX	Fokker F28 Mk 0100	N1419D	FTW01FA127	Nonfatal	
	Probable Cause (11/25/2003)							
Probable Cause	Factual (10/16/2001)	3/6/2001	Montreal, Canada	Fokker F28 MK 0100	N1426A	CHI01IA102	Incident	
	Probable Cause (11/01/2001)							
Probable Cause	Factual (09/04/2001)	2/6/2001	Boston, MA	Fokker F28 MK 0100	N1457B	NYC01LA077	Nonfatal	
	Probable Cause (08/27/2001)							

NTSB online database
 Search: Fokker 28

Challenge 3 - taxonomies vs mapping

Do we need a common taxonomy or a common mapping?

ECCAIRS 4	Aviation Operations	Data Definition Standard
1000000	Commercial Air Transport <i>Commercial air transport operation. An aircraft operation involving the transport of passengers, cargo or mail for remuneration or hire. Annex 6 Part 1, Chapter 1.</i>	Commercial Air Transport
1010000	Scheduled air service <i>Scheduled air service: an air service open to use by the general public and operated according to a published timetable or with such a regular frequency that it constitutes an easily recognizable systematic series of flights which are open to direct booking by members of the public. ICAO DOC 9626.</i>	Scheduled revenue ops
1010100	Scheduled international <i>International air service: A flight with one or both terminals in the territory of a State, other than the State in which the carrier has its principal place of business.</i>	International
1010101	Scheduled international passenger flight <i>A flight carrying one or more revenue passengers. Note: this includes flights which carry, in addition to passengers mail or cargo.</i>	Passenger
1010102	scheduled international cargo flight <i>This is to be used for all-freight services only. Cargo includes freight, unaccompanied baggage and mail.</i>	Cargo
1010200	scheduled domestic <i>A flight not classifiable as international. Domestic flight include flights flown between point within the domestic boundaries of an air carrier whose principal place of business is in that State. Flights between a State and territories belonging to it, as well as any flights between two such territories are also classified as "domestic". This applies even though a flight may cross international waters or over the territory of another State.</i>	Domestic
1010201	scheduled domestic passenger <i>A scheduled flight carrying one or more revenue passengers. Note: The flight may also carry mail or cargo.</i>	Passenger

Challenge 3 - human vs system

Systems & taxonomies have to adapt to their users, not the other way around

The screenshot displays the ECC AIRS (European Cockpit Association Incident Reporting System) web interface. The top navigation bar includes 'Query Results', 'Query Database', and 'Statistics'. The main content area is titled 'Taiwan Island, ASC-AOR-06-03-001'. On the left, a tree view shows the incident details, including 'Narrative (English)', 'Events', 'Weather', 'History of flight', 'Injuries', 'Aircraft recordings', 'Aircraft meteo', 'Air traffic services', 'Flight Crew', 'Pilot-in-command', 'Co-pilot', 'Aerodrome (China - RCSS (TSA): Ta)', 'Recommendations', and 'Management'. The right pane shows the 'Filing information' section with the following details:

Filing information						
Headline	Runway Overrun during landing on TSA Airport, TransAsia Airways GE536 , B-22310, A320-200					
State reporting	Taiwan Island	Date entered	2-8-2011			
State file number	ASC-AOR-06-03-001	Reporting org.	Taiwan (ASC)			
When						
Local date	18-10-2004	17:59:00	UTC date	18-10-2004	9:59:00	
Where						
State/area of occurrence	Taiwan Island	Latitude of occ	23:30 North			
Location of occ	RCSS Airport	Longitude of occ	119:27 East			
Classification						
Occurrence class	Accident	Occurrence category	RE: Runway excursion			
Severity						
Damage aircraft	Substantial	Damage aerodrome	None			
Third party damage	No	Injury level	None			
Injury totals						
	Fatal	Serious	Minor	None	Unknown	Total
Total on ground	0	0	0	0	0	0
Total on aircraft	0	0	0	106	0	106
Grand total	0	0	0	106	0	106
ATM relation						
ATM contribution	None					
	Effect on ATM service					

Challenge 4 - formal reports

No easily accessible/searchable repository of formal investigation reports

Challenge 4 - formal reports

Not all formal reports in an ICAO language

Sadržaj Zračnog incidenta CESSNA CITATION BRAVO C550B, ZL BRAC, 15. srpnja 2010.

OSNOVNI PODACI

Zrakoplov

Vlasnik:	PA Beograd, Srbija
Operator:	PA Beograd, Srbija
Model zrakoplova:	Proizvođač: CESSNA – USA Tip i model: CESSNA 550 B Serijski broj: 550-1049
Država i registracija:	Srbija Registracija: YU-BSG
Mjesto događaja:	Zračna luka Brač
Datum događaja:	15.07.2010.



KRATKI SADRŽAJ

Zrakoplov YU-BSG poletio je dana 15. srpnja 2010. godine u 16:06 sa luke Tuzla, Albanija za Zračnu luku Brač, Hrvatska. Posada je dobila odobrenje od k. leta za slijetanje na Zračnu luku Brač. Staza u upotrebi bila je 04. Zrakoplov je do uzletno-sletne staze u 16:44. Nakon dolaska u podlogonu, piloti su prvo uključili ko motorom nakon čega su pristigom na poprište za kočenje pokušali završiti zrakoplov zaključnog kočenja došlo je do izljetanja zrakoplova s uzletno-sletne staze, preko ograde, prelaska preko zaštitnog pojasa i pada na kamenje i makiju na dubini od metara. Od posljedica udara zrakoplova u kamenje došlo je do zapaljenja zrakoplova. zrakoplova bezim reakcijom završila je devetke gurnu i uključila napajanje na glj prekidu, a u međuvremenu je domaćica zrakoplova pripremila putnike za evak Putnici i posada uspješno su, bez povreda, napustili zrakoplov i udaljili se na pr udaljenost. Brzom intervencijom vatrogasne postrojbe Zračne luke Brač ugašen je p zrakoplova.

1.1. PRIPREMA ZA LET I POVIJEST LETA

1.1.1. Općenito

Djelomična rekonstrukcija prilaza i izljetanja zrakoplova YU-BSG s u sletne staze napravljena je na temelju izjava pilota, kontrolora leta, očitanja iz Bilježnice parametara leta, Bilježnice razgovora i očevidaca.

AZI

Sadržaj

REDEGORELSE			
HCLJ510-000668	Havari	Registrering:	OY-POF
Luftfartøj:	DHC-6 Twin Otter	Flyvning:	Charter, VFR
Motorer:	2 - PT6A-27	Passagerer:	lægen
Besætning:	2 - ingen tilkædetkomne	Dato og tidspunkt:	29.7.2009 kl. 1200 LT
Sted:	73.24N 24.30W		

Havarikommissionen for Civil Luftfart og Jernbane (HCLJ) fik meddelelse om havariet fra operat 29.7.2009 kl. 1700 UTC.

Flyvningens historie

Havariet indtraf i forbindelse med en VFR fragtflyvning fra Mestervig (BGMV) til position 73.2 30W. Piloterne havde tidligere på dagen fløjet den samme rute (BGMV - 73.24N 24.30W - BG

Ved ankomst til det valgte landingsområde valgte piloterne at lave en lav overflyvning for at bed vindsforholdene. Det var piloternes vurdering, at vindretningen var skiftende med en vindstyrke p knob.

Umiddelbart før baneenden var det piloternes oplevelse, at luftfartøjet blev udsat for en uventet rettet vindstrømning (downdraft), hvilket medførte, at det højre hovedhjul fik kontakt med jorden i tilnærkede landingsbane. Luftfartøjet kom i luften igen, og ved den efterfølgende sætning tippede luft over mod højre, hvor et flaphængsel på højre vinge fik kontakt med jorden med skader på højre kare og flap til følge.

Havariet indtraf i daglys og under usædvanlige meteorologiske vejrforhold (VMC).

מדינת ישראל
משרד התחבורה והבטיחות בדרכים
חקירות תאונות ותקריות אווירדוח חקירה בטיחותית
(דוח סופי)

תיק תקרית חמורה מס' 100-14

תקציר האירוע

ביום ראשון, בתאריך 10.8.2014, בשעה 16:18 (זמן מקומי), המריאה טיסה OTJ874 על מסלול 08 בנתיב, עם 2 טייסים, 4 דיילים ו- 169 נוסעים. לאחר ההמראה ותוך כדי הטיפוס, בהיות המטוס בדומית מורחית לנקודה NIREL, בגובה של 6,000 רגל מעפ"י, הצוות הבחין בעליית הטמפרטורה של צינור הפליטה (EGT, Exhaust Gas Temperature) במנוע מס' 1 (שמאל) מעל 800 מעלות. במקביל, על פי דיווח צוות הקבינה, נשמע רעש חזק, רעית, בחלקו האחורי של המטוס וחורש רעידות חזקות בקבינה.

הטייס טיפל מידית בתקלה, מספר שניות מקבלת החיווי וכיבה את מנוע שמאל. הטמפרטורה ירדה ולא התקבל חיווי של אש במנוע. הצוות הדעיץ למגדל על הכשל מנוע בדיווח: "We have one engine failure Ben Gurion Departure OTJ874".

פקח הגישה בכו גוריון החל מיד בפינוי המרחב, לצורך נחיתת OTJ874, ולשם כך הפנה מספר כלי טיס ממסלולם. הדיווח הראשוני הובן במגדל כדיווח על כשל בשני המנועים, ולכן הוכרז על "מצב חירום 3" וחולו הבנת בשדה לחיית חירום, לרבות הוצעת כוחות כיבוי והצלה. לאחר כעשרים שניות שונתה ההכרזה ל- "מצב חירום 2".

צוות הטיסה שידר בתחילה שכונתו לנחות על מסלול 08, הופנה לנחיתה בגישת ILS למסלול 21 ובסופו של תהליך הוצע לו ע"י המגדל הוא נחת על מסלול 26. המטוס נחת בשלום, בשעה 16:35 (זמן מקומי).



המטוס נשאו התקרית

3

משרד החוקר הראשי – חקירות תאונות ותקריות אוויר

Challenge 5 - level of investigation

Funding and available manpower determine number of investigations

Recommendation 3

4.43 The committee recommends that the ATSB move away from its current approach of forecasting the probability of future events and focus on the analysis of factors which allowed the accident under investigation to occur. This would enable the industry to identify, assess and implement lessons relevant to their own operations.

Challenge 6 - transparency

Availability of accident information for research

The screenshot displays the ECC AIRS web interface. The top navigation bar includes 'Query Results', 'Query Database', and 'Statistics'. Below this, the breadcrumb trail reads 'Occurrence ASC-AOR-06-03-001 - Taiwan Island'. The 'Current view' is set to 'WEBDAS ADREP VIEW'. The left sidebar shows a tree structure of data categories, with 'Taiwan Island, ASC-AOR-06-03-001' selected. The main content area displays the following information:

Taiwan Island, ASC-AOR-06-03-001

Filing information

Headline	Runway Overrun during landing on TSA Airport, TransAsia Airways GE536 , B-22310, A320-200				
State reporting	Taiwan Island	Date entered	2-8-2011		
State file number	ASC-AOR-06-03-001	Reporting org.	Taiwan (ASC)		

When

Local date	18-10-2004	17:59:00	UTC date	18-10-2004	9:59:00
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Where

State/area of occurrence	Taiwan Island	Latitude of occ	23:30 North
Location of occ	RCSS Airport	Longitude of occ	119:27 East

Classification

Occurrence class	Accident	Occurrence category	RE: Runway excursion
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Severity

Damage aircraft	Substantial	Damage aerodrome	None
Third party damage	No	Injury level	None

Injury totals

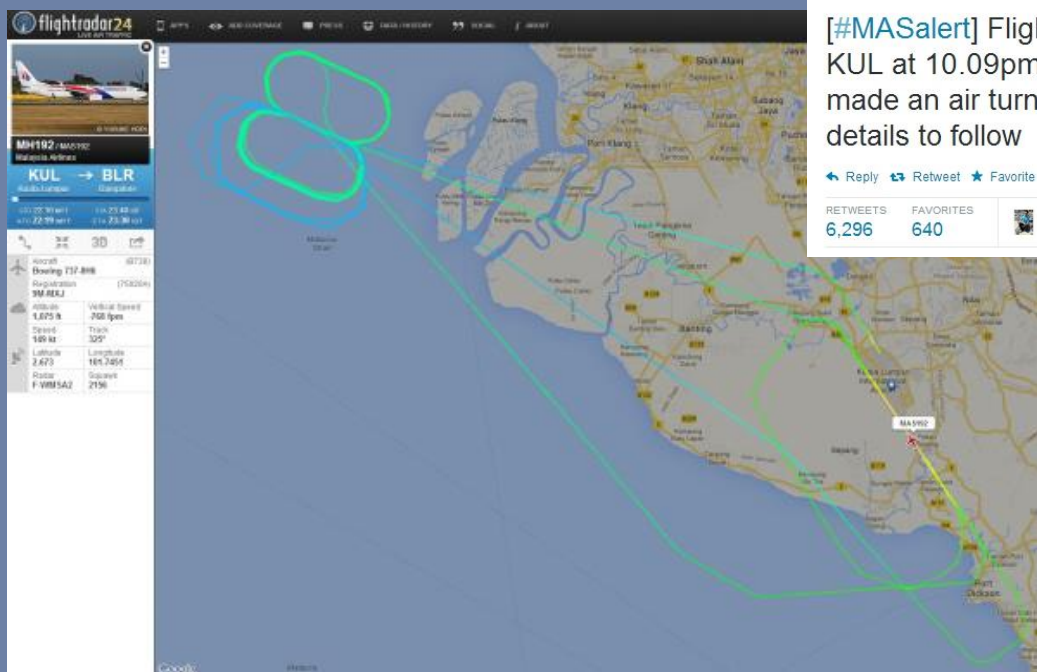
	Fatal	Serious	Minor	None	Unknown	Total
Total on ground	0	0	0	0	0	0
Total on aircraft	0	0	0	106	0	106
Grand total	0	0	0	106	0	106

ATM relation

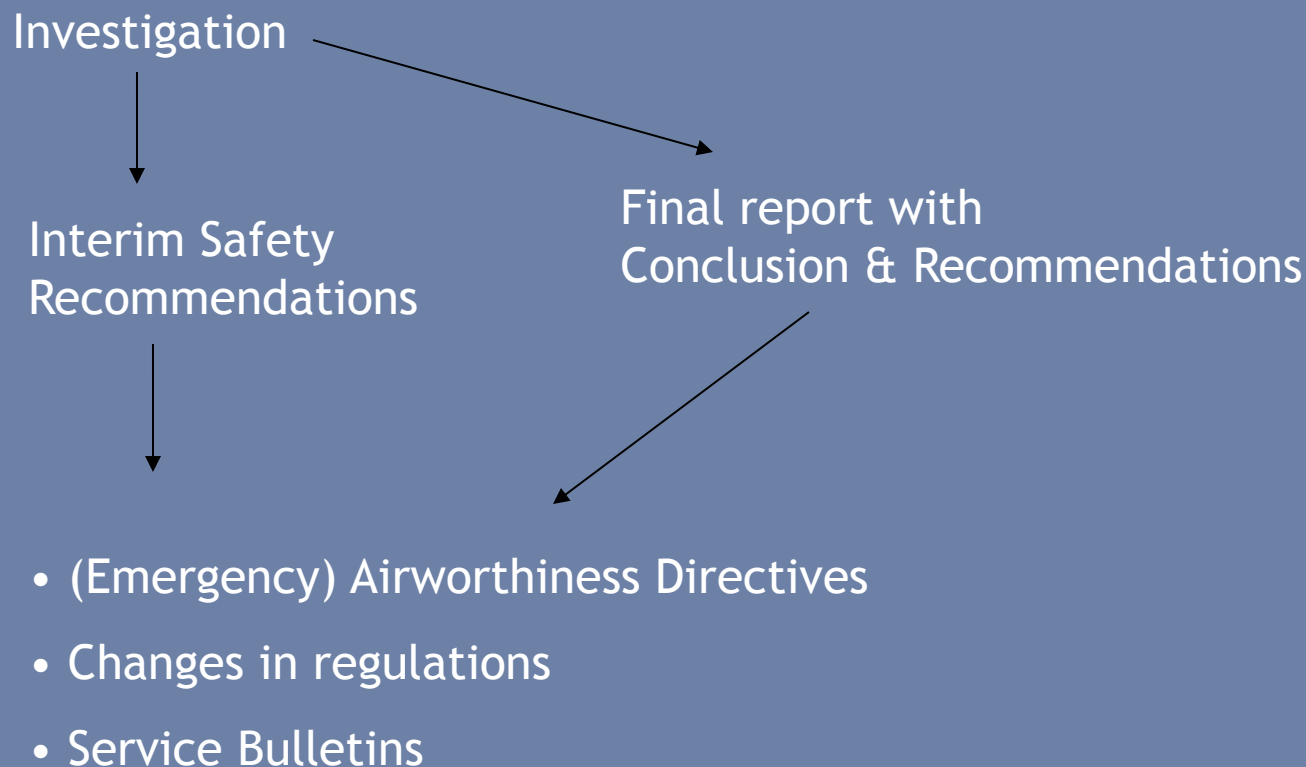
ATM contribution	None	Effect on ATM service
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Challenge 7 - timeliness

Media and public demand immediate incident information

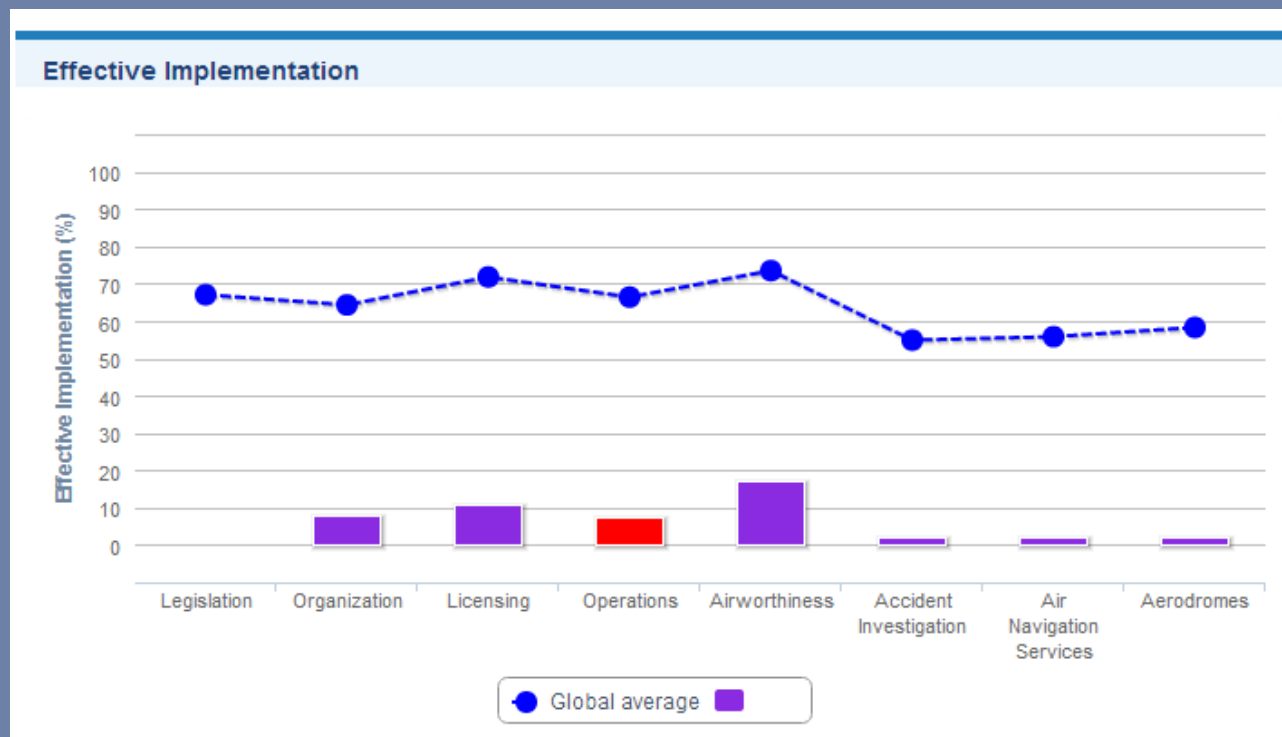


Challenge 8 - safety oversight



Challenge 8 - safety oversight

How sharing accident and incident information results in a.o. AD's and effectiveness also depends on country's EI.



Challenge 9 - Safety Recommendations

Safety recommendations of previous investigations regarding safety information

Consequently, the BEA recommends that:

- **EASA improve the feedback process by making mandatory the operational and human factors analysis of in-service events in order to improve procedures and the content of training programmes; [Recommendation FRAN-2012-052]**

and specifically,

- **that the DGAC take steps aimed at improving the relevance and the quality of incident reports written by flight crews and their distribution, in particular to manufacturers. [Recommendation FRAN-2012-053]**

AF447 report

Thank you

More information:

<http://aviation-safety.net>

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Aircraft accident prevention

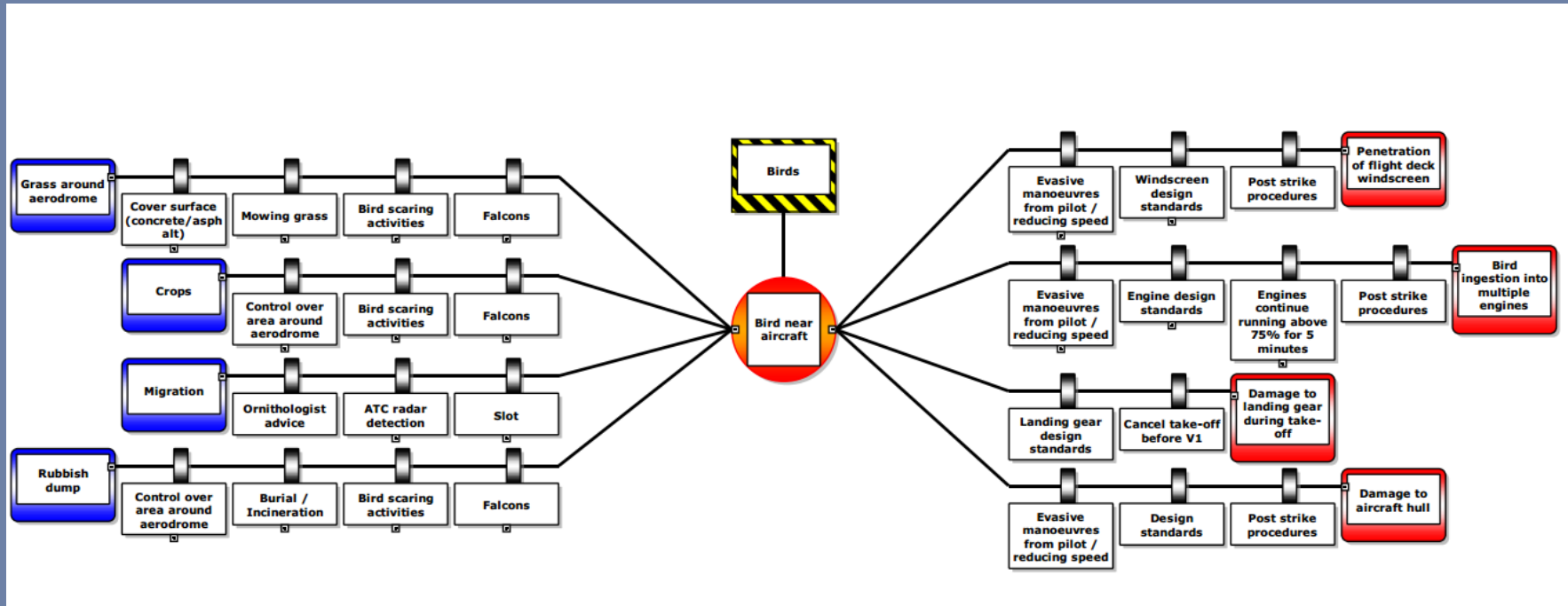
Visualisation missing airliners



2013 - accident locations



Challenges



Bird Strike Bowtie from
 CGE Risk Management Solutions