PRISM

A member of the SGS Group

FIXED WING NEWSLETTER

October 2022 | Volume XXII | Issue X

SAFETYWIRE

AINsight: A Visual Approach Gone Bad

(Originally Published in AIN online by Stuart "kipp" Lau– August 26, 2022 11:57am)

A visual approach is the first type of approach taught during primary flight training. A well-flown VFR traffic pattern in a light aircraft is benign. At each point, downwind, abeam the numbers, base leg, and turning final, student pilots are taught to fly the appropriate power setting, airspeed, and configuration, all leading to a nice stable uneventful approach and landing.

In a large turbine-powered aircraft, a visual approach is far less common or predictable. A past Flight Safety Foundation (FSF) study found that 41 percent of all approach and landing accidents began with a visual approach.

For a pilot, the primary goals of a visual approach are to be safe, legal, and try not to embarrass yourself. On occasion, the latter happens. If not properly planned and executed, a visual approach has the potential to lead to complete chaos on the flight deck.

Case in point, I will share a personal "experience" not only to show my vulnerabilities but to demonstrate that a pilot with nearly 40 years of flying experience will, on occasion, embarrass themself.

A visual approach gone bad will become deeply rooted in your memory. I may not remember what I had for dinner last night, but can recall every exacting detail of this botched visual approach as if it happened yesterday, even though this event occurred almost four years ago.

Here's the set-up: it was the fourth and final leg of the day from a small Midwest airport to a little larger Midwest airport. The scheduled flight time for this repositioning flight was only 45 minutes, and the weather was CAVU across the entire region.

I was the pilot flying and had a highly experienced first officer—although he was new to the company—who would be the pilot monitoring (PM). At this point, the sun was rising from the East—the same direction that we were flying. Before top-of-descent, the PM had copied down ATIS, computed the landing data for a reduced flap landing, and had sent the in-range message with the most important canned note: "call hotel van."

Next, I would thoroughly brief the approach—a "visual backed up by the ILS"—and we discussed the nuances of a reduced flap landing. At lighter weights, a reduced flap landing will provide a Vapp that is more appropriate for a heavy jet (plus it's quieter,

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more fuel efficient, etc.). Covered were the required items such as selecting the appropriate landing data, corrected Vapp in the FMC, GPWS flap override switch to "ON," and a discussion about a reduction in drag, which would require us to slow down earlier than normal.

The descent checklist was completed and, as we neared top-of-descent, we could see the airport. We were both familiar with this airport since it's a regional hub for our operation.

Passing through 16,000 feet, the en route center controller handed us off to approach control. The approach controller then cleared us direct to the final approach fix (FAF) and gave us a further descent clearance to 3,000 feet (2,500 feet was the FAF altitude).

At this point, the aircraft was in the clean configuration at 250 knots, and we were on a dog leg to the final approach course. We seemed to be squared away.

With the runway in sight and sensing a higher workload for the controller (he was also working a combined tower and ground frequency) and a desire to continue the descent to 2,500 feet, we both agreed that we could fly the visual approach. The PM requested it and the controller obliged and cleared us for the visual approach.

This is where it started to go bad. Although we were established "on path" to cross the FAF at 2,500 feet, I was fast—way fast. As I extended the speed brakes, my inner "John Wayne" kicked in and without further evaluation, I blurted out "autopilot off, autothrottles off" and flipped the flight director switch to flight path vector. Safety "experts" say there is an "an overreliance on automation" and "not enough hand flying"—that's what was going on in the back of my head.

In retrospect, this was a horrible idea. Not only did I increase my workload, but I loaded up the PM by now having him manipulate the speeds on the mode control panel, in addition to active monitoring duties, configuring the aircraft, setting the missed approach altitude, and running the landing checklist.

Through some miracle, a flurry of commands and arms flailing about the cockpit, we were able to configure the aircraft and slow a bit. Approaching the FAF at about 1,500 feet above field elevation, the aircraft was on path and the speed was slowing through Vapp+40.

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Our company's stabilized approach criteria called for no more than Vapp+10 at 1,000 feet above field elevation. At this point, I realized that the culprit was not only poor situational awareness on my part, but a strong southwesterly tailwind aloft.

Not at all pleased with my work, I made the decision to discontinue the approach, which with our aircraft is a nice, controlled procedure that is essentially a very soft go-around.

After my FO confessed my sins to the tower controller, he then cleared us to enter left traffic for a VFR pattern to the same runway. At this point, still hand-flying, I reverted to my training of the proper configuration and speeds on downwind, abeam the numbers, base, and final. The result was a decent landing and an overworked first officer. (I did apologize—a lot.)

During the ride to the hotel, the first officer and I unpacked the botched approach. In addition to the tailwind aloft and poor situational awareness, a direct clearance to the FAF reduced our track mileage to the runway—this hastened the deceleration portion of the descent. These are all common gotchas when attempting to fly a visual approach.

In addition, we discussed whether this visual approach was safe and legal. While there were several errors made during the descent and approach, the decision to discontinue the approach (as backed by a no-fault go-around policy) trapped most of the errors and prevented them from becoming an undesired aircraft state. So, yes, we were safe since we chose not to continue an unstabilized approach below 1,000 feet above field elevation.

According to the definition of a visual approach, we were completely legal. The approach was authorized by ATC, the airport was VFR, and we always kept the airport in sight during the approach and remained clear of clouds.

In hindsight, we were completely safe and legal, but I was completely embarrassed. If I had to do it over again, I would have considered—after a long day—getting vectors to an ILS approach or squaring the turn to final versus a slight dog-leg.

Most importantly, I should have relied more on automation by keeping the autopilot and autothrottles engaged, contrary to what the experts say. By disconnecting the automation, I increased the workload on the PM not only during the approach but also during the discontinued approach and subsequent VFR traffic pattern.

FSF has produced a series of informative approach and landing accident reduction briefings notes, including one on visual approaches. This is a great resource and should be helpful in guiding any future discussions on visual approaches.

The opinions expressed in this column are those of the author and not necessarily endorsed by AIN Media Group.

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Different Problems, Same Page?

Rhodri Norton-Quick, PRISM

I want you to start an argument. Well, I want you to start a conversation. I want you all to try to convince your peers in non-flying roles that we should be teaching ADM to our entire organizations. The benefit is a company that meshes like a well lubricated gearbox. Sure, someone can always throw a wrench in it, make a very egregious grinding sound, but if we're all using ADM then we can minimize the damage quickly and effectively, and more importantly we "should" all be on the same page about it.

Before we begin, it's probably a good idea to mention one glaring pitfall almost everyone falls into. ADM is not pilot specific. So, what is ADM? Well, it stands for Aeronautic Decision Making. In short, it's a systematic process of evaluation, co-ordination, and execution. You know, problem solving. As aviators this is pretty much beaten into us on every botched landing. Other professions, however, have a far less perceptible learning process. It's obvious when an engine catches fire, there are limited options and those of us in crew aircraft know exactly what is going to happen next. A statement of observation— "Fire Light, Number One", a pressing action— "Emergency Action Items", followed by a checklist— "Engine Fire, Failure, Separation checklist" followed by a calm, collected, and open discussion led by the PIC where options are evaluated, a gameplan is created, roles are assigned, and actions are executed. This realistically takes maybe 10 to 15 minutes. Similar situations happen in other worlds that surround your average pilot, but it's not formal, nobody knows what is going to happen next until someone tells them. It is inefficient and creates the opportunity for a certain level of conflict and confusion; especially between the departments that work with the pilot group such as: Crew Scheduling/Sales, Dispatch, Maintenance, HR, etc.

I would like you to imagine how arrogant, how entitled it must seem for someone in one of those roles to watch a pilot, completely blow up a plan, make wild sweeping decisions, and act without ever seeking approval. We were given the leeway to do these things, it's been codified into the federal regulations; but unless others understand the process it can become a source of conflict. Maintenance has a very good idea of what's at stake, so they are normally on board and frankly, their entire job is decision making and problem solving. They also go through an incredibly rigorous training regimen to earn their certification, of which decision making and crisis management are integral parts. Your average dispatcher/crew scheduler for a non-airline (Part 135) carrier? They were

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trained as well as the first company they worked for, and even more specifically: the manager they reported to, wanted them to be trained. In the Part 121 world, they must be certified, trained, and equally responsible for the outcome of the flight. They are one of the resources we as aviators are going to take advantage of when things go poorly, and they know it, and take pride in it. That can be lost in the specific processes a new hire dispatcher/scheduler is trying to learn, and unless we routinely refresh the collective memory, never rectified.

Let's break down ADM. Because this is "aeronautical decision making" there are three opportunities to put these tactics into play: Pre-Flight, In-Flight, and Post Flight. The reality is, you can use these processes any old time you feel like it, but if we look at it from the lens of a different department, think of it as "preparing for, conducting, and evaluating results". It's based off the 3-P model: Perceive, Process, Perform. (As an exercise, use the engine fire example above and try to get them to identify each P…..Hint: The fire was pretty obvious to my perception)

Perceive: This is self-explanatory, but in aeronautic decision making both pilots have a scan going. There is no singular individual that is perceiving hazards across the crew; even the Flight Attendant (FA) is keeping an eye out. We are each aware of the other roles. To the point where we may not be able to perform them in their entirety, but we know what "normal" is supposed to look like. We know that unless your fellow employee was deified it's impossible to always see all things. We work together to make sure that things go the way they should. For example, take a typical airline flight. The FA needs to do something critical, so she parks the trolley in her galley but fails to correctly set the brakes. Let's pretend the pilot just got up to go to the bathroom and sees the trolley is unsecured so they push the trolley firmly into its berth on the way to the lavatory. The part to focus on there, is unsaid; he "perceived" the trolley as a risk. The pilot had enough knowledge of the FA's role to know that the brake on the trolley hadn't been set, they may not have known how to set the brake, but they did know where the trolley belonged when no one was with it.

Typically, we use several different models to utilize ADM. One such model is the PAVE decision making model. Quick refresher:

- **P**-Pilot
- **A**-Aircraft
- **V**-enVironment (really FAA? enVironment? That's the best you could do?)
- **E**-External Pressures.

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A pilot would utilize this model in this way:

⇒ **P-** is there a hazard that would affect the pilot's ability to make sound decisions? (Tired? Sick? Emotional?) for a non-aviation role, is there something that would cause them to perform poorly?

⇒ **A-** This is where we look at the aircraft as a whole and make sure it's not a hazard. So, for a non-aviation role they would be looking at their team goals and processes to make sure that there isn't something preventing forward movement. Are we missing a teammate? Do we have enough resources?

⇒ **V-** what effect will the environment have on the operation? This doesn't need a descriptor but think about the company culture, think about where you're physically going to be completing a task.

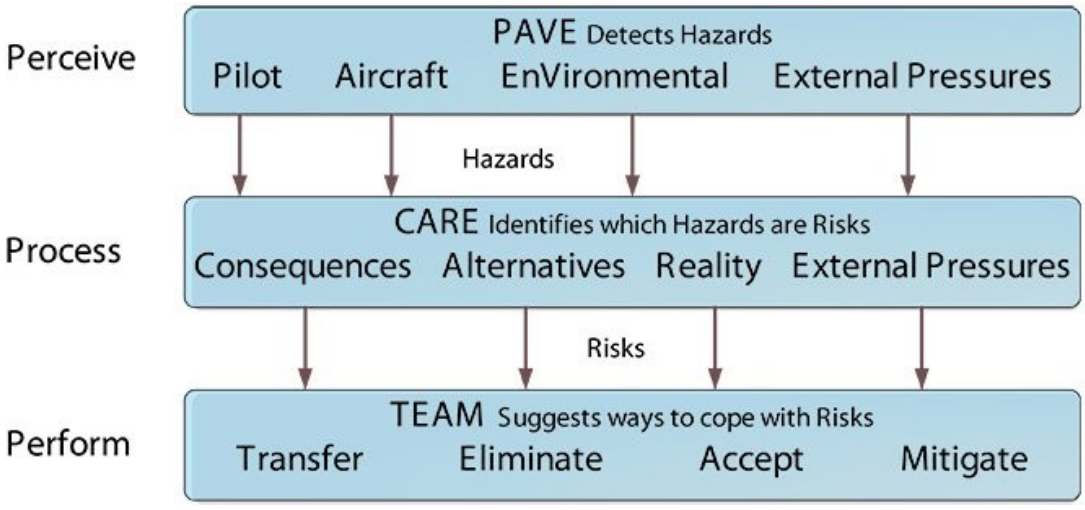
⇒ **E-** What's pushing me to make a bad decision? Typically, this is going to be pressure from above, or a time constraint, or a desire to be promoted.

The PAVE model is a method of catching risks inherent in an operation before they become an issue by promoting high situational awareness.

Process: Lets stick with the trolley analogy. The pilot "perceived" the threat that the trolley presented, he processed all the information and associated skills at his disposal. "Trolley not secured, trolley brake not set, bad trolley, how to set brake? Not known. Only choice: Move trolley". (I'm sure much to the frustration of the Flight Attendant who is probably screaming "IT'S A PEDAL! STOP STEALING THE DIET COKE AND STEP ON THE PEDAL!").

The alphabet soup to apply is CARE. (I am secretly hoping that someone will create an acronym that comes after this called BEAR.) Care stands for:

- **C**-onsequences: what happens to who and where?
- **A**-lternatives: What other options do we have?
- **R**-eality: This is what I can accomplish.
- **E**-xternal Pressures: What other factors are having an effect?



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Perform: This one is simple to describe. Just do it. Ok it's not as simple as just doing it. This is the most complicated part of this whole scenario. You see when pilots act, both the action itself, as well as the thought process to reach that action were studied, memorized, and at a minimum every 12 calendar months rehearsed. This means whenever something happens the flight crews have the tools to function autonomously, and their leadership knows "roughly" what to expect and when "roughly" it should happen. When is the last time your sales team rehearsed what would happen when one of your aircraft has an issue in flight? Did you run a scenario with them during indoc? How would your dispatch react? Can you be certain of that? Unless you create the processes and train them, no, you can't. The common acronym for this "P" is TEAM:

- **T**-ransfer: Think delegation, can this task be delegated to someone more capable?
- **E**-liminate: Is there a way to eliminate the hazard?
- **A**-ccept: Is this a reasonable risk to accept?
- **M**-itigate: Can this risk be mitigated down to an acceptable level?

To go back to the trolley example, the pilot looked around and didn't see anyone to transfer the responsibility to. He then looked to see if there was a way to eliminate the risk. The answer was yes, there was. That then becomes the best solution. As you can see, the ADM process is more about designing a uniform problem-solving thought process across your crew, or in this case company. You go through each of the letters until you find the best solution. It is important that you stress that the headspace this is all designed to come from is one of SAFE completion. In other words, no, the best solution isn't ALWAYS transferring responsibility. Try to get your executives to apply the pave model to some examples. You guys know your operations inside and out. You know what's going to resonate. Just try to show them how beneficial it would be to invest in your nonflying employees' decision making.

Great, you say. I Now have 3 models to assess the risk of a thing and I know less than I did before. Mission accomplished. But wait, there's more. We need to put all of this together. The CFI's out there have been chomping at the bit to get this nugget into the discussion. **DECIDE**. That should ring some bells. If not, look at the chart below.

Basically, you take all the thought models on the previous pages and apply them here. Think of the other acronyms as building blocks to this one.

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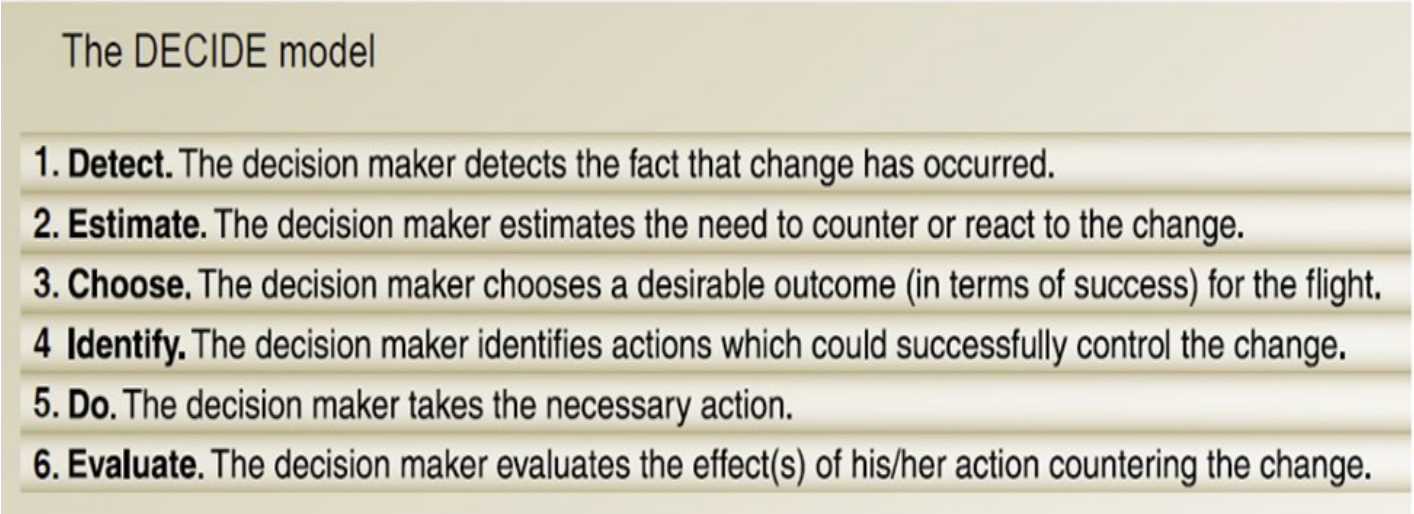
- To **detect** a problem, you must have excellent situational awareness: **PAVE**
- You've looked at the issue and now you must make an **estimation** of how serious the damage will be.
- Evaluate the alternatives, see what you think may work and won't work, and explore the reasons you may rush to **choose** one over the other: **CARE**
- **Identify, Do, and Evaluate** can all be covered by **TEAM**. You've identified the best person for the job and transferred authority over that area to them. You've tried to eliminate the risk, if possible. You've determined whether the remaining risk is acceptable. If it's not, you've mitigated it to a level you feel is acceptable.



We have the plan, we've identified the risks, and we know who's going to be involved. This is going great, but now comes the hardest and most frustrating part. We need everyone to work together. Guess what? There's an acronym for that too! CRM, or Crew Resource Management is basically grown up or dumbed down (depending on how smart you think pilots are) teamwork. There are so many articles, books, YouTube video's, etc. that deal with CRM and its science. We're not going to go too in-depth with the techniques here. Partially because you can go look it up and partially because it really boils down to separating the ego from the title. That'll get more of a spotlight when we discuss common errors in judgement a little bit further down.

What you need to understand about CRM to take it to your other employees is this: No-one has the only answer. Having said that, to preform CRM effectively there must be a leader. A point person that co-ordinates idea's and makes the ultimate decision. In the aircraft, it's the captain. In your departments it would be team leaders, project/program managers, VP's, etc. For that person to make the best possible decisions there must be a few things in place:

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Communication: There must be open lines of communication. (See? That ego thing is creeping in already). Without open lines of communication, a member of the team is not going to feel that it is acceptable to open their mouth and say something. They may have noticed a small discrepancy that is actually a large issue, but they won't say anything for fear of retribution. There was that famous crash in the everglades back in the 80's where the crew flew the aircraft out of gas because no one wanted to tell the captain he was wrong in a direct manner. So yeah, tell that brash individual that ego does in fact kill. If you were to observe a sim session for a crew practicing this, you'd notice the communication is open, but concise. There's not a whole lot of extraneous detail. It's short, to the point and very, very direct. I want to make a note here, this form of communication, while effective in a crisis is not what the rest of the world grew up dealing with. Except for the military, law enforcement, and other high stress careers most aren't used to direct and blunt information delivery. It will take some getting used to, and it should be stressed that just because it's direct is no excuse for rudeness. We're not evaluating the quality of someone here; we're putting out fires.

Well-rehearsed: CRM takes practice. Being able to jump into a life-or-death situation with someone that you've never spoken too, or worked directly with is not easy, and it's not as intuitive as you would think. Flight crews spend hours and hours every year rehearsing this. It is sneakily put into all our tasks. We utilize checklists as a crew; one reads, the other answers while the reader double checks the answer. This ensures that there are two sets of eyes on any given task. We use "flows", these are memorized tasks that happen at certain "triggers". For example, the captain may say "Before start checklist". He didn't tell the other pilot to prep the engine to start, but the First Officer knows that those words are his trigger to get everything prepped to start the engines; meanwhile, the captain knows that those words are his "trigger" to prepare for the Taxi checklist and get everything together. Another one from the fog bank that is my memory, is "Number two for departure". Why would the captain say that to the FO? He's got a window. Well, that's the FO's trigger to ring the call button and tell the flight attendant that it's time. It's also his trigger to do the before take-off flow so he's ready for the before take-off checklist. This brings us neatly to the next point.

Steps for good decision-making are:

1. Identifying personal attitudes hazardous to safe flight
2. Learning behavior modification techniques
3. Learning how to recognize and cope with stress
4. Developing risk assessment skills
5. Using all resources
6. Evaluating the effectiveness of one's ADM skills

Set Procedures: Someone, you already know who in your minds, is going to say "That works for the airplane, but our world is way less rigid". I call…, well, this is a professional publication. Yes, we know that every flight begins with the same steps. But every time we go up it's never the same.

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Something new happens. 50 landings at the same airport and none were identical. What we need to realize is that these set procedures aren't how we "accomplish" the tasks, they are how we prepare to accomplish the tasks. What you're doing is making it an automatic reaction when certain things are triggered. For example, you have an Indoc class coming up; 5 people, all new hire mechanics. Let's show you a trigger and a flow from the lens of HR. The Indoc class gets scheduled; it shows up on the calendar. That's the trigger. The HR professional knows that Indoc training means there are 5 new employees who are going to need accounts in 3 programs, a company email, etc. Their flow is to get that accomplished so that when the Indoc class starts, everyone is ready. No one told them to do it; they heard the trigger and just did it. The trainer knows that he issued the trigger, he knows that HR is going to accomplish the new hire setup, so now he's free to complete his prep and they can circle back and check against each other prior to the next trigger. In fact, that would be the next trigger. This happens in your departments today I'm sure, but it isn't automatic. Someone had to go to the HR professional and say, "Please complete this". In the environment I'm talking about that role would already be assigned to someone and there wouldn't need to be a conversation. They know that they're tasked with this. They know what the trigger is. It was all explained a head of time. This is an article, I have limited space to expand, but I'm sure your fellow leaders are already coming up with scenario's where that wouldn't work. Time to use CRM and ADM to figure out a solution to that. (Couldn't resist).

Use of every resource: While talking to a friend, he expressed hesitation at asking for assistance from one of his colleagues in another department. The pilot in me balked at that statement. Why would you eliminate a resource and waste time doing something that you could complete in a third of the time? They aren't pilots, so they are factoring in things that we don't consider. (We'll explore that in the next section). The reality is, pilots, mechanics, air traffic controllers, we all use each other. If I look at the weather and our destination airport socks in en-route, and my EFB dies, I'm not going to wait until I'm in the missed approach hold and charged to 10% before I look at options, I'm going to ask ATC. "Hey, my EFB died, what's close by and legal?". I'm definitely not going to hesitate because my chief pilot is also on freq and he might think poorly of me. I'll even ask Dispatch where there's a cheap FBO. All my resources. No pride. Speaking of dispatch/scheduling, here's an example for them: Aircraft is halfway to its destination and experiencing stronger headwinds than planned at FL450. Pilot messages in and says "hey, we're going to need to add a fuel stop." Remember how they don't have to be trained in performance and all that? When's the last time one of your dispatchers walked into the FBO and asked one of your company pilots for their advice? "Hey, fuels cheap but is there anything that would make a better choice?" That pilot will probably tell you, "Yeah if you send them into APA for cheap gas they're going to get delayed by the Denver departures that time of day." How would the dispatcher have known there was a better choice for that reason if they hadn't asked?

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We've been through the risk analysis models, we've explored the 3 p's, we've touched on CRM; it's time to talk about the errors. These don't need a large intro paragraph so let's dive right in.

Confirmation Bias: Basically, this amounts to already having your mind made up. You're not looking for solutions at this point, you're looking for evidence that proves you right. Think along the lines of a marketing professional looking at a planned campaign and saying, "This will never work", getting some limited data and rushing to show you how its failed. That data indicated that the campaign was mis-distributed, but the employee wanted to confirm his bias. So instead of bringing the solution, they brought destruction. To combat this, look to the "reality" of the situation (3 p's).

Filtering: Our brains are semi-autonomous. They automatically learn to sort the information that comes our way after we train them to do it. Our brains will recognize patterns and make assumptions on what to process. Think about a salesperson working on a quote. The day-to-day task is so repetitive that they preform most of it on autopilot, but that day the customer they're quoting has a unique situation that they missed. Their brain triaged the information and said, this all looks so familiar, just move on. They failed to recognize the upcharge and had to re-do the quote. The PAVE model can help to combat this. It is specifically designed to make you assess all the aspects of a situation. "Situational Awareness" or if you want to sound like Maverick "S.A".

Patterns and Expectations: Once again your best friend brain is here to ruin your day. Our brains are quite adept at recognizing patterns. This can lead us to expect a certain outcome without considering all the factors. "It normally goes like this, then like this, and then VOILA!". Only, this time there are several mitigating factors you omitted because the pattern was so much like something else. Think about your janitorial staff. Office closes at 5pm every day and by 7:30 the place is empty. The janitorial staff comes in to clean the conference room at 8:30. They slam open the door and turn on the vacuum. Only this time your company president is on a long-distance business call with Dubai and he's in there. Whoops. There was a note posted, but who would read that? No one is ever here past 7:30. The pattern and expectation just made someone slightly unsure about their job security.

Filling in the gaps: This one is self-explanatory, so to save trees we'll skip to the example. When my wife and I watch movies, I have a bad habit of following the plot and then trying to guess the ending. It drives her nuts. The reality is, I'm often wrong. There's a lot that happens between the climax and the conclusion, and if I'm guessing at the build up stage, well, I'll be wrong. If your sales team walks into your dispatch and says, "we're working on a trip to somewhere in California", there's a good chance the first place that will come to mind is Van Nuys. Now to round out this example, let's say the dispatcher prints up a release and a trip sheet that repos an airplane and crew to VNY and sends it out. Then sales walks in and goes, ok it's confirmed, Oakland. That's an expensive "best intention".

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Framing: Ok, so this one is a little more subjective and requires some social intelligence. Be careful with the language you use when discussing things with others. If you go to someone and say, “If you don’t do X, my boss will be furious”, they may be biased towards accomplishing the task regardless of risk. They’re afraid of speaking out and damaging their reputation to a superior, especially to the superior of that superior. Instead, try something along the lines of “How is X coming along? We’re all ready to go as soon as that’s finished up, let us know how we can help”. Same information delivered, “Hurry up”, the tone was far more approachable. As a wise woman that raised me once said “You catch a lot more flies with honey than vinegar”.

I’ll close with this thought. I won’t mention him by name, but many years ago one of my instructors framed crisis management this way. “When you feel the most pressure, when there is panic and confusion, get up and pour yourself a cup of coffee.” What, you might ask yourself, was that? Well, what he was getting at was, slow down, evaluate the situation, stop for a minute, and collect yourself. Rushing to a decision has killed countless aviators and passengers. They fall into the traps we just discussed. Slow down. Planes fly fast, so we move slow. That mantra is applicable to every facet of your organization. Remember the tortoise and the hare? Which one won the race in the end.

Every year PRISM sends out the SMS Audit Results Report that highlights any major trends we’re seeing across the industry based on the audit results from the year prior. As we prepared the report this year, we noticed there were quite a few operations who were getting “dinged” for not training ADM/CRM to all employees who interface with the flight operation.

Decision making is not “different” in other arenas, it just happens at a different tempo. There have been massive increases in complaints about fatigue and safety cultures. Unfortunately, this is all related. As an industry it’s time to identify some root causes. This can be a way to bring everyone together. Your support staff will have the knowledge to recognize why decisions are being made in the way they are. They’ll be more efficient in their reactions to dynamic situations. And ultimately, you’re giving them skills that they can use to further your organization’s success. Think about it, when you’re looking for a manager, the first thing you look for is their decision-making ability. Well, what if everyone in your organization had that skill? Now you’re just looking for the best fit for the technical part. You’re finally able to put the best person for the job in the position instead of the best leader who can learn just enough not to fail. Your employees will thank you for investing in them; this is the type of continuing education people want. It’s a pathway to their success that benefits you by giving them a marketable skillset. Better yet, when you have a company that invests in ALL its employees, those employees tend to want to stay with the company and not to go searching for other opportunities. I’ll say it again, “ADM is not pilot specific”. It’s time to start investing.

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SAFETY MANAGER'S CORNER

Assurance Checks—What are they?

We all understand that safety management means action; no flight operation ever improved safety by doing nothing and looking the other way. When a new safety report comes in or an internal evaluation identifies several items needing attention, it's time to analyze the information and initiate a corrective action plan. Every diligent safety manager performs these actions consistently in the normal course of duties, making certain the necessary solution is developed and documented in the safety management system.

What comes next?

Safety management concepts and practices demand that corrective action gets a second look at a minimum. It can't be assumed the employed corrective action for any safety report or internal evaluation finding will be 100 percent effective. A follow-up evaluation is in order, something we like to call an "assurance check." Wait a certain amount of time and then have someone with sufficient expertise evaluate the corrective action put in place and make sure it meets expectations. If the problem remains unrectified, wholly or partially, then further action is obviously needed. If you're a PRISM website ARMOR user, there's some good news: an assurance check is automatically set up for every closed safety report from the HazRep Program Tracker and every closed finding in the IEP Manager. Simply check on the ARMOR Dashboard once a week or so and look for any new items that appear under the headers labeled IEP Assurance Checks and HazRep Assurance Checks. The checks will automatically appear 90 days after the respective corrective action was closed, prompting the necessary follow-up described above. Every assurance check can also be scheduled for an additional follow-on evaluation at your discretion; simply look under the Quick Links on the assurance check page and find the appropriate link to do so. Once completed, the assurance check will be documented on the safety report or IEP checklist right along with the corrective action.

Effective safety management requires process discipline, and actions like assurance checks maintain and measure those very processes. Ignorance may be bliss, but it's not good safety practice. Find out how every single corrective action performed and document those results. Be assured, that's just good safety practice.

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Quote of the Month

“It’s all to do with the training: you can do a lot if you’re properly trained”
– HRH Queen Elizabeth II

Queen Elizabeth was a prime example of what all you can achieve with training. She was constantly training and learning in her role as Queen and when you look at her life it is amazing to see everything that she was able to accomplish. Practice makes perfect. No matter what your role is, there is always opportunity to learn and train to be better.

On Short Final...

Have you seen my stapler?

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UPCOMING COURSES

Oct 3 to Oct 7, 2022—PROS Course
IOSA Auditor Training
Denver, CO

Nov 28 to Dec 2, 2022—PROS Course
Aviation Lead Auditor Training (ALAT)
Denver, CO

Dec 12 to Dec 16, 2022—PROS Course
IOSA Auditor Training
Denver, CO

Go to Upcoming Training Classes to register.