BUILDING ON THE Basics

Lately, several high-profile accidents and incidents have involved violations of basic sterile cockpit procedures. This troubles me, and I know that I am not alone. The U.S. National Transportation Safety Board recently suggested that monitoring of cockpit voice recorders (CVRs) should be considered to keep crews on their toes and discourage this sort of unprofessional behavior. I have not been very supportive of that position, and I should explain why.

To be honest, it is painful to think that things have slipped so far that we have to consider this option. I worry this will demoralize good professionals who have already endured a thousand other indignities. But at the end of the day, I get it. Lives are at stake. If this is the only answer, we will have to seriously consider it, but I would suggest that we don't run off in this difficult new direction until we have the other basic safety building blocks in place. We have to consider the opportunity cost of the CVR monitoring. There has never been a time when safety resources were stretched so thin, or when safety was less a priority. Everyone's first worry is the economy, then security, then the environment, and then maybe safety. To some extent, this is due to a safety record that is pretty good; there is no crisis. The best we can hope for is a zero-sum game. In this environment, safety priorities have to be set carefully.

So let me discuss the pieces I think have to be put in place before we take on something as difficult as monitoring CVRs. This discussion is being led from the United States, and there we are still missing a vital piece of the puzzle. In response to a recent call to action from the administrator of the U.S. Federal Aviation Administration, many U.S. regional airlines have committed to voluntary flight operational quality assurance (FOQA) programs, and new Congressional legislation may make these programs mandatory. But many of these programs are still in their infancy, and some of the airlines that need them the most are lagging.

Would a FOQA program have prevented the lack of cockpit discipline that preceded the Colgan crash? Maybe not, but it might have prevented the accident. I am sure that crew was not the first one to be surprised by an unexpected stick shaker with the deicing system activated. That sort of problem, or a hundred other training deficiencies, would have been flagged if FOQA had been in place. It might have even told us about an accident that hasn't happened yet. When crews know a FOQA program is in place, they operate differently. They know odd excursions will be questioned. They report mistakes, because they would rather admit them under a reporting program than wait for the chief pilot to ask.

We know FOQA programs work. They have been an international requirement since 2005. We know they help drive voluntary reporting. We also know that FOQA plus voluntary reporting plus line operations safety audits provide a very complete picture of risk in the operation. Am I fundamentally against using data from the CVR? Not really, but I am against diverting resources from the things that are needed and the things that are proven. Let's get the basics in place first.

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