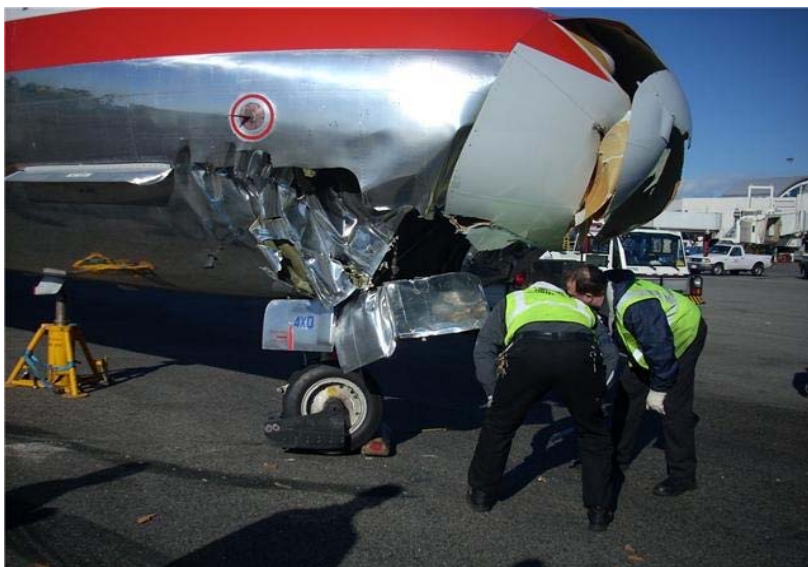


SOSAP NEWS

Station Operations Safety Awareness Program

Volume 1 – 3rd Quarter 2009



On-time departure is important, but not as important as safety!

-Important News-

- Employees covered by the SOSAP program are now able to file SOSAP reports from the internet at home.
- If you are facing daily operational processes that are proven to be difficult to accomplish as trained such as the operation of a cargo loader, PLB, or other ground equipment, United, the IAM, FAA and the SOSAP Team wants employees to file reports on “Potential Hazards” they are encountering on the job before an event occurs. The program gains valuable knowledge from near misses. Please tell us about your near miss.
- The SOSAP ERC met with Senior Leadership of UAL, FAA and IAM this last quarter in its first “Safety Round Table” (SRT) to reiterate the non punitive aspect of the program and discuss SOSAP enhancements and how to better utilize the program.
- SOSAP - All work groups at UAL now have a voluntary safety reporting program. All Station Ops personnel covered under the IAM agreement (Ramp, CSR, and Stores) now have the ability to file under the SOSAP. Station Operation Safety Action Program.

SOSAP

The SOSAP program has received over 2000 voluntary safety reports since June 2008 and with the help of IAM members, the FAA and UAL, the program has improved flight & ground safety by identifying and implementing corrective actions to aid in preventing future occurrences of safety events.

The SOSAP program tries to create a non punitive environment for the open reporting of safety related events and issues. The SOSAP program is not only for incidents that have already occurred that may involve a violation, such as notification by SAMC, or other organizations non standard work, or other operational error, but also to report near-miss type events that occur in the ground environment. Such as, (1) a local policy, process or procedure that although having been successfully completed in the past, has the capability to lead to a safety or non-compliance issue, (2) lack of, or limited access to, documents or associated equipment to effectively perform your assigned work functions (3) Lack of resolution to previously identified safety problems.(4) Chronic or systemic problems you are seeing within your work area or any other safety related

issue that we may document and pass on to the appropriate Department, (5) Tell Us About Your Near Misses!!!

If you find that there is room for improvement to an existing “Standard Operating Procedure” (SOP) submit a SOSAP to the ERC. If you experienced a sense of being rushed to complete a task and felt that you’re safety was at risk, notify your manager and file a SOSAP report.

From the Event Review Committee:

The following are primary recommendations to you, the UAL IAM to keep yourself and the flying public SAFE.

- 1. Read and Understand All Work Documents: Take the time to read and understand all work documents prior to and during all assigned tasks.**
- 2. DO NOT ACCEPT A TASK YOU ARE NOT TRAINED OR QUALIFIED TO PERFORM.**
- 3. PRIOR TO SIGNING OFF A TRIP, THE LEAD/SERVICE DIRECTOR SHOULD REVIEW THAT ALL TASKS WERE COMPLETED.**
- 4. Follow The Steps: EVEN WHEN YOU FEEL LIKE YOUR RUSHED OR HURRIED!!**

Double Checking Work Accomplished: Whether due to time constraints at the gate, too far from a computer, or thinking “someone else (my lead/service director) will follow up”. We all have the requirement to double check our work. It is a Standard Operating Procedure! Uncompleted or skipped tasks, not only violates the SOP, but it can and does cause confusion and operational errors for the next RSE/CSR, controller, or anyone else continuing to work the trip.

SOSAP Forms: Please help yourself and the ERC out. When filling out an SOSAP report, provide enough detail in your narrative to fully describe what occurred. Information such as what step was missed in the SOP?; What were the events leading up to the incident?; and How did you become aware of the issue(s) or event(s)? Not providing these types of details are critical as well as time consuming for the committee to research. PLEASE TAKE THE OPPORTUNITY TO DESCRIBE THE EVENT COMPLETELY. IT IS DIFFICULT FOR THE COMMITTEE MEMBERS TO UNDERSTAND THE EVENT WHEN ONLY PROVIDED ONE LINERS.

*****Featured Station Operations Events*****

Weights & balance: Above / Below Wing

Weight & Balance Issues –SOSAP reports have identified 41 incidents where aircraft have been loaded improperly causing a WTS & balance issue.

-30 reports deal with improperly loaded aircraft below the wing

-11 reports deal with inaccurate passenger counts being submitted

Reporting frequency and duration indicates a system wide issue. Below are the items that have been completed by the AO team to address the issue:

- Briefing item JUL 2009
- CG e-lesson TL 17/76
- CS e-lesson in final stages of development
 - Assessment and testing remain (AT delivery by 15 SEP 2009)
- Multi Year Plan... Enabler Request “Apollo ACI Status Event” (Delivered July 2009)
 - Pass Apollo ACI status changes (FO and FG) as type ‘B’ messages
- Forwarding of ORD Local Process to Hubs (July 2009)
 - Briefing items
 - Investigation sheet
 - Computer stickers (attached)
- HHB manager call AUG 2009 to address any deficiencies or failures in our plan.
- Policy creation that provides guidance on handling individual customer deplaning and full/partial aircraft deplaning and re-boarding during Irregular operations. This policy supports accurate flight final counts



Dangerous Goods Hazmat

Dangerous Goods/Hazmat Acceptance –13 SOSAP reports have identified failures in the DG acceptance process and complications planeside.

- 3 reports deal with Hazmat paper work irregularities
- 6 reports deal with hazmat exceeding its weight limit
- 4 reports deal with hazmat improperly loaded onto the AC

Reporting frequency and duration indicates a system wide issue continues to exist. Below are the items that have been completed by the AO team to address the issue:

These include the following programs:

- HAZAWB – collects DG data from the point of check-in (Unimatic Development System)
- HAZCOR – Assigns the DG to a flight (Unimatic Development System)
- HAZHOF – Holds DG off a flight after its been assigned (Unimatic Development System)
- DHAZ – Assembles a summary of DG items which will be sent to the flight deck (Unimatic Development System)
- DHAZ/ - Displays an individual DG PNF with all required data and will also be sent to the flight deck (Unimatic Development System)
- DANGER Tables – Displays DG limits by UA DG haz code, aircraft type, station restrictions, radioactive and unique DG characteristics (Unimatic Production)
- IMP codes – Programming complete which effectively allowed UA to replace the existing H codes with consistent IMP codes or in a few special circumstances a variation of the IMP

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UNIMATIC DEVELOPMENT-2
** HAZARDOUS MATERIALS MENU **
▲HAZADD/○ AIRWAY BILL /○ * ADD HAZ CODES TO AWB *
▲HAZAWB/○ AIRWAY BILL /○ * ADD HAZ DETAIL TO AWB *
▲HAZDEL/○ AIRWAY BILL /○ * DELETE HAZ FROM AWB *

▲DHZCOD ○ DISPLAYS HAZARDOUS CODES AND DETAILS
▲DHZSEG ○ DISPLAYS SEGREGATION RULES
▲DHZATP ○ DISPLAYS AIRCRAFT TYPE RESTRICTIONS
▲DHZSTA ○ DISPLAYS STATION RESTRICTIONS
▲DHZRAD ○ DISPLAYS RADIATION SPECIAL REQUIREMENTS
▲DHAZ ○ DISPLAYS HAZARDOUS ON A FLIGHT DEPARTURE
-TEST-

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These functions are still pending development:

- DSTG – Split the DSTG program to allow for the additional required enhancements as the program file has reached its capacity
- DSTG Interface - Develop program to handle new DG/Cargo interface to DSTG
- DSTG Segregation – Develop new interfaces between DSTG DG and DANGER Table rules

UNIMATIC-1								
DHZATP/° **HAZARDOUS AC TYPE RESTRICTIONS **								
AC	NO OF	MXTOT	MXFWD	MXAFT	RAD	RAD	CMPT	
TYPE	CMPTS	ICE	ICE	ICE	PIT	MXTI	MXWT	
°319/°	2/°	1/°	500/°	2000/°	5	1/°	7/°	55/°
°320/°	2/°	1/°	500/°	4000/°	5	1/°	7/°	55/°
°737/°	2/°	900/°	1/°	1/°	4	1/°	6/°	55/°
°747/°	3/°	2500/°	1/°	1/°	31	1/°	12/°	55/°
°757/°	2/°	1350/°	1/°	1/°	5	1/°	7/°	55/°
°767/°	3/°	1350/°	1/°	1/°	16	1/°	11/°	55/°
°777/°	3/°	1/°	2000/°	400/°	33	1/°	10/°	55/°
°	1/°	1/°	1/°	1/°	1/°	1/°	1/°	1/°
°	1/°	1/°	1/°	1/°	1/°	1/°	1/°	1/°
°	1/°	1/°	1/°	1/°	1/°	1/°	1/°	1/°

B767 / B777 Tow Bar Inspection / Identification

As discovered through several SOSAP report the current Wide Body Tow Bar fleet supporting B767 and B777 aircraft are not clearly distinguishable as to what type of aircraft they support. This scenario may expose personnel to unsafe work practices and increased risk of aircraft damage.

The Ground Equipment Department has initiated a project to rectify this problem. The completion of this project will verify and identify specific Wide Body tow bars throughout the UA system as they are applicable the following parameters:

- Verify and Document current tow bar fleet per station:
Unit ID / Make / Model
- Aircraft currently supported with current Tow Bar Fleet
- Current shear pin configuration
- Label each bar as to currently what type of aircraft the bar will safely support



The inspection, identification and labeling of the current UA Wide body Tow Bar fleet is the first of three phases designed to ultimately designate B767 Tow Bars and B777 Tow Bars. Phase II and Phase III of this project will ensure all UA Mainline Tow Bars are easily distinguishable from each fleet type and ensure stations have the correct Tow Bar Fleet volume to support their respective operations.



The following are de-identified but unedited SOSAP reports filed by members covered by the program. Each issue is followed by a brief summary of the recommendations and/or actions taken by the committee.

Early Brake Release

Narrative: While still loading front of AC the brakes were released from the flight deck. No one was in the push back tractor or in communication with the cockpit. When we were finished loading and asked for brakes to be released there was extreme pressure on the tow bar.

What can be done to prevent this from happening again?

Push back operator should be the only one in contact with flight deck for making decisions like this.



Recommendations and/or actions taken by the committee:

SOSAP & FSAP ERC team partnered to track these events concurrently. Additionally, the FSAP ERC has published several Flight Safety Briefing Sheets (FSBS) to flight crews about the importance of following SOP for brake release as well as reaching out to pilot group via ALPA.



Since their partnering, early brake release has shown a significant drop as a safety issue by employees: Reporting frequency and duration indicates system wide reduction (53% drop in reports from last quarter).

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Gate A17 EWR Gate Layout Change

Narrative: The stop mark for a airbus I think is in the wrong spot and does not leave enough room to work the rear pit. The clearance is about 10 feet from fuel hose to food service trucks.... reference the attached picture. This was brought up at safety meeting and was told plans show stop marks in right place... I feel this is still a safety issue...

What can be done to prevent this from happening again?

We could park the airbus back about 10feet and all would be good...Just because the plan shows it in the right place doesn't mean its right or adjustments can't be made to make it safer.

Before**Recommendations and/or actions taken by the committee:**

An employee submitted a report that along with a picture showed how the fuel truck was directly in the path for aft loading / unloading Airbus planes at this gate. In partnering with the gate layout team at OPC along with local management they were able to come up with a workable solution.

After

The SOSAP team has visited the gate to confirm the new painted line and how the fuel truck is no longer in the way making it a safer operation for all parties involved.



Aircraft Damage

Narrative: I knew TSA typically shuts down at 2130pm and the UAX (Canadian) bags had not shown up yet, so to avoid these bags missing there international outbound departures, I knew I needed to go and get the bags from the A terminal.

I was in a hurry to get to the A terminal, because it was time critical, I choose to drive the tractor over to my crew instead of walking over. I then drove forward, turned left, drove in between the PLB and the #1 engine, then under the fuselage and exited out between the belt loader and the #2 engine. I approached the engine at a angle, when I made contact with #2 engine, the front part of the tractor hood made contact with the bottom part of the engine cowling, the yellow safety handrail on the passenger side of the tractor made the large dent on the inside part of the cowling. In a panic, I wanted to remove the tug from the engine; I backed up, straighten the tractor up, and exited out by the #2 engine. I then proceeded forward, past the #2 engine and stopped, because I was now blocked by the tractor that was hooked up to the cart getting the inbound bags. I had to back up again to reposition my tractor to get around the parked tractor, once I was clear of the parked tractor; I drove around and parked the tractor and called the gate Lead, who notified Management.

Employee suggestion on what can be done to prevent this from happening again in the future? Follow SOP's, distribute the work load evenly between all the leads, especially on the weekend.

The ERC along with local management worked with employee to produce safety letter that was shared with fellow employees discussing the consequences of not working safe...

Excerpt from safety letter written by employee:

“Hello my name is I’m writing this letter in hopes that my fellow employees will not experience the regretfulness and emotional reminder that I have. These feelings are a result of the accident. The accident was a result of my lapse of judgment which included aircraft damage and these feelings mentioned

above. This event impacted both my work and my home life. My hopes are that by writing this I can change one person's behavior or prevent one such accident. If this occurs than I have succeeded. One of my favorite sayings is "accidents begin where safety ends".

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WTS & balance: below Wing

Narrative: I was the lead on flt XXX star flt for the morning bank. A mechanic on duty told me we had a rear pit inop on flt XXX to den my next flt. I did not pull up a card for my flt. I loaded the flt not knowing that XXX was the flt that had the rear pit inop. Upon putting in the card I saw the note about the rear pit being inop. I had the plane brought back to the gate and corrected the error and loaded all the bags forward. The lesson learned here is don't take anyone's word for something. As a lead I was responsible for many flights at that time of the morning. We have one flt after another which makes it tough not to make mistakes.

Employee suggestion on what can be done to prevent this from happening again in the future? In the past when there was an inop pit on the acft a placard was placed on the acft door. The placard that said this pit was inop was placed inside of the door switch panel and not in plain sight to see.

The ERC along with local management worked with employee to produce safety letter that was shared with fellow employees discussing the consequences of not working safe...

Excerpt of safety letter written by employee:

"After twenty three years of loading and unloading you sometimes become lax in your operating procedures and this is one time when I was lax in doing my job which taught me a hard lesson. The lessons that were taught are just don't accept what someone says about your flight, check it out for yourself...and secondly always pull up an inbound or outbound card. Know what is coming in or going out on your flight, and if there are any variables you should pay attention to in your loading standards. These are two lessons I choose not to repeat."

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Driving: Gate / Non Gate Area:

Narrative: On 5/XX/09 at approx. 1810, I was driving back to the D Gates after dropping off carts at the bag room. I proceeded to look to the left before turning into the breezeway next to C-X to make sure no one was coming. When I looked back the ramp agent from XYZ Airlines was right there and we collided into each other.

Employee suggestion on what can be done to prevent this from happening again in the future? Be more aware of what's going on around you.

The ERC along with local management worked with employee to produce safety letter that was shared with fellow employees discussing the consequences of not working safe...

Excerpt of safety letter written by employee:

“Safety is everyone’s job, and even if the problem is not at United’s gate area, it could still have an impact on us. The lesson here is to make sure the Company knows, possibly through a SOSAP report, that a safety issue exists, no matter where it is, so that it can be addressed. In addition, being aware of your surroundings and the rules of safe driving on the ramp can prevent accidents from happening, which creates a safer environment for everyone”.

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Facility: Work Area

Narrative: Today again I am working in the bag room on flight XXX and flight XXX at the same time on lateral 1X-1X. This is an everyday occurrence that both flights will come up on top of each other causing massive congestion on the line. Today I have taken pictures of the congestion on the line. Someone is going to trip over all these bags or even get hurt by having to carry bags anywhere from 5 to 20 feet through all these bags on the floor.

Employee suggestion on what can be done to prevent this from happening again in the future? There should be better planning of flight assignments down the laterals.

Local stations response: This SOSAP has been addressed with the bag room staff involved. Resolution to this issue is as follows: 1) Due to the overlapping of these flts, a mixed

foreman cart of city and TB bags for flight XXX is always staged across from laterals by the wall due to the volume of bags employees can't handle. 2) Effective immediately, XXX bags from lateral 1X-1X from the start of the shift will be programmed to the run out for processing permanently at 0730, these bags will be restored to lateral 1X-1X. BSO will be responsible for reassigning the lateral at 0730. This practice is being done to cross-utilize the staffing. 3) Outbound XXX TB's currently on lateral 1X-1X will now be moved to lateral 1X-1X where XXX TB's are staged. We have come to an agreement that we will be advancing approximately 30 TB bags from XX onto XXX on a daily basis. The Lateral lead will be responsible to call CLP to inform them of the additional bags on flight XXX. The Control Center has also been informed of the change. 4)The following movement of lateral assignments will alleviate the volume of bags on 1X-1X and will provide a safe place for our employees, preventing them from sustaining potential injuries. The bag room staff involved were pleased with the groups decision in finding a resolution to this safety concern.

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Facility: Passenger Loading Bridge

Narrative: The jet bridge at gate 11 drives and turns very quickly. As a result, the jet bride jerks and lurches to the point that the spacer limit was tripped. This needs to be addressed before aircraft damage occurs.

Narrative: On Oct XX Inbound ua XXX from SAN was arriving at the Gate D8. Loading Bridge stopped moving. Wheels would not turn. The Wheel indicator showing position of wheels was out of service. The vertical indicator was also out of service. Building and maintenance was called and the plane was met.

Narrative: I was pulling the plb at gate C2 for ua XXX to FRA. When I went to close the door it would not budge....it was stuck. The floor was up to the door, pushing the door upward...as if the auto leveler was not working... I Called zone and informed them....and asked for a mechanic. By removing the canopy and lowering the PLB....we could move the door, but felt it needed to be examined by maintenance.



A number of SOSAP reports have identified issues while operating specific passenger loading bridges throughout the system at our hubs and line stations. Based on the information reported our GQ/PV department at all our hubs have been working through each item as reported and corrected or updated as appropriate. Several hubs have also implemented a plan whereas a PV mechanic and a CS trainer will conduct audits in concert on every jet bridge approximately every two months. PLB issues that were reported at our line stations have been shared with local management for corrective action with the appropriate governing bodies.



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