CHIRP

Air Transport FEEDBACK

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CONTENTS

EDITORIAL

There has to be a better way. We are printing just 2 of the many reports received about the change of contract for offshore helicopter support that resulted in the demise of an operator in July (Commercial Pressure and Practice and Safety Concerns Dismissed). The downturn in the UK oil and gas industries is making it a very uncomfortable time for this sector of UK aviation with the threat of further job losses already prompting more CHIRP reports. It would be futile to try to insulate aviation from the cut and thrust of competitive commercial tendering but is it unreasonable to apply some moderators for a safety-critical industry particularly sensitive to human performances?

CAP1145 (Offshore Helicopter Review) recognised that current notice of contract termination and award may leave little time for the winning contractor to train new employees. Left unsaid was that, for the employees of the losing contractor, 90 days' notice of possible redundancy may be perceived as a very short period to seek alternative employment but more than enough time for high levels of stress to develop. If the first 30 days of those 90 are characterised by rumours and lack of reliable information, the potential for unsafe stress levels and in-cockpit distraction could be very high indeed. The operator's creditable efforts to mitigate the risks by encouraging pilots to stand themselves down if they felt unduly stressed were partially offset by pilots' concerns that demonstrating weakness, particularly mental weakness, could jeopardise future employment prospects.

Although the offshore support industry appears to be particularly vulnerable to contractors playing operators off against each other, similar pressures on employees are possible in any sector as a result of commercial failure or takeovers. It is not enough to tell pilots that they should not report to work if they are not mentally focussed or stressed. A way must be found to generate the conditions in which pilots can do what they know to be correct without fear of long term disadvantage.

Stresses and strains are not confined to periods when facing redundancy. Modern life can be stressful due to any of the domestic, family, financial and professional factors etc. that make up our individual circumstances. When peaks occur it is easy to assume that we should 'hang tough' lest seeking assistance is perceived as a sign of weakness. Not so! Think of your capacity to deal with all that life throws at you

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as a pint pot. When your pot is full to overflowing you need to do something to take off the top inch and restore some 'ripple room'. A base manager, flight safety officer or chief pilot would be a good starting point to seek advice and reassurance about professional issues and could potentially arrange work-place alleviations to relieve some of the pressures. However, this is no substitute for seeking professional medical advice, which should always be done immediately if you feel you are not fit to fly.

The Germanwings 4595 tragedy of 24 March 2015 has highlighted the importance of ensuring pilots' fitness to fly. Although the investigation is ongoing, the preliminary report published in May 2015 indicates that the crash may have been intentional. We may never know whether the pilot's actions were related to any underlying medical condition; even if a pilot has a known condition it is often difficult and may be inappropriate to attribute behaviour to a medical problem. What is important is for pilots to be in the best possible frame of mind when undertaking the mentally, and often physically, demanding task of flying an aircraft.

It is in the interests of the whole aviation community for psychological stressors or mental ill-health to be actively reported so that a pilot who experiences a transient psychological disturbance or any other episode of mental ill health can be assessed and investigated, with the aim of them being supported during their recovery and returned back to flying duties as soon as possible.

The aeromedical examiner (AME) network exists to oversee pilot fitness. The AME should be the first point of call for any pilot who develops a medical condition or who has concerns about a colleague's fitness. Most conditions present between medicals and it is important that timely intervention can be undertaken to speed recovery and minimise time away from flying.

Aviation safety depends upon unfitness being declared and, of course, it is a legal obligation for a pilot to do so. Some medical conditions are associated with a lack of insight where a pilot does not recognise they are becoming unwell. In this situation, colleagues are often in the best position to flag up a concern. The whole aviation community needs to remain alert to the importance of a fit pilot for a safe flight and for the operating environment to be conducive to facilitating non-punitive reporting of all types of illness. Operators and regulators need to work together on this.

Ian Dugmore - Chief Executive

Return to Top

ENGINEERING INTRODUCTION

Having recently been appointed to the position of Deputy Director (Engineering) CHIRP, I would like to thank my predecessor Bruce Hunter for all his hard work in the interest of safety and on behalf of the wider aircraft Engineering and Maintenance community.

Taking on my new role my initial task is to ensure that Engineering and Maintenance personnel continue to be represented both within CHIRP and across the wider aviation community.

The industry, as always, faces many existing and new challenges with the introduction of new technology and the capability required to maintain it, in an ever increasing competitive environment. Whilst we work in a heavily regulated industry with supporting procedures and processes, the role of the individual in maintaining aircraft in a safe and airworthy condition, should not be underestimated. The Engineer's role in not compromising on safety is vital in maintaining airworthy aircraft. It is with this in mind that I hope, in some small way, I may, with your help, improve our safety systems and culture.

I started my career, many years ago, as an engineering apprentice and since then have worked in many locations across a wide breadth of Engineering and Maintenance disciplines. I hope my experiences will help you and me in my new role.

Finally I look forward to working with you all and dealing with your reports and queries in the months ahead.

Dave Tattersall - Deputy Director (Engineering)

Return to Top

ENGINEERING REPORTS

LACK OF TRAINING ON NEW AIRCRAFT TYPE

The reporter works in an area of the airline that has recently had a new aircraft type introduced.

Report Text: This is not about a single incident but more about the company's present position with regard to training. I am an A licence holder in the XXX area of the airline. In this area the A licence holders probably do most of the "hands on" work assisted by the LAEs [B licence holders] who basically perform a supervisory role at most times.

I would like to know what CHIRP thinks about the fact that the vast majority of the A licence engineers working on new aircraft types have had no training of any sort on this aircraft type even though we have had the aircraft for well over a year now? We are constantly informed through Technical publications about how different this aircraft is to others in our fleet and how everything must be carried out exactly as per the manual to make sure that the operation of and that personnel working on this aircraft type are all safe.

The problem as I see it, is that the vast majority of personnel working on the new type (apart from the LAEs who have been on the type course and a very few A licence holders) have had no training on this type whatsoever. In that I mean not only any sort of type training but no general familiarization courses (which I think should be run on health and safety grounds) no course on how to use the very different remote manufacturers manuals and no courses on how to use the electronic log or how to use the Ground maintenance or aircraft laptops

This leads to some very frustrating situations, in that to do the simplest things, for example to raise a defect we have spotted we have to find an LAE who knows how to use the electronic log.

We have raised this with both local managers and higher managers and we are told that either there are not any courses, as in no familiarisation courses, or, when there is a type courses places are always very limited. This points to a lack of both available training staff and a company that doesn't really want to spend out on training.

I really do not want to be in a situation that we only get training suddenly after someone has an accident.

To highlight the need for specific training even more, even the type rated LAEs, have recently had an update from our quality department stating that they must do a number extra courses to keep their type rating valid (I cannot remember them all but there are a number including the E log) If it is required for the LAEs why not the A licence holders?

Company Comment - The airline was approached and advised that due to a reorganization the aircraft in question would be moving to another area. They have further advised that staff who will be utilised in the new area are being trained to enable them to effectively manage the aircraft.

They have also reviewed the establishment of trained staff and feel this is suitable to manage the current operation. They do recognize that this decision will disappoint some staff who would like to be trained on a new aircraft type

***CHIRP* Comment**: Clearly the reporter was concerned that he was not being trained to the level he believed desirable and appropriate for a new aircraft type with new systems technologies. This issue is increasingly common and there are potential risks associated with different standards of training on aircraft with integrated systems. A general familiarisation course would be beneficial but is not essential. The key element when working on any aircraft type is to ensure that you do not exceed the scope of your certification responsibilities and personal capability.

Part 145 organisations should establish the competence of all staff performing maintenance. Certifying staff are required to have specific training on the aircraft type prior to being authorised to certify any work carried out. Category B and C staff will undertake type training specified in Part 66/147. Category A staff will undertake 'task' training on type for those tasks to be authorised.

Where staff are 'managing' maintenance they are required to be trained on, and familiar with, the maintenance documents and procedures, as well as the company certification system for the type. There is not a requirement to train all staff, especially those working under the instructions/supervision of a properly 'trained' and 'authorised' engineer.

If in doubt guidance should be sought from a local manager or engineer with the appropriate qualifications.

Return to Top

MEMS MEDA Report

(MEMS - Maintenance Error Management Systems) (MEDA - Maintenance Error Decision Aids)

Incident

The incident resulted while the aircraft in question was undergoing a hangar input for a C Check. During the refit of the FWD galley post floor structural re-work the galley frame pelmet made contact with and severed power cables. Following the first event, and after rectification, a separate group of engineers undertook the galley refit the team now working on a night shift experienced similar difficulties and again severed the galley power cables. This again caused damage to the aircraft galley power cables and the galley structure. Ultimately the events resulted in significant rework and a delay to the aircraft check.

Investigation

The HF investigation revealed a number of issues relating to the task. During both attempts to fit the galley the staff involved lacked specific task knowledge to accomplish the job. This was exacerbated by failures to record and stage the work effectively. Some staff who were assigned the task left the job part way through to attend to other tasks resulting in a lack of continuity. In addition the organisation found there was a lack of adequate supervision associated with the task to be performed.

The Aircraft Maintenance Manual (AMM) has instructions to remove the pelmet however on this aircraft the pelmet was bonded to the galley structure. The engineers attempted to follow the instructions within the AMM and were focused on the location of the galley and failed to observe the risk from the cable looms impacting the galley structure.

Analysis: There were several elements of human factor failings relating to this event as outlined above. In addition on one of the occasions the task started at 03:00 AM during a night shift. This is noted as a low point for many people when thought processes and reasoning can be impaired.

No information was passed to the second group of engineers regarding the initial event. Had this information been passed to the second team it could have acted as an additional caution regarding the risks associated with this task.

The event highlighted several shortcoming in the processes associated with the fitment of large aircraft structural components. Invariably they are bulky heavy and are being fitted into small restricted spaces. These items need to be handled in a planned and coordinated manner.

Follow-up Action: The organization and airline involved undertook a change to the AMM to highlight the fixed pelmet and also the risks associated with power cables during galley refit. The AMM did not cover the circumstances in which the pelmet was bonded to the structure and therefore was inappropriate for this work. Part 145 permits the creation of supplements to the AMM but that had not been done in this case).

The maintenance organisation issued a notice to staff to seek authority/advice when the AMM differs from the aircraft equipment that is fitted.

The maintenance organisation has organised training to mechanics on the hazards associated with fitting large pieces of aircraft equipment, galleys, toilets etc. In addition it has issued an instruction that all complex tasks need to have a team leader to co-ordinate the activity.

The issue was used as an example in the HF training for all staff.

***CHIRP* Comment**: Adequate supervision and training of maintenance staff are key to ensuring procedures are followed correctly and any discrepancies between procedures and practices are highlighted with appropriate corrective action undertaken to ensure safe working practices are followed. As always, consideration of the human factors on undertaking critical and complicated tasks at the low point of the circadian rhythm needs to be accounted for in work allocation.

Return to Top

FLIGHT CREW REPORTS

COMMERCIAL PRESSURE AND PRACTICE

This report should be read in conjunction with the report titled 'Safety concerns dismissed'

Report Text: [ ] was awarded the [company name] offshore support contract in 2012. The contract entailed a significant ramp-up of personnel and a large training commitment. However, [ ] was unable to advertise the fact due to the conditions of the contract negotiations. This had a marked affect upon subsequent operations and Flight Safety suffered due to 'fire-fighting' until sufficient manpower had been recruited and trained. The usual company training protocols suffered as gaps had to be filled. We had an incident the following winter which I personally attribute to coping with the way the contract was awarded.

CAP 1145 'Safety Review' recognized that all was not well in the offshore sector and CAA sought to take a very welcome tighter grip on the industry. For example, we look forward to landing on decks with current lighting standards. One area which they quickly discounted was the helicopter support contract practice of the oil companies. The operators were told that the CAA had been assured that there was no commercial pressure in the process and therefore no effect upon safe operations. This was met with incredulity by the majority of offshore pilots and personnel involved in negotiations. It was as if the CAA had briefly lifted the stone and replaced it quickly after some re-assuring mutterings from the higher-level echelons of the companies involved. In my opinion, this particular stone of how the oil companies play-off the helicopter operators against each other, and award contracts with minimal notice, needs to be kicked over and whatever lies beneath inspected deeply. Forget the ethics - it is the detrimental effect upon safety that is the main concern - affects which could be avoided if the willingness was there.

[Company name] had repeatedly told us how pleased they are with our performance. Even when they misunderstood the wave-height restrictions (despite our 'warnings') and found themselves 'grounded' on numerous occasions throughout the winter. Our aircraft was the cheapest to operate and ad-hoc could be chartered when Hs>2.5m. The contract was extended to 2020 and everyone seemed happy and could settle/concentrate on the job in hand. We had managed to catch-up with the no-notice start. However, credible sources from our competitors then confirmed that [a rival operator] had been awarded the contract - having been in negotiations since January. Despite [company name] insisting no one should utter a word, word leaked out in such a small 'world' and the practice of underhand negotiations and last minute contract awarding continued - after all, that is how it was awarded to us back in 2012 and it affects us all!

So the result was offshore passengers flying in commercial helicopters that were being engineered and piloted across the sea by people uncertain of their future and distracted by what lay ahead.

Such practice had a tangible affect upon safety. I assume that was why it was included in the safety review? Despite what the CAA have been told - the practice is alive and in good health, flourishing nicely under that stone that appeared barely disturbed by the authorities at the start of the review.

Lessons Learned - The CAA needs to get down and dirty and review the way their AOC Holders operate during contract negotiations as it has a direct affect upon safety. The fact that clients have calculated the 'cost' of a life lost in an accident and balanced that against their 'best practice' is telling.

Return to Top

SAFETY CONCERNS DISMISSED

Report Text: I'm submitting this report due to concerns that oil companies can pull out of contracts with 90 days' notice (a concern shared by the Transport Select Committee and BALPA) in order to secure another operator's services at reduced cost, and the subsequent effect on flight safety.

This concern was raised post the Sumburgh accident during the CAP 1145 safety review, and the CAA apparently queried this problem with [industry], who stated that this practice has no effect on flight safety. This lies at the heart of my (and many of my colleagues) concerns; why did the CAA consult with the body that represents the oil companies and helicopter operators, who have unsurprisingly marked their own homework? I would be interested to know how many pilots and engineers were consulted.

As an employee who has recently been subjected to this process, I can confidently state that this causes a significant distraction and threat to flight safety. Hiding behind the Ops Manual reference to being fit for duty is a cop-out as it places all of the responsibility with front line employees and effectively removes companies from the safety process and its attendant responsibilities.

All of us are aware of the volatile and cut-throat nature of the oil and gas industry, but for the CAA to be so easily convinced that there is no safety impact on aircrew is very disappointing, and suggests a lack of willingness to investigate which leaves questions as to their impartiality.

This "short term-ism" and subsequent safety impact should at least be fully acknowledged by the Authority and widely promulgated throughout the industry so that it can be studied and addressed at least as rigorously as passenger size, sea states, seating position and breathing devices. A lengthy review process with committees, meetings, presentations and corporate showcases attended by senior industry figures is therefore NOT complete until this very serious problem is addressed.

To sum up: The 90 day clauses are one matter, but the main point of this CHIRP report is that the safety effect must be acknowledged and addressed.

***CHIRP* Comment:** These reports concerned a non-UK AOC-holder based in UK. The CAA was alerted and in turn alerted the relevant NAA to the safety concerns expressed in the CHIRP reports. The CAA then worked closely with the relevant NAA, which shared its study of FDM data that revealed that there had not been any Level 1 deviations. While there was clearly more to the issue than this, the CAA, having extensively discussed the matter with the foreign NAA, was content with the oversight provided. Nonetheless, recognising the conflict between normal commercial pressures that affect almost all elements of industry and safety concerns associated with changes of contract, the CAA decided that this is an issue that will be taken up for discussion with industry in the CAA-led Offshore Helicopter Safety Action Group (OHSAG).

In addition to the comments in the Editorial to this edition of FEEDBACK, it is noteworthy that the dynamics of offshore operations have changed as a result of the lowering of oil prices. There is a 'production versus protection' conflict built into the aviation industry which currently leads to great concern over employment prospects in operators providing helicopter support. There have always been swings between shortages and surpluses of people but the current situation appears to be particularly severe with reduced employment opportunities with other contractors. In these difficult circumstances we note the professionalism of the flight crews and engineers who 'kept the show on the road' during the rundown period to the end of the subject contract. A great team performance.

Return to Top

PROCEDURAL APPROACH OR RACE

Report Text: Main Point A: When two aircraft have agreed to accept a procedural service, can the aircraft second in the sequence subsequently abandon the procedural service and overtake the aircraft ahead, but still fly the published approach?

Main Point B: If that is permissible, how can the aircraft still following the procedural service ensure separation in IMC from the overtaking aircraft?

I was PNF in (aircraft A) flying a night service to a regional airport. The other aircraft involved (aircraft B) was scheduled to arrive 10 minutes later. At this time of day it is normal to be offered a Procedural Service and a published approach procedure established outside controlled airspace. It is usual for aircraft to be asked by [area] ATC for an estimate for the VOR that is the start of the approach procedure and the aircraft can then be sequenced. When we called ATC we heard aircraft B estimating [ ] at 0245 (Z), which was 3 minutes ahead of our estimate. Nothing was then said about the order for the approach but aircraft B was higher than we were; when aircraft B crew then asked for descent, they were told they would be number two for the approach. They did not query this. We were given an initial descent and passed to [destination] ATC. We were at FL70 in IMC. The cloud-base was later seen to be below 3000 feet. We were cleared for the approach with no delay and we agreed a Procedural Service. Aircraft B then came on frequency, was told this was a Procedural Service, that they were number two, and they were given an approach time; they accepted this. After some time aircraft B crew asked why they would not be number one, as their estimate was earlier than ours. The explanation given was that they could not descend through our level and still

maintain safe separation. Aircraft B then asked for a "Basic" service. They did not explicitly cancel the Procedural Service. ATC sounded surprised and confused, but agreed aircraft B then said they were descending to MSA and would follow the approach procedure without delay. The effect was that aircraft B overtook aircraft A without guaranteed horizontal separation, and passed through the level of aircraft A, even though they had just been told there was not the required separation to do so. We were then given various height and time restrictions in an attempt to maintain separation from the other aircraft. We also chose to slow down. While ATC did the best it could in this situation, the proper operation of a Procedural Service failed and we could only actually ensure separation visually when below cloud. I was sufficiently concerned to ask that the ATC tape be marked and preserved. The issue is whether aircraft B is allowed to do this?

The reported operator commented that Aircraft B was above and ahead of aircraft A. The crew in aircraft B legitimately chose to change the type of service to initiate a descent and accelerate away from the other traffic. At all times they were VMC and the separation was never less than 15nm. The operator noted that the actual Met from the time around the event does not substantiate the reporter's account of the flight conditions (METAR 19010KT 9999 FEW048 09/06 Q1001=).

***CHIRP* Comment:** As frequently happens, the 2 crews involved had different perceptions of the events. The reported flight crew were acting legally in Class G airspace and there is no evidence that their appreciation of the geometry or dynamics of the reported event was incorrect. However, they did cause the reporting crew concern, which is something to avoid if at all possible. The incident also prompted the ATCU to arrange a workshop to discuss the issues raised.

Leaving aside the particulars of this incident it is worth making a few general points. Non-radar units are reliant on pilots providing accurate estimates; unless estimates are grossly incorrect, it is difficult for ATCOs and other flight crews to detect any error. Moreover, an estimate which is accurate when passed can become increasingly incorrect as time goes by with significant effects. Of course deliberately passing incorrect estimates could be interpreted to constitute a breach of the ANO. Judging distances accurately at night by eye is virtually impossible. It may be tempting to rely upon TCAS as an aid to Situational Awareness but it was not designed, nor is it suitable, to be used as a separation tool; it is difficult to detect overtake/undertake using TCAS, not all proximate aircraft may be displayed and the azimuth of contacts can be significantly in error.

Return to Top

CLEARANCE TO LAND

Report Text: I was taking off from [ ] to [ ]. I had an IFR clearance from ATC and clearance from my operations that the handler would be at the airport upon my arrival. I took off from [ ] and I experienced a problem with the aircraft; I fixed the issue through the use of the QRH. I was in contact the whole time with ATC. I told ATC I had resolved the issue and continued to [ ]. About 25 nm I asked for lower they said it will be in 8 miles. At no time did ATC ask me what approach I wanted. After getting lower ATC gave me a squawk code of 7000 and a change to a different frequency. I did [change frequency], to no answer; I thought I might be 'lost comms'. It was VFR conditions so I was not worried about going into the clouds. We joined the ILS and continued in bound to the airport. While I was on the ILS I was making position reports at 10nm and 5nm. I did not see a flashing red signal from the tower telling me not to land. I did not see a big flashing X on the runway and it was all during day light hours and VFR conditions.

Lessons Learned - To query ATC if something doesn't seem right. Call my office and ask them again if we have clearance for the handler. All and all, don't just take some ones word for it - ask questions.

***CHIRP* Comment:** The reporter departed an aerodrome inside a Class D zone. Having then flown through Class A airspace he left CAS and entered Class G airspace for the final portion of his route. Unbeknown to the pilot, the delay in sorting out his aircraft technical problem took him beyond the published operating hours of his destination, which had closed before he called on the RT. Had he returned to the previous frequency, he might have learned that the destination was closed rather than his assumption that they were simply not responding to his calls. His perception that the aerodrome was open may have been reinforced by the ILS remaining functional. Pilots may be surprised to learn that it is common practice to

leave ILS switched on, including the in-service ident, outside aerodrome operating hours to avoid serviceability/calibration problems associated with cycling the systems on and off.

Return to Top

EXCESSIVE DUTY HOURS

Report Text: The report time for the duty is 0630 local and the end of the extended duty is 2245 local. This is a period of 16 hrs 15 mins. Three sectors of flying followed by a positioning sector. Between sectors 2 and 3 there is a period of waiting of 3 hrs 40 mins for sector 3.

Whilst the Flight Duty Period is in compliance with EASA flight time regulations as the last sector is positioning, and a positioning duty can take as long as necessary, it does not devolve the employer from statutory Duty of Care laws under UK legislation.

Under UK Employment Law the employer has a duty of care to "ensure that staff do not work excessive hours". This includes taking into consideration the waking up time of the employee, which must, in this case be in the region of 0400 to allow for preparation and travel up to 90 mins to work. It must also take into consideration the employee travelling home after finishing work. From 2245 local this could mean for example travel up to 90 mins = 0015 local. This could equate to a waking period of 20 hrs 15 mins in order to complete the rostered duty within the company regulated maximum travelling times.

If anyone was to have an accident on driving home after having to complete such a duty, it would be regarded under UK employment law as excessive work hours, and the company would be liable to prosecution by the UK authorities.

Whilst the Flight Duty Period is in compliance with EASA flight time regulations as the last sector is positioning, and a positioning duty can take as long as necessary, it does not devolve the employer from statutory Duty of Care laws under UK legislation. Furthermore these duties are always rostered before days off, which means that the excessive rest period and recovery time is carried out on the employee's day off, with no compensation.

ACAS's website reference http://www.acas.org.uk/index.aspx?articleid=3751 which defines an employer's duty of care. To expect an employee to be awake for duty for 20 hrs 15 mins is not acceptable and quite unreasonable and would be considered by the UK authorities to be very dangerous to be travelling home after midnight when having awoken at 4am. Therefore I am also filing an Air Safety Report in advance of this duty. A fatigue report will also be filed after the flight.

***CHIRP* Comment:** The reporter contacted the crewing department about the roster and explained that a hotel would be required to avoid the risks associated with driving home after such a long duty. To their credit, the crewing department agreed that the duty was excessive and reduced it for the reporter and the rest of the crew. However, the question remains about what is an acceptable duty period and what exactly are the rules about total waking time.

Neither the CAA nor EASA regulate the Health and Safety aspects of commuting before and after duties. That said, in FODCOM 2009/10 (subsequently subsumed into CAP789) the CAA highlighted the duty of care issue but from a high level when talking about long duty days - "operators may wish to consider any implications for the duty of care towards staff of requiring such work patterns". The CAA does not promote other legislation. Long duty days are captured within the subsequent rest period (the crew must have the same length of time off as they have been on duty and all the hours count to the cumulative limits).

CAP371 and the EASA regulations are the same in the approach to long duty days where the flight duty period has finished but the crew are positioned as passengers to another location. The issue of long duty days would fall under the requirements of ORO.FTL.110 Operator Responsibilities for managing the fatigue of the crew associated with long duties. However, this is not the same as the duty of care requirements which are outside Aviation regulations but for which the company also has responsibility. Although the advice provided by ACAS is titled 'Defining an Employers Duty of Care', the use of the word "may" in the text means that the advice is anything but definitive and it does not provide metrics. What is required is for operators to determine, agree and publish their policy for fulfilling their Duty of Care proactively rather than develop policy in response to challenges to individual rosters.

Return to Top

ROSTER DISRUPTION

Report Text: I am writing to you to report severe roster disruption at [ ]. Disruption is running at around 80% of rostered duties. In my case, over the last 10 days' work, I have had 22 different duties rostered, involving 3 different changes of base, including start and finish times changing by over 5 hours.

The latest batch of changes involved another 2 nights away from home. I picked up the changes at the start of a duty and for at least the first 2 hours of work (operating a flight), I was only half concentrating, whilst wondering how to sort out my life for the rest of the week. I noticed numerous small slips and missed calls. I have raised my concerns with BALPA, my manager and filed an Air Safety Report, but I hold out no hope of change. The company has clearly cut crew numbers to the bone and simply does not have enough pilots.

Lessons Learned - The root cause of this is management bonus chasing culture resulting in not enough staff. This happens with monotonous regularity at [ ] over a 4-5 year cycle. I am aware that the CAA are supposed to monitor roster stability, but no action appears to be taken. Any actions I may take simply treat the symptoms and not the cause.

***CHIRP* Comment:** Under EASA FTL operators will be required to "establish and monitor performance indicators for operational robustness of rosters".

> GM1 ORO.FTL.110 (j) Operator's Responsibilities
>
> "Performance indicators for operational robustness of rosters should support 'insert airline name' in the assessment of the stability of its rostering system. Performance indicators for operational robustness of rosters should at least measure how often a rostered crew pairing for a duty period is achieved within the planned duration of that duty period. Crew pairing means rostered positioning and flights for crew members in one duty period."

With the deadline for implementing EASA FTL of 18 February 2016 (see CAP1265), the majority of operators will transition over the coming winter season. This means it will be well into next year before the regulators begin to assess roster stability.

Return to Top