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Feeling pressure

Some crews increasingly feel compelled to operate when unfit to do so, but they shouldn't – and here's why



Steve Forward
Director Aviation

Company sickness policies are beginning to raise their profile within CHIRP reporting, with many reporters saying they are feeling pressured to operate when they are sick because of either personal financial loss or company/management pressures to fill rosters. Although sickness policies themselves are not a direct safety issue, their second order ramifications for crew wellbeing and the potential for operating aircraft when unfit to do so are clear safety concerns.

Operators obviously have an imperative to discourage inappropriate absences but they must also meet their obligations regarding the health and wellbeing of their staff and be seen as being fair by flight and cabin crew. For their part, crew responsibilities in respect of their fitness to fly are clear within [Regulation \(EU\) 965/2012 Annex IV Part-CAT CAT.GEN.MPA.100 'Crew responsibilities'](#) which states at (c)(1) (as amended by Regulation (EU)

CONTENTS

02	Editorial
03	Comments on previous feedbacks
05	Reports
05	<i>FC5182 – Inexperienced cabin crew</i>
05	<i>FC5183 – Distractions at critical stage of flight</i>
06	<i>ENG 712 – Safe working</i>
07	<i>FC5188 – Company communications</i>
08	<i>FC5219 – CRM issues</i>

2018/1042) that: *“The crew member shall not perform duties on an aircraft when under the influence of psychoactive substances or when unfit due to injury, fatigue, medication, sickness or other similar causes.”*

So, although it is a legal requirement for crews not to fly unless fit to do so, some companies appear to lack suitable sickness policies that recognise this and the different physiological imperatives that underpin aviators’ fitness to fly; ‘normal’ sickness policies that might be appropriate in non-aviation sectors are often not appropriate for commercial aviation.

Here’s an example: *“Last month I suffered a cold, could not clear my ears and went ‘sick’ for seven days as a result. This was supported by a doctor’s note. I was informed this week that my sickness had triggered the long term sickness policy, and that I was now being monitored. I then received a letter informing me that this meant if I was to go ‘sick’ again before [a specified date a year on], then this would be more serious and could then lead to further action, and eventually to my job being in danger if things did not improve. I perceived this letter as very threatening and have been very worried about it since. On the one hand it is my duty to report sick if not fit to fly, on the other hand the company sick policy is bullying me into coming in so as not to suffer unpleasant consequences, effectively breaking the law. This is causing me undue stress and an irrational fear of getting ill and has a detrimental effect on my mental well-being. The sickness policy applied to flying staff should be different from the policy applied to ground staff.”*

Other companies are financially penalising those who go sick because they not only lose their flying component of pay but may also suffer a reduction in, or even loss of, basic salary for the days they are unable to report for duty due to being unfit to fly.

Here’s another example: *“My employer has recently changed its sickness policy for pilots and cabin crew such that if they report sick even for one day their salary is reduced by salary/260 for each day of sickness [there being 260 days available for work in a year given a 5-day working week]. This is compounded by the fact that the basic salary represents approximately 50% of the pay for the lost day with the other element (variable pay) being lost completely. This is entirely counter-productive to safety where we are legally required not to fly when unfit. This new policy will financially force crew to fly when unfit. Yesterday a senior cabin crew member told me she will lose £600 from her pay this month because she tested positive for COVID and stayed home. She said, “Next time I’m coming to work, as I won’t have any savings left to pay the rent.”*

Noting that safety may be being compromised by crews feeling pressured to operate when they are unfit to do so, CHIRP has highlighted its concerns about some specific operators to the CAA.

Although company responses to sickness vary, it seems that some operators apply standard HR rules inflexibly rather than consult occupational health physicians with aviation expertise; it is notable that operators that have a medical department are generally more active in managing sickness absence and proactive in obtaining clearance to return to work.

Whilst the regulations about fitness to fly are clear, the problem of crew absence management relates to industry-wide behaviours, and the search for a holistic common solution to recording and dealing with sickness absences should be overseen by the regulator as an industry-led activity with inputs from HR specialists, legal advisors, trade unions and aviation-medical specialists. The aim should be to produce best-practice protocols that operators can adapt to their own requirements not just for flight and cabin crews but also for other safety-critical staff such as ATC, engineers and others who must not conduct their tasks and should not be induced to work when not fit to operate (be it flying, controlling, engineering etc).

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CHIRP Air Transport Advisory Board

Want to give something back?
CHIRP needs you!

CHIRP functions through the contributions of our Board members who freely give their time to provide advice and wise counsel on issues raised in reports. The Board meets every 3 months and we are always looking out for new members to assist in our work. If you’re interested in participating in this worthy endeavour please contact Steve Forward, Director Aviation, at mail@chirp.co.uk.

WE NEED



YOU!

Engineering Editorial

In an ideal world there would be no need for CHIRP. In reality, aviation benefits from CHIRP and CHIRP needs the input of all “stakeholders”. Interestingly, there has recently been a number of Cabin Crew reports identifying engineering issues. CHIRP is of course very pleased to receive all reports and a crossover of sources is not necessarily a problem. The question here though is, if Cabin Crew are reporting engineering issues, is there a reluctance by engineers to report, or are they simply adjusting to a certain level of things being wrong (Norms or Learned Helplessness perhaps)?

One such report was in reference to a widebody aircraft with a large cabin panel missing! The Cabin Crew reporter’s initial concern was of something being secreted away in an area that was difficult if not impossible to inspect for security because the missing panel was high on a bulkhead.

Did the engineer that carried-forward the panel consider the impact of other (non-malicious) FOD being dropped behind the area below the missing panel? Did they consider if any components (EWIS or otherwise) might be compromised by FOD? What are the implications of fire containment with a large cabin panel missing? Oxygen in the cabin air could feed a fire more easily of course.

Although there is the chance that a missing panel could provide early fire detection, it is not really the work of a licensed engineer to make such a judgement. The operator did contact its design organisation for a temporary cover but a spare was procured before the temporary work was started. How was the missing panel carried-forward, it would not be in the MEL or CDL, and the operator in question does not use a Non-Essential Furnishings list (NEF)?

On balance, an internal report was raised and appropriately processed. The Continuing Airworthiness Management Organisation (CAMO) in this case is an organisation within the airline and CHIRP received a professional response. However, internal reports from Cabin Crew or Engineering do not necessarily get submitted to a CAMO.

Whilst on the subject of CAMOs, CHIRP hardly ever receives reports from CAMO staff, whether they be Licensed Engineers or other appropriately competent staff. Due to the fact that the CAMO personnel are routinely identifying errors on flight and maintenance records, perhaps they feel as if being the last chance to put things right precludes them from reporting incorrect practice.

We should think of the CAMO as the glue between Operations and Engineering. If it becomes evident that an in-house or contracted Maintenance and Repair Organisation (MRO) is performing in an unsafe manner either as a single issue or continually, the CAMO has a responsibility to report it by submitting a Mandatory Occurrence Report (MOR) to the applicable Regulatory Authority. At a lesser level of concern, CHIRP is ready and willing to record, highlight and progress CAMO staff reports of any shortcomings. Maybe managers and engineer staff in CAMOs could raise the awareness of CHIRP to their competence-based colleagues.

CHIRP has very strict processes to ensure confidentiality but we do understand that, for any number of reasons, it is not an easy decision to submit a report. We encourage you to submit an internal report first when possible even though that might make subsequent confidential reporting to CHIRP more difficult. Your employer's Quality/Compliance/Safety manager is not particularly interested in who you are, only what you report; although they do need to know who you are to give you feedback in accordance with the regulations. It stands to reason that many issues are not reported to anyone because confidentiality would be compromised if, for example, you were the only staff member on duty.

When a report arrives at CHIRP we issue a holding response to acknowledge receipt and a formal response is then sent by the most appropriate CHIRP team member. The formal response very often contains various questions, thereby requiring the reporter to commit more time. Sadly, some reporters never reply and the report does not continue. Junk Mail may be a causal factor here but it may be that the reporter

is just relieved to have got something off their chest, or they simply did not envisage further work. CHIRP will not contact any other organisations without being given the go ahead from the reporter. Therefore, without questions being answered, reports cannot proceed to a conclusion, cannot be published for the benefit of us all and worse still, the reported issue remains a problem or a safety compromise.

Finally, two more reminders and a request. We need you to submit near-miss reports (where you nearly made an error) and we need you to self-report when you feel you should hold your hand up because you have made an error that others might repeat. CHIRP has to have buy-in from Quality/Compliance/Safety and Engineering management - being open with staff about CHIRP is in the interest of all stakeholders and we ask that you bring CHIRP into your processes so that this useful source of intelligence about things that might not otherwise be reported can be tapped.

Phil Young, Engineering Programme Manager

COMMENTS ON PREVIOUS FEEDBACKS

Comment No 1: Judgemental Editorial

I've just finished reading your latest edition of CHIRP (Ed 143) – I continue to spread the word about the great work you do at your organisation and know many crew who now are aware of CHIRP and its benefit; I know my friend has recently reported after losing confidence in their internal mechanisms.

I just had a question around the wording used within Page 2 of the edition's editorial. It states that under Just Culture, "*sometimes people should have known better (unprofessional)*", and I just wondered what your thought process was behind this?

From my perspective, and considering Human Factors, this read as opposite to the intention of Human Factors and Just Culture and almost puts the blame back on the end user? I don't know if I've misread that. The interesting point with Human Factors is to understand 'why' people should have known better. Was it a case of lack of rest, poor procedures, poor CRM, poor working environments, a degraded safety culture... equally even if an event is a 'violation' and someone 'should have known better', is it a case that the individual felt that they had no choice despite correctly knowing the procedure - i.e. in the case of on-time performance, lack of resource, and all the challenges we know exist in the industry currently. In which case it's not unprofessional per se, it's more likely a wider system issue.

CHIRP Response: The comment the reader refers to was my shorthand to acknowledge that 'Just Culture' and 'no blame' don't mean that there may not be consequences for those who might act in a reckless manner.

In this respect, the context and circumstances of every incident should of course be fairly examined to find out whether there are any systemic issues behind the incident but ‘no blame’ cannot be universally applied for example if people deliberately break the rules for their own gain when they know that what they are doing is not what they are supposed to do, or they conduct deliberate malicious sabotage.

Any such review must distinguish between mistakes, errors, situational violations and exceptional violations as instances where there may be systemic lessons that should normally be addressed without ‘blame’ being apportioned. But instances of sabotage, recklessness or violation for personal gain are often ‘blameworthy’ for want of a better expression and amount to professional lapses at the very least.

Violation for organisation gain is another aspect that can lead to a marginal outcome, sometimes it’s easy to see that there were good intentions to someone ‘bending’ the rules to achieve the task, but sometimes it might be that someone was borderline ‘reckless’ in doing so.

As ever in Human Factors analyses there are rarely black-and-white outcomes to anything and so ‘apportionment of blame’ is a matter for much debate. That’s why it’s important that companies convene broad-ranging teams when reviewing safety incidents so that multiple perspectives about the motivations and thought processes that might have pertained can be offered to investigators. Ultimately though, a purely ‘no-blame’ approach can lead to reckless behaviour if there are no consequences for inappropriate or egregious ‘unprofessional’ actions.

Comment No 2 – Fuel tables

Air Transport FEEDBACK Edition 143 contained an article under the heading ‘Fuel Tables’. I noted that you said, *“It’s human nature to reflect upon one’s own performance in relation to others, and some less experienced captains might conceivably perceive implied pressure or incentives to carry less additional fuel even if they felt they needed it in what was ultimately a safety-critical decision”*.

You may already be aware of the similar perception problem about fuel ‘League Tables’ that, little more than 20 years ago, CHIRP had agreed should be addressed. In consequence, the CAA initiated what was termed a Special Objectives Check that required Flight Operations Inspectors assigned to relevant companies to look into the fuel planning policies and associated instructions.

The results, together with the analysis and options/recommendations that followed, were contained in reports that were subsequently published both by CHIRP (ATFB Edition 58 – April 2001) and in the UK Flight Safety Committee [Spring 2001 Issue 42 of Focus](#). Key within the reports were the texts contained within ‘Company Cultures on Fuel Planning and Usage’. These addressed shortcomings associated with what CHIRP termed ‘Fuel Leagues’ that reporters had described as implying pressure to depart with less fuel than they felt to have been adequate or indeed essential.

To add detail to the report, two reporters (co-pilots) described how their captains had deliberately departed with less than the amount that should have been calculated in accordance with the fuel planning procedures specified in their company Operations Manuals – simply with the aim of ‘improving’ their exposed position in their related league tables. Now I wonder if lessons learnt during the process of managing the survey and publishing the results – with attendant recommendations – might have been lost? Perception is a powerful motivator, and I would hope that operators – and their line managers especially – will not promote a return to ‘League Tables’ as CHIRP then called them.

It doesn’t surprise me that concerted efforts are once again being made to reduce margins where cost savings are thought likely to be achieved, but it behoves industry to do so only where the safety of operations will not be compromised. It follows that at times like these, the regulator should ensure that a close watch is maintained upon what every company publishes as guidelines and what is applied by the captains they employ, most of whom I am sure would want both to save on costs as well as to demonstrate that they are worthy ‘company men/women’.

Finally, the concept of Statistical Fuel Planning has been discussed many times in the past and I recall that many were previously uneasy about its lack of transparency and the inability of captains to carry out easily a gross error check on the amount of fuel thus specified.

CHIRP Response: It just goes to show that sometimes there are recurring issues in aviation that may have featured in the past and resurface with new circumstances and initiatives.

Although the company concerned in the recent report were keen to reassure CHIRP that their fuel usage graphs were not used to pressurise captains, and that their statistical algorithms for additional fuel requirements were robust based on historical analysis, the overall CHIRP view was that fuel usage graphs remain open to the risks of human nature because some may feel the need to improve their position on the graph so that they can avoid potential conversations with their fleet managers.

CHIRP understands that other companies also employ fuel usage monitoring, with some systems sending automated emails to captains depending on pre-set targets. Captains must resist being sensitive about their relative position or performance on their company’s fuel usage spectrum and must continue to employ context-specific judgement in the exercising of their command privileges in this respect. Although there is a clear obligation not to load less than the planned fuel uplift, there are often times when a rational decision to add more fuel is appropriate where uncertainty or risk exists; it’s a command decision, and any responsible fuel monitoring process should not invite line managers to second-guess such judgements or even subliminally hint at associated incentives or disincentives.

Reports

Report No.1 – FC5182 – Inexperienced cabin crew

Report Text: Taxiing out for departure, Number 1 cabin crew called the flight deck and advised a pax had been physically sick in the cabin and that they needed time to check on their wellbeing before departure.

The Number 1 was attending the passenger and the three other cabin crew had limited experience (Number 4 was only recently on the line). Number 2 or 3 called the Number 4 via the interphone and asked them to turn on the cabin lights (as the cabin was in darkness prior to departure at night). Number 4 was unable to simply locate the cabin lights switch on the attendant panel. Unable to turn on the lights, the Number 1 then had to leave the ill passenger and return to the front galley to turn on the lights themselves to then go back and assist the passenger.

My concern is that new cabin crew are unable to locate simple, yet critical equipment and switches used daily, and the experienced cabin crew (only the Number 1 in this case) was doing all the work themselves dealing with the passenger, communicating with the flight deck and managing the cabin environment. This was a simple medical issue; however, it could very well have had a disastrous impact given the level of experience in the cabin that day.

Operator's Comment: All crew complete initial and conversion training and a number of familiarisation flights prior to becoming part of the operating crew. Training does include operation of the cabin lighting system contained within the flight attendant panels onboard. The flight attendant panel and lighting is mainly used by the senior crew member so it is possible the crew member had only used this on a small number of occasions prior to this flight.

There are 4 crew members onboard and, as such, tasks are delegated to each crew member so as to reduce the workload during a medical event. This is all delegated under the guidance of the SCCM. However, flight crew also need to be aware of the surprise and startle effect which can effect cabin crew when they are presented with an inflight event such as a medical. This can reduce reaction times for dealing with an event or task.

A debrief with all crew at the end of the day will ensure effective communication of issues during the flight and will provide an opportunity for crew to learn from mistakes made during events. Crew are encouraged to report events internally where an additional debrief can take place for the crew involved.

CHIRP Cabin Crew Advisory Board Comment: All Cabin Crew receive initial training on how to use the cabin systems such as the forward attendant and the additional attendant panels. This information is also available in the Cabin Crew manuals.

When new crew go on their aircraft visit as part of their initial training they would have been shown how to operate the lights at the attendant panels. Also, when the

crew operated their first familiarisation flights, they would have had a checklist that probably included cabin lighting, amongst many other things to be covered on the day. Once the crew member is then online, often the SOP is that the crew complete their checks, sit down, pass on their 'secure' to the senior and, once the senior has the 'secure' the senior will dim the cabin lights for landing and take-off.

The fleet structure of some operators can vary massively, crew can operate on different types and within those types there can be subtypes; even if the aircraft are all the same type, unless they are all the same vintage then the attendant panels can still vary from aircraft to aircraft.

CHIRP Air Transport Advisory Board Comment: In addition to the Cabin Crew Advisory Board's comments, we would add that junior cabin crew might not operate the associated panel at all in day-to-day operations and, although this may well have been a one-off event, there is a case for cabin crew to receive periodic recurrency/refamiliarisation training in all cabin equipment and its operation for the purposes of resilience should the SCCM become incapacitated or over-tasked.

Although current cabin crew annual recurrency training covers safety equipment and they are encouraged to make sure that they are familiar with all equipment in the cabin, such familiarisation should be a formal requirement, not simply encouraged and relying on individuals' diligence. Also, procedures ought to be in place to give cabin crew regular opportunities to operate all routinely used equipment and panels; simply providing initial training by PowerPoint and reference to manuals is not sufficient – time is always pressing during flights we know, but more-experienced crew can also help here by taking inexperienced crew members 'under their wing' when possible and refreshing their familiarity with panels and equipment.

Report No.2 – FC5183 – Distractions at critical stage of flight

Report Text: The cabin was secured and the cabin crew seated. At 8nm final, the cabin crew called the flight deck with an emergency '[alert code]' chime. The Captain answered and was told a passenger had left their seat and was lying down in the aisle. The cabin was therefore not secure and we cannot land as it is. The Captain agreed and stated we are not landing and will go around.

The First Officer had less than 500 hours and so time was taken to execute the go-around as we prepared ourselves. I pressed TOGA at about 1400ft AGL. Cabin crew during the go around were continuously pressing '[alert code]', so much so that it was distracting for the flight deck crew to manage the go-around manually, talk with ATC, change frequencies and avoid a CB [Cumulonimbus thunder-cloud] at the time.

The Number 1 had to be told during the go-around to stop pressing the intercom buttons. The Captain asked if the passenger was conscious to which the answer was yes so the Captain said he would call back once we had levelled off and it was safe to do so. The First Officer was

left with controls and radio in a demanding situation whilst the Captain spoke with the crew to find out the nature of the emergency. The cabin crew said, "I don't know what to do, I have never done this before." and was very nervous and panicky on the interphone.

Cabin crew managed to seat the passenger who was experiencing a panic attack and motion sickness for landing. Landing was made and medical assistance met us on the stand. More training is required to cabin crew to appreciate the critical stages of flight. More training is also required to deal with medical emergencies and situations in the cabin. The Captain could have kept the controls and asked the first officer to find out what the problem was but, given the severity of the call '[alert code]', it was expected to be something very serious and the Captain wanted to hear first-hand what the event was.

CHIRP comments: Although it is important not to second-guess the crew because we do not have all of the information and context that may have pertained, go-arounds have their own additional risks and factors that should be carefully considered in such circumstances compared to continuing the approach - there's an important decision to make about which is the more hazardous, continuing the approach with a potentially sick passenger in an 'unsecured' cabin or increasing the workload of both flight crew and cabin crew by going around in marginal conditions?

Nevertheless, with regard to the repeated use of the emergency call facility, whilst one would hope that this is covered in training, it may not be apparent to cabin crew what level of distraction this might be causing at critical stages of flight – although they were dealing with two events at once, a medical and a go-around, in the heat of the moment it is important to be disciplined in who is giving alert calls and when.

Report No.3 – ENG 712 – Safe working

Report Text: We are using Mobile Elevating Work Platforms (MEWP) for access against engines at great heights, leaning over the engines with only our feet on the lower floor of the MEWP whilst sprawled onto the engine. Very easy to fall Left or Right. Numerous times on a 4-day shift this can be observed.

Safety boots are not being used by certain people for the entire shift and no use of high-vis jackets on the apron at any time despite being mandatory. Critical Tasks such as lifting [aircraft] pylons by hand and fitting them are occurring at the end of a 12-hour shift, with a heavy push to have them up and fitted before end of shift with a lack of a tea break.

My local area management are simply not overly worried about the use of high lifters in dangerous positions as long as they do not have to witness it. I was stood witnessing work carried out to an aircraft D-duct and my manager deemed it safe and accessible for my LAE to lean from the MEWP with only heels on the basket and the rest of his torso exterior of the basket.

Working through break times is more than acceptable to me - I understand flexibility - however the culture is shifting in a way that too much is expected in too short a timeframe with rushing and using incorrect equipment. Our man hours are not adequate for the work being pushed for and I can see standards slipping and I do not want to be on the receiving end of it. We have less than 3 people working for sometimes 8 hours solid with no break, trying to fulfil 12 peoples' work in the shortest timeframe possible due to our lack of personnel. This in my eyes is recipe for disaster.

Finally I'm just totally in disbelief that more and more people are not wearing PPE such as safety boots, and it's just shrugged off when pointed out. High-vis jackets are not being worn in pitch black on the apron; this is even more ludicrous when not 2 weeks ago a member of engineering was taken downstream from an [aircraft] engine exhaust blast. I'm overly done with health and safety becoming second to aircraft delivery, and my own wellbeing put behind the wrath of a [Management Position] phone call demanding aircraft be finished earlier.

Company comments: Working at height is a focus for us and we are working on developing and improving our Safe Systems of Work, especially around engine changes, and training on the use of MEWPS. Regarding line managers' attitudes to H&S, since the start of the year we have been running 'H&S Management' courses. We plan to cycle all Line Managers through this course, currently [##] have completed this training. The scope of this training is to highlight H&S law and specific responsibilities of management personnel and is part of our Safety Plan to improve H&S competence in Engineering.

I don't recognise the issue of PPE not being worn, and I have spoken to my Quality Engineers who do not recognise this statement either; I have asked my Quality Engineer to monitor this and they have not identified any shortfalls. I don't concur with the reporter on PPE. I have had no internal reports, or from the airport authorities, and my Quality Engineers, who conduct weekly checks of all areas, have not found any issues of PPE not being worn.

Regarding working time, there's no doubt that [Operator], similar to the rest of our industry, is in the process of recruiting various levels of maintenance staff, which has left some shifts below the expected levels. We have been monitoring this and deferring work to maintenance lines away from the reporter's location. We continue to work hard to increase recruitment and are now seeing new Licenced Engineers and Mechanics being deployed into the maintenance areas.

However, I don't recognise the issue of engineers being forced to routinely work through their tea breaks. There is a potential that there is a quid pro quo between staff and local management allowing staff to leave early in exchange for working through breaks. I don't agree with this practice and will follow up, but this is an age-old issue.

The jet blast event mentioned in the report happened about three weeks prior to this report and was during a [different aircraft to reporter] engine run. We are still in the process of the investigation, which is highlighting some

interesting behaviours. When complete, I have no objection to sharing with you the learning from this event. Having reviewed our internal reporting system, we already have actions for the Engine Change risk assessment and the Jet blast event, but I cannot find any reports for non-adherence to PPE requirements.

We can Categorically state that no staff member has died falling from height. To hear that a staff member has a concern of repercussions for raising an internal report is always disappointing but I know the perception is out there, based on rumours and myths, and it's something we continue to communicate.

I receive a [very large number] of occurrence reports raised per week. Throughout [considerable years' service], I cannot recall anyone being disciplined for raising a report. To make the system even more robust, earlier this year we implemented a change so only select people are able to view the reporter's name. The reporter's name can only be released if it is specifically required to aid the investigation and we centrally record each time we release a name and the reason why. We have communicated this to all areas.

I understand his opinion, [in working through breaks] but looking through the time data will give us the facts. When I have checked recently, I find many people leave earlier than their shift finish time.

I accept, less managers tend to be on nights, and will send a note out to managers to speak to their night shifts. I will ask my teams to focus on this when on nights, but I know they are doing this already. Being super-critical, I would agree that sometime engineers don't use task specific PPE (like eye protection, ear protection and gloves etc.) but this is the continual journey our people are on.

CHIRP comments: The CHIRP-relevant aspects of this report are that work and inspections carried out whilst a risk of injury is evident, affects concentration and propagates hurried actions. Additionally, HF concerns associated with staff shortages, long periods without rest and a dilution of standards on night shift are obvious. Many of us have experienced nights, and any "slack" afforded by management is gratefully received, but we also know our performance is reduced on nights and any lowering of standards may be more of an exposure to error than we realise.

The Quality Manager and the Health and Safety officer of the operator were contacted with the reporter's permission. The Operator disputes many of the statements made, and the jet blast incident was adequately investigated and resulted in seven recommendations.

Your employer's Safety Management System should be sophisticated enough to integrate both airworthiness and H&S hazards, or any issues that present a risk. Compliance auditing can cover both areas. However, although H&S permeates SMS, the differences between them need to be understood.

Changing an engine comes under Part 145 (therefore requiring an SMS). Working at height to carry out the engine change comes under H&S. Hazards associated with either

subject should be considered as a part of the overall activity. All staff and management should adopt safe working measures and strive for a safe working environment. There has been considerable dialogue in CHIRP publications in respect of potential risks of inexperienced people new to the role, being recruited to fill recent gaps. These staff need to be brought up to speed on how they fit in with the organisation's safety culture as a matter of priority.

Despite the fact that the PPE issue was unconfirmed when surveyed by Quality, everyone should comply with the Health and Safety at Work Act 1974, enforced by the Health and Safety Executive (HSE). These responsibilities cannot be delegated or failure to comply "blamed" on others. You are responsible for your own safety and the safety of others. Managers need to be alert to deviations from the required standards and be prepared to enforce the correct practice. The HSE have their own reporting vehicle on their website: <https://www.hse.gov.uk/contact/>. However, it is probably more straight forward to submit an internal report to your organisation first, provided of course you are confident with the system. Organisations need to work with their staff to ensure reporting systems are open, objective and viewed as non-punitive.

Report No.4 – FC5188 – Company communications

Report Text: My employer regularly sends texts to its pilots late in the evening as they seek to find crew for departures early the next morning. This means that anyone responding has disturbed their rest only a few hours before reporting for duty. An example of this is below:

Text message receipt timed at 22:37.

Good evening from [Crew Control] – Sorry for late text. We have the following flight available tomorrow, if you can help with this, please call Ops.

[Flight No]; [Route]; Report-0500; Depart-0610

Thanks [Crew Control]

I feel uneasy about the quality of rest that a pilot would have achieved if they respond to texts such as these sent so late in the evening. This seems to be an established process and has occurred numerous times.

CHIRP comments: 'Out of hours' company communications is a theme that reappears now and again and it's one that we've debated within CHIRP many times before. The general view being that it's highly dependent on circumstances and wholly down to individuals whether or not they respond in light of their individual responsibility to adhere to FTL requirements.

That being said, although FTL adherence is a personal responsibility, companies need to be alert to the risks of crews being induced to work duties that might impinge on rest requirements and so such communications need to be appropriately targeted and with sufficient warnings about the need for individuals to ensure they meet their personal FTL obligations.

When we have engaged with companies on this in the past, although they acknowledge that some might feel pressured to accept extra duties, they comment that it is entirely an individual's choice and that they have to retain the ability to seek volunteers to fill vacant duties due to unforeseen circumstances; especially in the current circumstances of reduced crew availability etc.

For those who are not able to respond because they know that they must wait for FTL rest times to be satisfied, the option to turn off notifications on their phone is the best way of avoiding disturbance; this can be done selectively these days so that important emergency contacts can still call through but those that you wish to block can be excluded for specified times.

The bottom-line is that peoples' rest periods and FDP cycles are all different and so it is conceivable that the duty highlighted could be legally performed by someone who was in the right phase of their FTL cycle. Therefore, although we would prefer to have seen a more nuanced approach to targeting and warnings about FTL requirements, it was appropriate for the company to send out requests like this because ultimately it is for individuals to look at their rosters and take personal responsibility for ensuring that they are legal to operate before they accept such additional duties.

Report No.5 – FC5219 – CRM issues

Report Text: I was a First Officer for a duty that was for a planned FDP of 11hrs 5mins. The day already started delayed because our aircraft arrived late from the previous flight (at the time that we should have departed). Disembarking from that flight also took more than 30mins due to airport delays. So, before we took off for our first sector, it was obvious that we would go into discretion. As this was not unforeseen, the cabin crew Number 1 asked the Captain if they would give Ops a heads-up so that they could maybe organise another crew on standby for the last sector. This was completely ignored by the Captain, who denied that we would go into discretion.

On the second sector, more delays accumulated so that there was no doubt anymore of going into discretion. The cabin crew consulted me and asked what to do and why we were not informing Ops. I tried to talk to the Captain about that issue, but the Captain just blocked any conversations about it. A very high gradient of authority was unfortunately present so talking about such issues wasn't easy.

Between the second and third sector the Number 2 approached us in the cockpit after asking the Number 1 for permission. They also wanted to know why the Captain didn't want to talk about the obvious fact that we would have to go into discretion on the last sector and why they were not asking any of the crew whether they had any flight safety concerns or were not feeling fine to do the last sector. The Captain's answer was only that it was their sole decision to go into discretion or not, and that they did not have to talk to any of the crew about it. A loud discussion between the Captain and the Number 2 started and, after showing the Captain the associated company memo regarding discretion, the Captain then just ignored them.

The next sector was uneventful although the atmosphere deteriorated after that discussion. After the passengers disembarked, the Captain then approached the cabin crew whilst the passengers for the next sector were already waiting at the L1 door in the airbridge. The Captain initially informed everyone that it was his decision to go into discretion or not. The crew then informed him that the proper way would have been to talk to everyone individually to evaluate if they were still fit to fly or if safety was in question because we, as a crew, were one team. The Captain responded that they couldn't just go to the back of the aircraft to talk to everyone, and that this would be ridiculous.

Whilst that discussion also got louder, the Number 4 started to cry silently in their seat. The Captain then said that if anyone wanted to offload themselves they should feel free but that they would have to consider the 173 passengers who want to go back home. This put an unfair pressure on the crew not to tell the Captain if they felt fatigued. So, in the end, everyone said that they would do the last sector but only because they didn't want to be the one responsible for the whole crew staying overnight.

On the last sector, due to exhaustion, we made a number of mistakes. On line up we recognised that the flight directors were not engaged; after take-off while doing the 'after take-off checklist' I recognised that the autobrake had never been in RTO; and in-flight due to turbulence with cost index 100 and being at Mach 0.8, the speed increased to 1 knot below the overspeed warning. When I mentioned this I got rudely told by the Captain that they knew that and that I didn't have to mention it as long as the overspeed warning was not activating.

I feel I should have spoken up more forcefully to defend the cabin crews' wishes.

CHIRP comments: Aside from the debate about the use of discretion, this report represents some of the worst aspects of poor CRM that we have come across in recent years. That someone could be so un-empathetic to their crew beggars belief and seems a real throwback to the dark ages before enlightened Just Culture and modern safety management.

Although the reporter's comment that they should have been more forceful is pertinent, we should not underestimate the cockpit gradient that was evident and so speaking out in such circumstances can take real courage.

With regard to the use of discretion, [AMC1 ORO FTL 205\(f\) Flight Duty Period \(FDP\)](#) for UK Regulation (EU) 965/2012 comments on the "...shared responsibility of management, flight and cabin crew..." and that consideration should be taken of "individual conditions of affected crew members...". Regulation does not state how the Captain should consult their crew or whether this should be conducted face-to-face, individually or as a whole crew.

Ultimately, the decision to go into discretion is not made collectively as some sort of 'committee meeting'; the crew make their representations to the Captain but, in the end, it is the Captain who decides whether to use discretion or not, most usually in discussion with the Senior Cabin Crew

Member, having consulted with all the other crew members to note their personal circumstances and ensure that the flight can be made safely.

In this latter respect, it is the responsibility of each crew member to know the maximum FDP that they can operate and they should ensure that the Captain is aware if they think they will exceed this. Also, if any members of the crew have been called from standby to operate the duty, this information should be relayed to the Captain because this also might affect whether they can continue the duty into discretion.

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