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## Change? It's a question of management

Companies need to consider the impact on personnel, so early communication and engagement with staff is crucial



**Steve Forward**  
Director Aviation

**A**belated Happy New Year to all our readers. Let's hope that the continued recovery of aviation post-COVID is matched this year by an increase in resources to meet schedule requirements and that the many lessons from the highly-pressured summer of 2022 are taken on board for operations in 2023.

In the last 6 months of 2022, CHIRP received 233 Air Transport reports of which a considerable number related to changes introduced as organisations come to terms with the new realities of post-COVID operations and economic pressures. Issues such as fatigue from pressured rosters, inadequate sickness policies, planned use of discretion within rosters, problems following changes in service provider, poorly introduced software updates and equipment upgrades all featured and are being worked through with the CAA and the companies concerned: many of these are indicative of the need for more effective change management and the need to recognise and incorporate variations to previously established risk profiles.

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ICAO recognises the need for change management within [ICAO Doc 9859 Safety Management Manual, 4th Edition, 2018](#) Sections 8.5.6 and 9.5.5 which provide frameworks and examples for the sorts of changes that are likely to trigger formal change management requirements such as: introduction of new technology or equipment; changes in the operating environment; changes in key personnel; significant changes in staffing levels; changes in safety regulatory requirements; significant restructuring of the organisation; and physical changes (new facility or base, aerodrome layout changes etc).

ICAO goes on to comment that before introducing any change in a system (operational or organisational), a detailed description of the particular change, the potential associated hazards, as well as impacts to other interfacing systems and the effectiveness of existing defences should be reviewed so that the proposed changes can be planned and executed in a structured way. In particular, new hazards and related safety risks may be inadvertently introduced into an operation even when small isolated changes occur, and no operation should take place in a changed system or operational context until all safety risks are considered.

Looking at the post-COVID operating context in particular, we've seen some of the biggest global changes to aviation operations in recent history, which is all the more reason to initiate robust change management processes through company SMSs to ensure that changes are properly considered in all their facets. That is what the SMS is there for - to provide a systematic approach to risk management and decision making so that more obscure or interrelated aspects are not missed.

In this respect, and although published in response to COVID in August 2020, [CAA Safety Notice SN-2020/015 'Effective Change Management for Organisations During Covid-19'](#) provides a very useful summary of recommendations, considerations and frameworks that can be employed in the management of change in aviation.

But it's not only the introduction of new procedures or equipment that should attract attention. As mentioned in a related [Skybrary article on Management of Change](#), as a system evolves, seemingly small, incremental changes can also accumulate over time and an important part of change management is to periodically review the baseline hazard analysis to determine its continued validity. The start of a New Year often brings with it the need to refresh periodic risk assessments and this is the ideal time to review what might have changed last year both in macro and micro terms.

Fundamental to effective change management, organisations should also consider the impact of any changes on personnel because this could affect the way a change is accepted by those involved. Early communication and engagement will normally improve the way a change is perceived and implemented and, in Human Factors terms – be it the introduction of new equipment, processes, route structures, fatigue risk management systems, service providers or organisational policies – any economic or operational changes must always take into account a fulsome and candid appraisal of the associated risks and impacts on those enacting the change.

In this respect, and whilst continuous improvement is of course always desirable, many of the procedures and structures that exist in aviation have been hard-won through bitter experience and lives lost. Theoretical modelling and assessments of any changes are useful tools, but the real-life experiences of those enacting any change must also be taken into account as theory meets the reality of operational actuality.

It appears to CHIRP that, too often, economics or the haste to introduce changes sometimes override a cautious approach to hazard analysis, risk assessment, the practical realities of operations and an effective acknowledgement of workforce concerns and occurrence reports. Breakdown of company monitoring/safety systems, failure to feedback on occurrence reports, gaps in transition between company systems and seeming lack of regard for workforce concerns have all been evident in recent use of CHIRP as a reporting conduit of last resort when company internal processes fail during change management.

As a final thought, many new staff will have been hired over the last few months as companies recover to full manning, and many of these new staff may not have extensive experience of aviation, especially winter operations. The 3 Cs of Caution, Consideration and Courtesy for others apply now more than ever – do those ground operators really understand your requirements, has that FO much experience of operations into winter-bound airfields, do you need to allow a little extra time, space and understanding all round for those who may not be familiar with bad-weather operations?

## Engineering Editorial

Let's start with all due sympathy for all staff that had to work on the principal festive dates due to shift cover; the travelling public will no doubt be forever grateful. The New Year date change and a fresh year ahead means the restart of all the annual projects that a maintenance operation must consider: 2023 shelf-lives and calibration dates may have seemed a long way off towards the end of last year but some may now be imminent.

This year's Recurrent Training also needs to be scheduled, hopefully with an inspiring instructor and not mind-numbingly boring CBT based on old familiar examples. As an example, Dangerous Goods Training needs to reflect the ICAO Technical Instructions (TI) using a Competency Based Approach to Training and Assessment (CBTA) and is now a mandatory requirement for those involved effective 1 January 2023 (see UK CAA Skywise Alerts [SW2022/344](#) and [SW2022/363](#)). If you do not fall into the category of staff that require the revised training, do not think for one moment that Dangerous Goods are nothing to do with you. A customer's spare battery deposited into the rear freight hold may be the same type of battery as one bolted and connected in the equipment bay but your act of assisting the customer just put the aircraft at risk and the regulations have been contravened.

The New Year requires that Risk Assessments will have to be revisited, although accepted wisdom suggests that risk assessment should be iteratively reviewed throughout the

year. Areas with ongoing reduced staff levels may make risk assessments seem to be an unwelcome burden, or a luxury that can be skipped, but that approach must be resisted if we are to ensure the continued safety of our operations.

We all carry out risk assessments prior to undertaking an individual task, even if only subconsciously. How well placed is the organisation you work for to commence a raft of new risk assessments? For those staff who normally carry out formal risk assessments, how well prepared are you? Do you remember the difference between a hazard and a consequence? Could you still visualise your Risk Tolerability Matrix showing Severity against Likelihood? Has the company risk assessment process been changed since the last time to adopt modern thinking, including the documentation of assumptions, and how are surprises addressed?

Has the period since the last assessment brought about changes that the last assessment did not feature; IT changes for example or fleet additions perhaps? Have any Maintenance errors occurred in the last year that the risk assessment at the time did not prevent? Were there any Internal Reports that indicate last year's risk assessment is now lacking? Have previously recommended actions been implemented and were they successful? Is your employer using the same service providers?

That newly contracted crane driver lifting off an engine may not possess the knowledge and experience of the previous contractor. If you query the fact that the crane is covered in building site debris that might contaminate the hangar, is the driver going to clean it off onto the ramp outside the hangar doors? This year's supplier may be cheaper and therefore not as sophisticated as that risk-assessed last year. Plenty of risk assessments would have been carried out last year due to new staff joining an organisation but has an assumption since then been made that all new staff are genuinely up to speed, or are there still gaps in knowledge waiting to surface as a latent error?

Everything we do has some element of risk, and not all risks can be mitigated against. The aim is to get the overall risk 'As Low As Reasonably Practicable (ALARP)', also now referred to in some circles as 'As Far As Practical (AFAP)' in recognition of the highly subjective nature of the word 'Reasonable'.

We must calculate the Tolerability of accepting some of the risk/s and consider the balance of investment in production, versus the investment in safety. In doing this, there is great merit in conducting risk assessments with all staff. Who better to identify and analyse the risks than the staff members involved? This concept also contributes to an organisation's Safety Culture, and brainstorming for a risk assessment brings staff together. To include many staff in risk assessments requires training which, needless to say, carries a cost but this could be part of recurrent safety training and could reduce staff spending time away from the work area.

Finally, whilst organisations are responsible for implementing and facilitating an effective Safety Management System (SMS), it is the role of employees

to be mindful of, and operate within, the policies and procedures that are published. Perhaps the new year is the time to consider how well the SMS is performing. Is it a collection of procedures that simply satisfy regulations but have little real relevance to the operation?

SMSs should be based on User-Centric Design (UCD) – i.e. be applicable to the work as actually being done rather than the work that management imagine or believe is being done. Just as our risk assessors are chosen for their task familiarity, UCD focuses on the requirements of the user of the SMS. Quality Control and compliance with the Company Procedures (SMS or other procedures) is the responsibility of the staff fulfilling the task, and the procedures should be regarded as belonging to the staff that use them, not solely the heads of departments. The SMS should provide a vehicle to allow staff to instigate changes to the current procedures. Perhaps we can make 2023 the year of all staff improving our organisations' Safety Cultures and SMSs.

Have a great year and bear in mind that worrying about the post-Christmas credit card at work is a Human Factor issue. Roll on Spring.

**Phil Young, Engineering Programme Manager**

## COMMENTS ON PREVIOUS FEEDBACKS

### Comment No 1 – Sickness management

Glad you have finally woken up to this issue of pilots being pressured to work when sick [Editorial Air Transport FEEDBACK Edition 144]. I have written to you before about this and the reply I got was dismissive. Because of this pressure there are pilots and cabin crew everyday turning up to work when they shouldn't. [Airline] has a desk of people whose sole job is to apply pressure to people who go sick.

This is no secret, they are in the main crew check-in area. They of course will claim they are there to help but if you actually ask them for help they quickly fob you off. The fact that many people have reported this to you and nothing has been done is a disgrace. If you really mean what you say than this needs to be your top priority.

**CHIRP Response:** We're grateful for any feedback on our work, be they plaudits or brickbats. In our defence on sickness policies, we've been representing the problem to the CAA and airlines since at least 2018 and probably regularly before that if I was to look up our files before my time as Dir Avn.

Our problem is that we at CHIRP have no powers to fix anything and so all we can do is to keep banging the drum with airlines and companies to get things changed. Sometimes frustrations mount as we seem not to get anywhere and so that's why I chose to make it a feature of my editorial to raise its profile again publicly. Perhaps

encouragingly the CAA responded that they also think that there's scope for doing something, but we've had false dawns before.

At least they are talking with the likes of the UK Flight Safety Committee to scope the problem of absence/sickness management policies they tell me. Sickness and absence management is something bigger than individual companies and so that's why we're supporting their initiative to look for an industry-wide, best-practice approach but, as with most things, that'll be a long-term solution.

Late-breaking news is that as a result of CHIRP's representations, the CAA have been able to engage with one airline in particular about their sickness policy and that airline now has a revised attendance management scheme in place that takes a more enlightened approach to pay and days off when sick. Sometimes such successes are few and far between but this outcome illustrates the value of reporting to CHIRP when the usual avenues of engagement do not lead to a satisfactory outcome.

With regard to priorities, we try our best to keep things bubbling across the board but we're largely a one-man/one-women band short on (part-time) resources so pretty much everything becomes a top priority, especially at the moment with reports of fatigue, bullying, sickness/absence management, use of discretion, rostering, ground handling pressures, ATC resources, I could go on...

As we come out of COVID there are many 'top priorities' that we're trying to champion and keep in the minds of the regulator and companies. To be fair to the regulator, they listen and say that they are engaging with the companies but tangible progress is sometimes slow, not least because they themselves are somewhat hampered by the regulations (carried forward from BREXIT for expediency) which, in typical European fashion, are vague and lack teeth in many areas; the CAA say they have aspirations to review and refocus them on UK requirements but resources to do so must compete with other priorities.

### Comment No 2 – Living with COVID

I refer to your comments concerning positive Covid tests [Air Transport FEEDBACK Edition 144]. This needs some further explanation. There is no reason why you should not attend work having produced a positive outcome with a SARS-CoV-2 rapid test. It is really a matter whether the person involved has symptoms that are incapacitating or likely to be incapacitating.

In terms of coming to work with a positive test this is a cultural and social issue. You should not lose sight of the fact at the present time the infection rate is currently 1 per 35 persons in England and increasing so it is highly likely that you are already in contact with an infected person. We are going to have to learn to live with Covid along with the Influenza/Respiratory Syncytial virus.

**CHIRP Response:** This comment again refers to the editorial where one of the quoted sickness reports

mentioned that a Cabin Crew member had stayed away from work due to testing positive for COVID and had lost pay as a result. The background to this report was that it was received in early summer and, whilst we don't know what the specific date of the Cabin Crew's reported comments was, perhaps they were at a time when they were required by their particular company to stay away from work.

Whether they were actually suffering from symptoms of COVID is unknown by us, and individual airlines have differing policies, but the underlying regulatory requirement is to stay away from work if suffering from symptoms that make you unfit to fly. The thrust of the editorial was to highlight company sickness policies and this particular COVID comment was just part of a wider piece about inconsistencies in the way that sickness and absence are being handled by companies. We hope that the comment about COVID didn't detract from that particular aim.

### Comment No 3 – Pronouns

The pronoun "they" was used to refer to the captain several times in your response to a report [Air Transport FEEDBACK Edition 144, Report No 8 (FC5219)]. In one instance it was used when talking about the captain in a verbal dispute with cabin crew members. It was difficult to understand who was talking to whom. Please cease this politically correct idiocy and continue to use correct English. The use of "they" in this way is grammatically incorrect and potentially confusing. As you are no doubt aware it is also encouraged by the current gender hysteria. Why not simply continue to use the word Captain?

**CHIRP Response:** We don't use the pronoun 'they' out of politically correct idiocy but as a deliberate policy to assist in protecting confidentiality. Many small airlines have few female captains for example and so if we used 'she' then it could narrow down the field if someone was familiar with the circumstances. Repetitive use of 'the Captain' or other titles can become stilted in reported speech so we'll continue to also use 'they' in reports where appropriate but it's a fair point that we need to make sure that in doing so we do not detract from the ability to understand the report itself.

## Reports

### Report No.1 – FC5196 – Inadequate crew bunks.

**Report text:** Refurbished bunks in the [aircraft type] are very, very hard. So much so that it is hard to sleep; when one does fall asleep due to extreme tiredness one wakes up with pins and needles and subsequently can't get back to sleep. [Airline] don't listen to pilots concerns when this has been reported consistently via tech log and fatigue reports. In fact in the tech log it is signed off with 120 days rectification interval!

**Company Comment:** A number of reports have been received on this matter, and are taken seriously. Flight Operations and Engineering have been assessing the situation. These aircraft

mattresses have now all been replaced with our preferred alternate supplier in response to received ASR reports.

**CHIRP Comment:** The company informed us that the refurbished bunk mattresses mentioned in the report were different from the originals because the OEM had changed supplier due to problems with the original supplier. There's probably no specific standard or spec for mattress thickness/support but basic comfort must surely have been a factor in their procurement by the OEM one would have hoped. Although it appears that changes have now been made, the comfort of mattresses is probably somewhat down to personal perception as to their suitability, some crews were likely happy and some were not.

### Report No.2 – FC5204 – Temperamental headsets

**Report Text:** There is an ongoing issue with [Manufacturer 1] headsets. These headsets are woeful. They have a tendency to fall off your head easily, under minimal acceleration, particularly relevant in a rejected take-off (RTO). I know of other ASRs filed by colleagues where this has happened during the take-off roll. However, another major issue is the mismatch between listen and talk levels - this seems to be worse on aeroplanes where one side is fitted with the older (better) [Manufacturer 2] headset and one side is fitted with newer (dreadful) [Manufacturer 1] headset. But it is also an issue with both sides fitted with the new [Manufacturer 1] headsets. I believe this to be a serious flight safety issue.

**Company Comment:** The concern relating to headsets has been under investigation by Flight Operations and Engineering for several months. A large scale trial of three headsets is underway across fleets to find a suitable replacement. There are a limited number of headsets available on the market which meet the specified requirements and include an ANR function. Additionally, some headset models requested by the pilot workforce have been specified by the aircraft manufacturer as not suitable for use. An alternative headset is also available to purchase for personal use if preferred.

**CHIRP comments:** Technical compatibility problems between headsets aside (which we're told is sometimes down to user adjustments), it seems that the stability problem with the new headsets is because they only have a single headband as opposed to the [Manufacturer 2] headsets that have a twin band and are thus more stable. Stability is a fundamental requirement in CHIRP's view given that there is no room for such distractions even during normal operations let alone potentially disastrous consequences during an RTO. We're heartened that the company involved have acknowledged the problems and are trialling alternatives; however, we wonder whether this issue is also prevalent in other airlines or fleets.

### Report No.3 – ENG723 – Differences in corporate risk taking and application of the MEL

**Report Text:** Aircraft was flown to [Location] with multiple ADD's, including FMGC 1 inoperative, and no APU (air start and full ground service required). Inbound crew noted Engine 2 Overspeed Protection Fault appeared on shutdown. MEL consulted – no dispatch. I contacted [Base] engineering and informed them of the occurrence of a nil dispatch fault. Aircraft

had previous history of ENG 2 OVRSP PROT ECM 3 days prior [Sector] in tech log. [Base] engineering initially dismissive that aircraft had a previous occurrence of the fault, despite being logged in tech log.

We were attended by 3 experienced [Same Type] engineers in [Location], being [a Foreign Operator's] main maintenance base. After approximately 2:30 hours of diagnosis and an engine run, the nil-dispatch fault remained on engine shutdown. The local engineers were convinced a bigger underlying issue was leading to the overspeed protection warning triggering when self-testing the FMU on IDG 2 during shutdown. After the first engine run, the local engineers declared the aircraft AOG.

The final solution recommended by [Base] engineering was to disconnect the engine 2 generator, so that the self-test of the fuel metering unit would not occur. Another engine run could then be performed and the ENG 2 OVRSP PROT FAULT nil dispatch ECAM might not appear. This would add an engine 2 generator ADD but might prevent the ECAM caution to enable dispatch to [Base]. However, we would be unable to do this using MEL reference 24-22-01A because dispatch in accordance with that MEL procedure requires 2 operative generators, and the aircraft APU was already inoperative.

To the disbelief of the local engineering team, they were informed that the APU is only ADD'd because it had an oil leak that led to a fumes event. [Base] engineering required the engineers to check that if the APU oil leak is "only minor", then it "should be OK" to recertify the APU as only inoperative for air bleed and not for electrical generation. This would provide the second generator and get around the limitations of MEL 24-22-01A. By disconnecting IDG 2 and re-performing a second engine run, hopefully the ENG 2 OVRSP PROT FAULT ECAM would not reappear, and the aircraft could legally dispatch.

The Flight Crew had concerns about operating an aircraft at night in thunderstorms with the combination of defects proposed. The aircraft would require air start, with no APU bleed from re-classified INOP APU, and be level-capped through bad weather enroute, only 1 AP/FD due to inoperative FMGC 1, without an ENG 2 generator. I also had concerns that [Base] engineering solutions involved masking the underlying technical issue, rather than operating within the spirit of the MEL. These concerns were compounded by the local engineering team stating that they would feel uncomfortable certifying that aircraft as fit to fly, and that it would be unacceptable for [Foreign Operator] aircraft to have that number of ADDs.

The Flight Crew were unable to contact [Base] operations or flight crew management via any number of provided phone numbers to express our concerns for over 2 hours. The only flight crew point of contact with [Base] was via Engineering, who informed the Captain "We are speaking with operations, but they are too busy to contact you". During a second engine run with the disconnected IDG 2, on shutdown the nil-dispatch ECAM reappeared, and the aircraft was finally declared AOG.

I had two primary concerns. Firstly, I now have a few years' experience at [Operator], but this was the first time I've encountered that level of dissatisfaction from local engineers. From their differing opinions on continuing the troubleshooting

process, to the desire to dispatch an aircraft with that combination of ADDs. Secondly, I found myself unsure around the applicability of MEL nil-dispatch clauses. From my understanding, we were locking out a system to prevent a self-test occurring, which was producing a nil dispatch message. I had a conflict about whether masking a message is an acceptable use of the MEL.

**CAA Comment:** After reviewing the [Base] engineering/crew transcript it appears there seems to have been some miscommunication potentially in trying to get to the root cause of the defect, and whether it was caused by power transfer issues because the APU was INOP or another source. The repeat requests for engine runs would not have helped but it would appear that not all the information requested came from the first engine run attempt hence the further run requests from [Base] engineering to the Third Party maintenance provider.

[Base] engineering were trying to recover the aircraft and, from the reviewed transcript, were doing so in a methodical manner. [Operations] is the main contact point for the crew and it appears that they were unavailable despite the crews attempts to contact them. Staffing levels at the operators control centres are currently under review. The operator dispatched an AOG recovery team from [Base] with the fault being traced to an EEC. The spares were held up by Customs and the aircraft departed [a few] days later.

Regarding the number of ADD's, the CAA have weekly meetings with the operator and these are reviewed and discussed. There are industry-wide spares issues; however, the despatch reliability of this operator's particular fleet is one of the highest of all UK fleets and, fleet-wide, the ADD's are now below 2 per aircraft for this operator.

**CHIRP Comment:** Concern was the initial reaction on receiving this report. Trying to outwit a modern aircraft sometimes ends badly and often the aircraft decides it is not going anywhere, which is of course the safest option. The MEL should be designed to prevent the clash of carrying forward conflicting defects but this is not guaranteed. It is largely up to the engineer to consider possible conflicts before they hand the aircraft back to the Flight Crew who then review the situation, including operational implications.

The CAA were confident that Base Maintenance Control had not acted in a cavalier fashion and had also sought advice from within their technical workforce. From a CHIRP point of view, we should be aware of the dangers of multiple remote organisations and departments working together and the risk of miscommunications or conflicting advice as a result.

We are all aware of the importance of good communications as an HF issue, and the stresses of inadequate communication with Base Operations may possibly have affected the frame of mind of the Flight Crew by sowing seeds of doubt about the validity of what was being done in order to recover the aircraft.

Ultimately, it's all about communication and if the Captain has doubts that the aircraft is safe to operate then the decision is clear; it's for the operator's engineering/operations teams to then convince them that it is safe through transparent

and unambiguous advice and information to remove any uncertainty. This appears to have been lacking in this case, and the inability of the Flight Crew to contact base operations or flight crew management for their perspective for over 2 hrs is woeful.

#### Report No.4 – FC5203 – New Flight Planning System woes

**Report Text:** My employer has introduced a brand-new electronic replacement briefing and flight planning application. The purpose seems to be because a new back-end system has been introduced to our flight planning and the flight crew must switch briefing systems to be compatible. This system has a number of bugs and negative features that have been highlighted to the company by a huge number of flight crew. They include:

- Inadequate NOTAM presentation with significantly less filtering than previously
- Poor presentation of enroute weather
- Aircraft MEL items hidden in the OFP
- Completely new briefing flow

Flight crew have been required to self-brief on this new application with minimal, poorly designed CBT and no formal time allocated for them to do so. As an example of the major issues the company has had to release a 9-page notice on how to do fuel checks in the new app.

Although a limited parallel run was attempted, it was not available at all for some fleets, and on others the flight plans were on completely different routings so no possible training benefit could be realised.

As it stands the current application is inadequate. The company are aware of a number of bugs and have listed them as "improvements coming" but have elected to launch anyway. This has massively increased pilot workload and increases the risk of:

- aircraft dispatching with incorrect fuel
- aircraft dispatching without taking account of MEL items
- incorrect flight plan fuel being missed
- hugely increased time required to brief leading to pressure on other aspects of the operation.

I feel that note should have been taken of concerns raised by a significant portion of the pilot group across various types the airline operates and the launch delayed until those concerns were addressed. I would like this issue properly to be raised with the regulator who may not be aware of the concerns reported mainly via a dedicated company reporting form for this application rather than the ASR route.

**Company Comment:** The new flight planning and briefing system was a long term project, which included the provision of the following training material:

- **Differences Guide** – this document summarised all changes associated with the move to the new Flight Planning and Briefing system.
- **Access to the new briefing application** – available for all fleets from 10th Mar 2022 to 14th Jun 2022.

- **Live Microsoft Teams Demo and Q&A** – 24 separate events held over a 14-week period on a variety of days and times to enable multiple opportunities for flight crew to attend.
- **Recording of a Live Q&A** – available on our internal documentation app available on each pilot's iPad for those unable to attend a live event.
- **Bespoke email address created to ask questions** – over 500 emails received and responded to.
- **Internal company feedback form** – available for app development suggestions only.
- **Safety reports** – all to be filed via ASR as per normal (282 related ASRs received and responded to).
- **Specialists** – available in the home base crew briefing area for 4 weeks prior-to, and post cutover to answer any queries at crew report.

**CHIRP Comment:** Although the required functionality was probably all available and it was just a matter of getting used to the new system, this report seems to indicate that insufficient user-testing was conducted (using real first-time users and not those who developed the system), and that user-acceptance and user-confidence (i.e. buy-in from the users to increase their willingness to adopt the change) were not ensured before the new system and procedures were introduced.

Some system changes are so large that face-to-face training should be given rather than simply asking people to read online manuals, view VTC sessions and conduct computer-based training courses - this should be factored into the deployment of new large-scale safety-critical systems and procedures and is a key lesson from change management.

Furthermore, the introduction of such a radical change might be questioned when most flight crew were flying their maximum hours during the summer-2022 ramp-up of operations with concomitant tiredness and likely lack of enthusiasm for large-scale extra-curricular self-study. There is a clear case in these circumstances for official time to have been rostered for the training, even if conducted as self-learning, and that that time should be scheduled for appropriate periods other than at the end of a tiring duty for example. All of these elements should have been highlighted by running the change through the company's SMS to ensure that it made sense, did not introduce unmitigated risks and was handled more empathetically overall.

### Report No.5 – FC5215 – Impact of ATC closures

**Report Text:** The closures (by short-notice changeable NOTAM to reflect controller availability) at [UK Airport] ATC are having an impact on Flight Safety. Having landed late on a schedule into [Mediterranean Airport], the Crew were naturally feeling a little pressure to get the turn done with no wasted time, especially as a tight slot was initially set. The way [Mediterranean Airport] works does not make this easy at the best of times, and all Crew were busy.

Meanwhile the Captain, who was PF on the way back to [UK Airport] spent at least 30 minutes on the telephone to Dispatch trying to work around the ATC closure at [UK Airport] which consisted of a fifteen minute period (but with buffers either side). Initially we were planning a high speed revision to

the flight plan to get in before closure but we then ended up going for a slow flight plan to go the other side of this closure. This generated a terrible slot in [Mediterranean Airport] to fit into the departure pattern. Most distracting for the Captain who had plenty on his plate anyway.

This is the "Bread and Butter" of commercial aviation in the current climate. However, this is now the end of Summer, and I have been working around this additional workload for the whole season. Is it conceivable that no ATC staff are available to hire, even 'Locum'? All businesses are having recruitment issues currently, and airlines and airports are no exception but the consequent increase in Crew hours is causing Airlines more Crew problems as we burn additional hours waiting for their rest periods.

[Mediterranean Airport] is a difficult airport to work from, we had to plan and brief the Noise sensitive departure with an 'Emergency Turn'. We had to try to negotiate our preferred runway for departure, all while operating under the normal pressure of a CTOT. I had to really concentrate on keeping it all safe and measured. I am angry because it puts so much additional pressure on all our Crews, not just me on this occasion. It is the first item I look for when I am flying, as it can ruin your day so easily. I know from talking to others that they all feel the same. This should not be the case, and is not consistent with safe operation, and has been going on far too long.

In another experience of the situation, we were turned around in [Greek Airport] in good time and could have easily made an arrival into [Airport] by the planned closure (with 10 minutes of buffer which is not on the NOTAM). By the time I had telephoned everyone I thought could help, other restrictions occurred over Germany. We ended up having to depart for the other side of the rest period. Over an hour of frustrating delay for Crew, passengers and [Greek Airport] who had to stay open to accommodate us waiting on an airfield extension.

Whilst whiling away the time, I spoke to ATC in [UK Airport] who were very helpful, and explained that it takes six months to train an ATCO. So little hope for this season then! I cannot help but think that this is not the only solution to the problem. From a safety point of view, this whole situation of flight crews extending their duties (I personally went into discretion on this flight), is wholly unacceptable. Why should I go into discretion for an ATCO rest period when I am the one in charge of an entire aeroplane and passengers? Would it not be safer for them to go into discretion to allow safe arrival of the aircraft? This is madness, and has to stop before an accident happens. It may not even be as a direct consequence, but more subtle, as a secondary factor in another incident.

**Airport Comment:** A shortage of ATCOs has meant that at times we have had to close to facilitate [CAP670](#) mandated breaks. Although these break requirements are more easily managed within the big centres of Swanwick and Prestwick where sectors can be joined and split depending on traffic levels, the 'SRATCOH' (Scheme for the Regulation of Air Traffic Controller Officer Hours) rules dictated by the CAA are not very applicable or suitable in the dynamic regional airport environment; there is no 'discretion' process for ATCOs, perhaps there should be for pragmatism, but that is an issue for the CAA to address.

We are very proactive with our mandated closures and fully inform our airline partners' ops centres via NOTAM and email. The airlines are given at least 6hrs notice of a closure and we move our rostering around to try to fit their schedules and predict natural breaks in the flow; sometimes these messages don't get passed on to the aircraft but we at [Airport] can't be responsible for that. We are also training at a pace never seen at [Airport], we have been all year, but we are hamstrung by regulation over the minimum hours and traffic levels an ATCO must train (there is little credit given for previous experience) and the requirement to rigidly follow the Unit Training Plan (UTP).

**CHIRP Comment:** To some extent this report reflects the day-to-day challenges that need to be overcome by flight crew as part of operational resilience - although undesirable, flight crew operating into discretion is not a flight risk in itself provided the situation is suitably managed and conducted appropriately. That being said, when such incidents become a regular feature of short-haul operations then we should be conscious of the cumulative effects of this and the many other challenges at the moment; it is all too easy to look at things in isolation and dismiss them rather than consider them in a holistic manner to understand the combined effect on overall performance of a number of perhaps seemingly minor issues.

This report is symptomatic of the overall aviation system not working in a symbiotic manner due to pressures in some areas causing problems in others. The solution is of course to resource all areas to the required scale in the long-term, and it is accepted that this is the goal of all organisations as they recover from the pandemic hiatus, but it's easier said than done when training pipelines are protracted and there is a global shortage of ATCOs.

Training and local knowledge requirements for ATCOs are specific to each location and so the use of ad hoc 'Locums' is not an option in the same way that it would not be reasonable for airlines to try to make use of pilots trained on other different aircraft types to fill flight crew gaps in a particular fleet.

There is scope for ATCOs to exceed their hours as a form of 'discretion' but every such exceedance must be individually reported by MOR and this may be a barrier to dynamic tasking at regional airports. SRATCOH itself has been superseded by Annex IV to [UK Reg \(EU\) No. 2017/373 'Part-ATS'](#), with specific requirements being detailed in [UK Reg \(EU\) No 2017/373 AMC1.ATS.OR.320\(a\)\(3\), a\(4\), a\(5\) & a\(8\) Air traffic controllers' rostering system\(s\)](#) which, in consolidated form, state that:

#### **MAXIMUM TIME PROVIDING AIR TRAFFIC CONTROL SERVICE WITHOUT BREAKS**

Together, the following rostering principles are means by which an air traffic control service provider can design a rostering system(s) which manages the risks of occupational fatigue of air traffic controllers:

- (a) The maximum time providing ATC service without a break should not exceed 2 hours.
- (b) Notwithstanding point (a), at units where workload for any part of the day is judged to be low and the activity is spasmodic rather than continuous, the maximum time

providing ATC service without a break, at these times, should not exceed 4 hours.

- (c) Notwithstanding points (a) and (b), for a controller on an 'early start duty' (see AMC1.45 Duty period) commencing before 0600, all operational duty periods shall be limited to 1.5 hours. For a controller on an 'early start duty' commencing at or after 0600, the first operational duty period shall be limited to 1.5 hours.

#### **RATIO OF DUTY PERIODS TO BREAKS WHEN PROVIDING ATC SERVICE**

The rostering principle below is a means by which an air traffic control service provider can design a rostering system(s) which manages the risks of occupational fatigue of air traffic controllers:

The ratio of operational duty periods to breaks should be 1:4; for example, 15 minutes break for 1 hour operational duty period.

#### **MINIMUM REST PERIODS**

Together, the following rostering principles are means by which an air traffic control service provider can design a rostering system(s) which manages the risks of occupational fatigue of air traffic controllers:

- (a) Notwithstanding AMC1.ATS.OR.320(a)(4), where the maximum time providing ATC service without a break is 2 hours in accordance with point (a) of AMC1.ATS.OR.320(a)(3), such periods should not exceed a period of 2 hours without there being taken during, or at the end of, that period a break or breaks totalling not less than 30 minutes during which period a controller does not exercise the privileges of their licence.
- (b) Notwithstanding AMC1.ATS.OR.320(a)(4), where the maximum time providing ATC service without a break is greater than 2 hours in accordance with point (b) of AMC1.ATS.OR.320(a)(3), a break, or breaks should be taken pro-rata, during, or at the end of, that period of operational duty (for example, 45 minutes after 3 hours or 60 minutes after 4 hours) during which period a controller does not exercise the privileges of their licence.

The duty and rest measures above were originally based on historic shift patterns and old fashioned cathode-screen controller environments; given the modern environment and management processes, it may be that at regional airports controllers could do more time on duty depending on traffic levels and so there may be value in reviewing the legacy requirements for mandated breaks. That being said, just because a console is quiet with no aircraft under control doesn't mean that ATCOs aren't working at other activities such as coordinating traffic with other sectors etc and so duty times also have to account for that.

CHIRP will engage with the CAA to investigate these aspects and explore whether a more pragmatic and flexible approach is possible. Similarly, the ability for airports to deviate more easily from their UTP to address day-to-day requirements would also be useful rather than require a rigid approach to training activities and when they are scheduled.



### Report No.6 – ATC825 – Use of Guard channel for Practice PANs

**Report Text:** As a commercial pilot I wanted to raise the issue of use of the guard VHF channel (121.50) for practice PANs, generally by GA aircraft. When flying across Europe, as a standard procedure my airline stipulates that we maintain a listening watch on the guard frequency, and rightly so. When this frequency is used by GA users for practice pans it adds to our radio traffic and we are often forced to stop listening/turn down our “box 2” in order to maintain situational awareness and comms on our primary ATC frequency.

My concern is that we therefore often forget to listen in again on the guard frequency after we think the practice PAN has finished, which means we could potentially miss genuine emergencies and attempts to contact us through loss of comms procedures. GA pilots need to be aware that every time they conduct a practice PAN they are being heard by commercial pilots and are blocking the emergency frequency for that time.

I would respectfully suggest that an alternative frequency be assigned and used for practice pans so that 121.50 can be used for genuine emergency and loss of comms situations.

**CHIRP Comment:** The issue of practice PANs causing problems for those who are required to listen out on Guard is not new and CHIRP has previously sought ways to introduce a training frequency for Practice PANs but this has foundered before because of lack of available frequencies. However, with the advent of 8.33kHz frequency spacing, more frequencies are now available and so there may be scope to address this again.

CHIRP has engaged with the CAA and MAA on the possibility of setting up such a frequency but there will undoubtedly be hurdles in the way, not least of which being the cost of setting up the same auto-triangulation facilities that exist with the Guard frequency. We will continue to engage on this issue but would be interested in the views of the community regarding setting up a VHF Practice Emergency Training Frequency (PETF). To what extent are transmissions on Guard a problem? Do those affected report such incidents (or inform ATC that they are ‘off Guard’ due to it being too noisy) and, if not, why not?

Current engagement with the CAA and NATS is coloured by the fact that a previous review into this showed few reports of any problems and so a change could not be supported. But a lack of reports is not the same as a lack of a problem and, not that we would advocate this, one wonders what might be the outcome if controllers were also listening on Guard whilst trying to control their own frequency.

Ultimately, the number of interceptions of ‘no-comm’ aircraft by air defence units indicates that the turning down of Guard is a real problem and, although a bit simplistic, if only one such interception was prevented then the money saved would probably pay for any change.

### Report No.7 – FC5206 – Aircraft V1 callouts

**Report Text:** I’m an [Airline] 737 Captain, having transferred from [other Boeing] fleet a few months ago. I was surprised to find a handful of the fleet don’t have automatic V1 call-outs. Automatic V1 call-outs are a safety enhancement, however, having flown [other Boeing] aircraft for many years without them, this is fine too as one is conditioned to call it during every take-off as PM.

Notwithstanding the small number of [Airline] 737s, many First Officers haven’t flown commercial aircraft without V1 call-outs, nor have we received any specific training on it during our simulator training and it’s notable the call is not always made in a timely manner, or sometimes at all. I have raised the issue informally with our fleet management, and the response was the regulator says it’s ok and it should be a briefing item when discussing the aircraft status.

From my point of view either the entire fleet should have that functionally or none of them should. The latter was the case on the [Airline] [other Boeing] fleet and it never seemed to be an issue. At the very least some take-offs without V1 call-outs during recurrent simulator checks would be appropriate as this is the most critical stage of flight and we’re not consistently getting it right. To be fair to [Airline], the Aircraft Configuration Card (ACC) details the differences in aircraft fit and the company’s suggested briefing format includes aircraft considerations. Only 1 or 2 out of [Airline] 737s are equipped as such and a lack of familiarity seems to be the core issue, so a recurrent simulator session would aid familiarity across the pilot workforce.

**Company Comment:** The 737 aircraft has a long history of evolution and development, and as new features have become available we have taken advantage of them. This has resulted in a long period where a mix of aircraft functionality, including aircraft with and without automatic V1 callouts, have been operated successfully. This mix of aircraft capabilities has been addressed by a comprehensive set of aircraft specific briefing cards which are automatically made available to pilots specifically for each flight via the flight planning app. There is a requirement for aircraft differences to be discussed during the pre-flight briefing. The normal procedure for all take-offs is to ‘verify the automatic V1 callout, or call V1’. In the event that an automatic callout fails to be issued, pilots are required to make a manual call.

**CHIRP Comment:** A positive check and callout of V1 is one of the key safety activities during take-off, and ideally these days as an automated alert. That some aircraft do not have automated capability is a fact of life but, in these cases, pilots should brief manual callouts as we all know.

It is certainly less than ideal for there to be mixed capabilities in the same fleet but, again, that’s probably a fact of life and it would be detrimental to remove the capability from those aircraft that were fitted. But the corollary is that pilots must be aware of the modification state of the aircraft and the company should ensure that each aircraft’s capabilities are prominently highlighted. Either way, and as the company comment above states, in mixed-capability fleets the pre-take-off briefing and TEM assessment should include a positive discussion/reminder as to whether calls will be automatic

or manual in that particular aircraft and non-handling pilots should be monitoring speeds such that they are prepared to make check-point calls if the aircraft does not for some reason (or make the calls even if the aircraft does have an automated system as a mitigation for any potential failure).

This is a key responsibility of the Captain to ensure that both pilots are aware of the aircraft's state and that the pre-flight briefing covers calls that will be made. Notwithstanding, we agree with the reporter that if there are differences in the fleet, then simulator training should cover this on a regular basis.

### Report No.8 – ATC826/ATC827 – Participating in Zoom call whilst on duty

**Report Text:** Since the pandemic it has been customary at this unit to have weekly briefing from MATC & SATCO by a Zoom meeting on Friday afternoons. On this occasion, as per usual, MATC hosted from their office but for a segment concerning Professional Standards we were addressed by the SATCO broadcasting on a mobile device for approximately 3 minutes from an operational position. It was unclear whether SATCO actually had traffic on frequency.

**CHIRP Comment:** The unit was contacted and they informed CHIRP that the issue had been raised and addressed internally as a result of an earlier internal report about the incident. CHIRP agrees that actively engaging in ancillary tasks such as Zoom meetings is not acceptable when conducting controller duties, even if only monitoring a sector with no traffic. It would be one thing perhaps to be passively listening to a briefing during a quiet period on sector but even that would be less than desirable.

That being said, it is recognised that controllers do conduct other non-operational tasks whilst monitoring quiet sectors (such as reviewing directives, reading documents or doing other tasks to keep themselves alert) and so there's a pragmatic compromise that must be reached when interpreting the regulations. Ultimately, in respect of things like Zoom or phone calls, [CAP493 MATS Part 1 Appendix E 'Communications Technique and Standard Phraseology'](#) states:

## 2. Distracting Conversations

- 2.1 Non-operational and other conversations have the potential to distract a controller from their primary task of providing a safe air traffic service. Examples include telephone conversations with external agencies, such as airline representatives, and discussions between controllers conducted on the telephone, intercom or, in some cases, face to face, following an unplanned traffic situation.
- 2.2 Non-operational conversations must not be permitted to interfere with a controller's operational duties. Procedures at units should ensure that non-urgent telephone calls from external agencies could be accommodated without prejudicing the controller's primary task.
- 2.3 Discussions regarding unplanned traffic situations, which may include incidents and alleged breaches of procedure, are not to be conducted from operational positions. If appropriate, only brief details of the occurrence should be exchanged between the controllers involved. If there is a need to discuss the matter further, this should be deferred to a time when all the personnel affected are relieved from their operational duties. Where staffing levels permit, unit management staff that are not working at an operational position should make arrangements for further discussions.

The CHIRP Aviation Programme also provides a facility for confidential reporting of **Bullying, Harassment, Discrimination and Victimisation (BHDV)** where there is an identifiable safety-related concern. CHIRP has no specific expertise or resources to investigate BHDV reports. CHIRP's role is to aggregate data to build a picture of the prevalence of BHDV in the aviation sector. See our [BHDV page](#) on the CHIRP website for further information.

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