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Trust in management and cultures is the key to promoting confidence in safety reporting

Looking back at 2023 – CHIRP reporting themes

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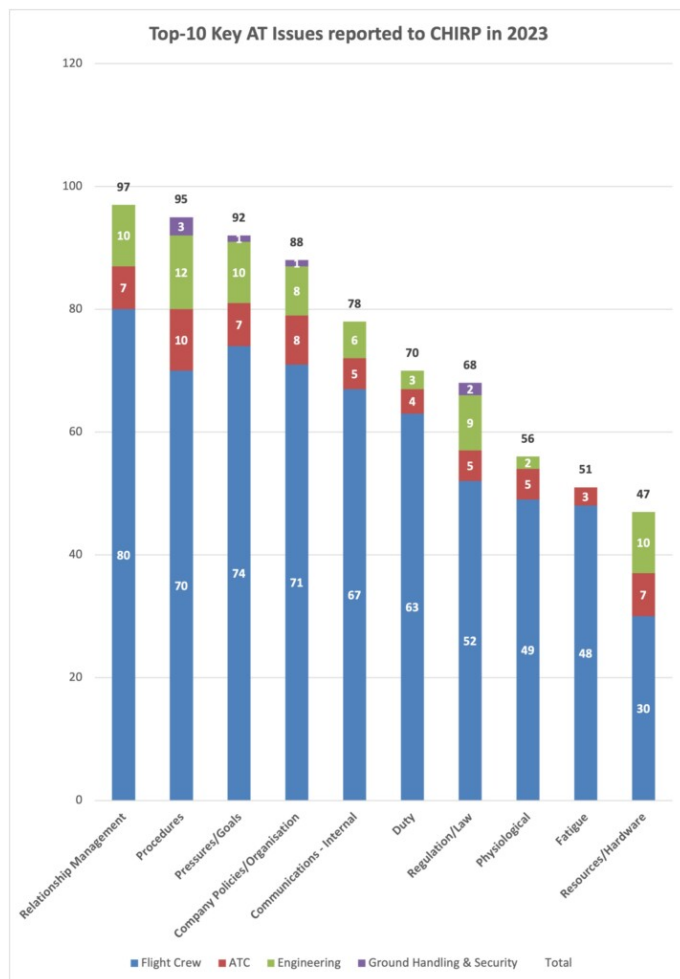
Steve Forward
Director Aviation

Now that we are firmly established in 2024, I've had time to review the reporting statistics that *CHIRP* saw in 2023. In total, we received 514 reports from all sources, with 132 of these being from the Air Transport (AT) sector (Flight Crew, Engineering, ATC

and Ground Handling & Security – note that Cabin Crew reporting is assessed separately at *CHIRP* as its own sector). This shows a return to normal levels of reporting post-pandemic, albeit slightly below 2022 levels (169 reports) which reflected increased

concerns as aviation returned in the immediate post-pandemic period.

The top-10 issues raised in the AT sector in 2023 are shown in the bar chart, with the second block chart at the end of the newsletter focusing on Flight Crew reporting as the largest element of the sector. Note that a single report can have more than one issue associated with it and so that is why there are more issues than reports.



The Flight Crew chart at the end shows the breakdown of sub-issues within the headline top-10 themes and its worth taking some time to review these. Historically, duty, fatigue and rostering/FTLs have been the mainstay of flight crew reporting to *CHIRP* over the years but, interestingly, in 2023 the themes are more to do with company policies, relations with management, and pressures/goals.

No-one doubts that everyone is working hard at the coal-face to meet scheduling demands and do all they can to ensure company profitability, and people will often go the extra mile to keep things on track. But the analysis hints that relations with managers are at risk of breaking down because crews don't feel that they are being listened to, communicated with, or being treated with respect. Once the feeling of trust breaks down and the perception of Just Culture is lost, things can derail very quickly in safety terms due to lack of reporting.

Within this, rostering, fatigue and absence management continue to be common themes in flight crew reports to *CHIRP*. Flight crew generally write to us when they have exhausted other options or grown disillusioned with fatigue reporting to the point of no longer bothering to report formally. Anecdotal evidence suggests that the issues reported to *CHIRP* are widely recognised among crews, and under-reporting is believed to be widespread; the reports seen by *CHIRP* may be the tip of the iceberg. It is part of the human condition that we find it difficult to discern a gradual accumulation of fatigue and corresponding erosion of performance, and aviation workers are perhaps more susceptible to accumulated fatigue because of their default 'can do' attitude. Flight crew are also subject to overt pressure to operate into discretion, including from home base and hubs, and all crews acutely perceive the pressure of company and passenger expectations. These factors weaken the safety barrier of declaring themselves unfit through fatigue. It is further undermined when operators do not respond appropriately and sympathetically to people declaring themselves fatigued during or after a duty. Operators who do not adequately distinguish between fatigue, illness and unauthorised absence, and those who react with perceived hostility to reports, create strong disincentives to fatigue reporting and create associated inducements to press-on as rostered.

People recognise that they are assets in a competitive industry and that their employers need to utilise them effectively and efficiently, but those reporting to *CHIRP* also express little confidence in operators' Fatigue Risk Management Systems (FRMS) or the associated regulators' interventions. They see their employers rostering within the numerical constraints of FTL but tell us that they perceive little evidence of compliance with the over-arching requirements to minimise crew-members' fatigue. An example being the move of reporting points to the aircraft gate for some companies which therefore lays the burden of delays getting airside and through security on the crews rather than the company. The result being that crews need to leave home earlier to achieve their report time and this then effectively reduces their rest period but without that penalty being evident on the roster. Overall, rostering and FRMS is seen as a reactive process that offers little protection and little evidence of its effect other than to justify company needs. People do not expect every fatigue report to produce a positive outcome, but there is a risk that reports will cease altogether unless confidence can be won through comprehensive and transparent feedback.

In the [performance-based-regulation CAP 2386](#) approach (as opposed to prescriptive rules-based regulation), there is a risk that commercial pressures may tempt operators to regard FTL numerical limits as an acceptable baseline for rostering and to use one-size-fits-all policies unless the adverse effects of doing so can be measured. It is not *CHIRP*'s role to 'solutioneer', but we believe that an alternative approach would be to demonstrate the adverse effects of unfitness to fly and the

corresponding commercial benefits of alternative HR strategies. For example, a study by the Norwegian AAIB a few years ago correlated self-reports of flight crew sleepiness as measured on the Karolinska Sleepiness Scale (KSS) with FDM data; sleepy pilots had a tendency to fly slower on the approach (down to $V_{ref} - 10$), had more hard landings, were later in decoupling the autopilot, had more fuel at shutdown (i.e. had carried more), taxied more slowly and had a higher fuel burn while doing so. The bottom-line is that there are commercial impacts to fatigue over and above the obvious safety risks and so it may be in the interests of company efficiency to conduct some analysis of KSS versus flight data – who knows, that extra night down-route to offset fatigue may well pay for itself in improved efficiency, operational effectiveness and fewer maintenance/rectification requirements.

Whilst all of the above might appear a bit downbeat and depressing, one glimmer of light on the horizon is that, taking into account *CHIRP*'s representations, the CAA have commenced a post-implementation review of the assumptions within the whole UK rostering and FTL/FDP regulatory set so that they can determine whether there are any areas that could be better defined, harmonised or re-evaluated now that we are no longer part of the EASA regulatory regime. At present, they have meetings scheduled with key stakeholders (airlines, unions, etc) over the summer period to get their feedback, with a view to conducting a formal consultation once that feedback has been collated, digested and recommendations have been formulated. We look forward to the outcome of this review as a potential reset and clarification of many parts of the FTL AMC and GM material.

Absence management policies were another frequently reported issue by flight crew. Operators are justified in seeking to discourage inappropriate absences but there are examples of policies that deter personnel from absenting themselves when they are unfit to fly through illness and fatigue. Operators are easily able to measure absenteeism, but *CHIRP* has seen little evidence of attempts to assess any adverse impacts of associated absence policies. Absence management policies should not be devised in isolation; remuneration policies in which a disproportionate element of the package is paid by the flying hour, or pay is markedly reduced when calling in sick, can be disincentives to declaring unfit to operate; job and financial security are powerful incentives to keep flying even when we all know that there is a legal requirement not to operate when unfit to do so.

We must acknowledge that *CHIRP* generally only sees problems reported and there is undoubtedly good practice in the industry of which we have no sight. Nevertheless, on the evidence of what we do see, there can be little doubt that real and perceived pressures may result in many operating when they are unfit to do so or potentially cutting corners to achieve the task. Be reassured, even if we can't publish some reports

due to confidentiality requirements, this concern is being relayed to the relevant regulators by *CHIRP*.

Steve Forward, Director Aviation

In Memoriam - Ken Smart

It was with great sadness that *CHIRP* learned that Ken Smart CBE, FRAeS, sadly passed away, peacefully, with his family with him, in early April 2024. Ken had a long tenure as a Trustee in support of *CHIRP* (2003 – 2013), six years of which he was Chair of the Charity. Ken had a long and impressive career, working as Chief Inspector for the AAIB, a non-Executive Director on the Board of British Airways and tirelessly in support of several charities and many other fields in which he was active. We at *CHIRP* are grateful for the commitment and support he gave us as an immensely valued member. He will be sadly missed by many working in the aviation and human factors sectors, and we offer his family our deepest and most sincere condolences.

Report to CHIRP!

Reporting to *CHIRP* is easy by using either our [website](#) portal or our App (scan the appropriate QR code shown or search for 'CHIRP Aviation' – ignoring the birdsong apps that may come up!). In our reporting portal you'll be presented with a series of fields to complete, of which you fill in as much as you feel is relevant – not every field is mandatory, but the more information you can give us the better. Although you'll need to enter your email address to get access to the portal, none of your details are shared outside *CHIRP*, and we have our own independent secure database and IT systems to ensure confidentiality.



CHIRP FEEDBACK Survey



We value your opinion about our FEEDBACK newsletters and associated engagement methods, please spend a few minutes

responding to [10 short questions about CHIRP Aviation FEEDBACK](#)

Engineering Editorial

It seems that a reminder of the dangers of assumptions is due, especially with the manpower shortages being suffered throughout our industry. A recently received *CHIRP* report mentions mechanics doing inspections which are signed off by licenced staff. This would apply equally to Part 145 Workshops and Production (Part 21 sub-Part G) organisations where fitters may come under pressure to sign/stamp their work in place of more expensive experienced inspectors.

The last time *CHIRP* Air Transport Feedback mentioned engineering assumptions (trust) was in Edition 140 (October 2021), where a Part 145 A1 approved organisation made assumptions about the staff of a contracted-in Part 145 B1 approved organisation. This incident led to a maintenance error investigation because not only did the customer find an engine system tube support bracket lying in the cowling after return to service, but approval ratings had been crossed. (One aspect of this was Part 145 B rating engineers signing for leak checks for an engine on wing, as opposed to one hanging in their test cell).

The main consideration about making assumptions has to be that, although you may have worked with certain staff for many years (or once a year for 10 years), from an HF point of view the staff member, perhaps a multi-licenced engineer (without type cover on your aircraft) or a mechanic, may have HF issues you are not aware of on any given day. If their work is not inspected, you have introduced an unnecessary risk to the task/s. Everyone in the industry knows that the B1 and B2 Support Staff are licenced and appropriately authorised to certify base maintenance task cards (and also sign the CRS in the Tech Log for line activities when not in a support staff role). These privileges do not allow delegation of a licenced engineer's responsibilities. An A-licenced engineer cannot delegate any of his line duties, inspections or otherwise to anyone else (or certify in a base maintenance environment). In Base maintenance, it is perfectly acceptable to let your mechanics do a General Visual Inspection (GVI) of a zone on the first day of the Check to give you an early heads up of impending defects, especially ones requiring spares that are not on the parts Pre-Load. Basically therefore, clearing an inspection task card requires an inspection by an inspector, B1 or B2.

Maintaining concentration is essential, you may have driven to work from home and not be able to recall any of that journey but that must never be the way you inspect. If your concentration drifts to other matters in your life, stop moving, pause, consider the other matter to the point where you can safely move on by going back and reviewing the last two (or more) points/stages of the task at hand. This good engineering

practice applies to all other interruptions as well we all know. In conclusion, you the Inspector, must still see a representative sample of the work being carried out for Condition Assembly and Functioning. [Reference: [CAP 562 'Civil Aircraft Airworthiness Information and Procedures'](#), 'Condition Assembly & Functioning' at Chapter H, Leaflet H20, Page 2, Paragraph 1.3 (Page 566 of the pdf) and 'Representative Sample' at Chapter H, Leaflet H20, Page 3, Paragraph 1.5 c) (Page 567 of the pdf)].

And finally, a large number of recent *CHIRP* reports cite management as a predominant issue. A wide list of cover and plenty of experience is an essential precursor to a senior role but should leadership skills training for managers not be required by the regulation? Is the competence assessment of senior staff done in accordance with a rubber-stamped tick-sheet? Does competence assessment become driven by performance above competence? What is a senior staff member's attitude to the regulations, the organisation's Quality/Safety Department, Internal Reporting (and it's requirement for confidentiality)? Would they actively promote *CHIRP* and the reading of our FEEDBACK publications? The amount of licence cover and experience does not make a person a good leader and, in a small Line operation, the opportunity to learn from one's peers is less than the help available in a Base operation with peers in double, maybe treble figures. An on-time return to service at all costs may help the bottom line, but an aircraft at the bottom of the ocean is much more costly.

Correction: It has been kindly pointed out that the *CHIRP* Air Transport Feedback Edition 149, January 2024, Engineering Editorial mentioned the BMA (British Medical Association) where the correct organisation should have been the GMC (General Medical Council). Please accept my apologies.

Phil Young, Engineering Programme Manager

I Learnt About Human Factors From That

[Air Transport ILAHFFT – One thing led to another on an approach](#)

What would you have done as PF or PM?

This report is taken from our US NASA [ASRS](#) ¹sister organisation's CALLBACK publication [Issue 529](#) (February 2024) and refers to an ERJ-175 flight crew who describe a confusing and convoluted sequence of events during an approach where CRM and SOP performance is questioned by

both pilots. The 2 reports seem to offer differing perceptions of what was going on and who was doing what at certain points in the approach.

From the Captain's report:

The flight was vectored to base for an RNAV approach while flying with full automation. The vectors brought us inside the fix that the FMS had been extended off of. I failed to direct the pilot monitoring (PM) to advance the FMS to a fix in front of us or to activate vectors. This caused the aircraft not to capture the final approach course, so I had to manually turn the aircraft back toward the final approach course. By the time we got back on course, we were significantly high, and the FMS still didn't capture the course. I directed the PM to go gear down, flap 3, then flap full. I then mistimed my attempt to get on glideslope by dropping the nose too quickly after disengaging the autopilot, overspeeding the flaps. Unable to regain glideslope, I elected to discontinue prior to 1,000 feet. As I did so, I directed the PM to go flap 4 and cycle the FMS forward. I believe my direction to sequence the FMS at this point was a key error, since it distracted [the PM] from getting the flaps retracted quickly. When the PM struggled to sequence the FMS, I opted to hit Takeoff/Go-Around (TO/GA) [mode] and do a go-around instead of discontinue. I was hand-flying and did not pull the nose up quickly enough, so the aircraft rapidly accelerated to the point we almost oversped the flaps again. I overrode the autothrottle to slow the aircraft, and we immediately got an EGPWS warning, surprising us both. After a split second of shock, I climbed rapidly to honor the warning. We then stabilized, caught our breath, and were vectored back around for a landing.

From the FO's report:

At around base, the pilot flying (PF) had me clean up the approach from a waypoint behind us. I suggested that we would not capture lateral guidance this way, but the PF said we would. We were cleared for the approach, but the aircraft did not capture lateral or vertical guidance.... No approach callouts were performed, because the course was never alive and [glidepath] was never alive. No missed approach altitude was set, due to the same reason.... I did not hear the missed approach callout, so I said, "Missed approach, flap 4," and the PF said, "Positive rate, gear up." I suggested he press TO/GA. I noticed that we were descending, and the flight director guidance was in its standard pitch up attitude for a go-around, so I suggested we pitch up. The PF did not pitch up, so I took the controls and pitched up, then handed controls back after we were established on a climb. ... I called, "Autopilot on, autothrottle on," because I noticed that those were not on, and it would increase situational awareness if those were on. I switched over to Approach, and they asked if we were climbing. I said we were, and they started vectoring us. At this point, the autopilot and autothrottles were on, and I continued monitoring the trajectory of the airplane. We were

vectored on downwind. On base, the PF had me clean it up from a waypoint behind us. I suggested vectors to final.... We may have gone through final again, I do not recall precisely.... By 1,000 feet we were stabilized and cleared to land, so we continued and landed and taxied normally.

^[1] As for *CHIRP*, *ASRS* collects voluntarily submitted aviation safety incident/situation reports from pilots, controllers, and others but on a much larger scale (*ASRS* currently receives 8-10,000 reports a month) and so, unlike *CHIRP*, they have limited scope to engage with the organisations concerned to gain their perspective when identifying system deficiencies and issuing alerting messages to persons in a position to correct them. *ASRS* educates through its newsletter *CALLBACK*, its journal *ASRS Directline*, and through its research studies. Its database is a public repository which serves the needs of FAA, NASA and other organizations world-wide that are engaged in research and the promotion of safe flight.



We need your ILAHFFT stories!

The value of ILAHFFT is that it provides insights from those who have been there, done it, and have lessons for all of us to learn. If you have any anecdotes or amusing 'there I was...' stories then please do share them with us so that we can pass on the messages and inform others (ideally in a light-hearted and engaging manner). Send any interesting tales to mail@chirp.co.uk and put ILAHFFT in the subject header – we promise full confidentiality to protect the innocent (and not so innocent!).

Reports

Report No1 - ENG739 – Engineering concerns

Initial Report

The reporter sent us a wide-ranging report about concerns about engineering practices at their company as follows:

1. **Commercial pressure.** Almost every day in the morning meeting, the [Senior] Technical Manager presents us with the amount of money that the company has to spend on claims from passengers under the Air Passengers Rights Regulations. This number is only the expected maximum and not divided if caused by engineering or other reasons.
2. **Lack of manpower.** During fleet transition from [Old Aircraft Type] to [New Aircraft Type] the manpower plan has not been adjusted to reflect the learning curve and the fact that the [New Aircraft Type] is a much more labour-intensive aircraft than the [Old Aircraft Type]. As a result, the amount of overtime is abnormally high and the

management doesn't care that the working time regulation max hours are breached constantly. This is made even worse due to away from base AOG's where, on short notice, people get sent away to recover tech aircraft.

3. **Lack of communication from management.** The Engineering Manager initially started with some investments in infrastructure (backed by the [Senior] Technical Manager who brought him into the organisation) but now he simply does things without asking people and doesn't even communicate his intentions.
4. **Reporting system.** We had one occurrence where the confidentiality of our reporting system has been breached by the [Senior] Technical Manager passing the details of a report to the Engineering Manager who then reprimanded the reporter the next day about being unprofessional. Other reports have been raised via the internal reporting system and even to Human Resources but everything moves very slowly or seems to dry up.
5. **Lack of leadership.** Since the Engineering Manager is not communicating professionally, no one knows in which direction we are going. A B1 got sent away to cover an AOG repair at another station, neither the shift Supervisor on a shift already inadequately manned, or the Station Manager, had been informed. An Internal Safety Report was raised about this but has disappeared in the system. (Refer to item 4).

New personnel get interviewed without the station Manager or a Supervisor present, which is a violation of company procedures. The result of all of the above is people are starting to leave, increasing the pressure on the remaining staff, as the company is unable to attract new engineers, and even then, it takes them about a year or two to come up to speed, as there are not many UK licensed staff with [Aircraft Category] experience.

CAA Comment

A review focused on regulation was carried out. This review has been completed, understanding that any observations and evidence is from a sampled snapshot at the time of the review. The content of the *CHIRP* report was used in preparation for an audit and oversight was carried out with this in mind – any issues raised can only be raised against the regulation. Ongoing oversight will be carried out as required and the content of the report will continue to be used as intelligence for future activity. Thank you for your support, whilst this review is now closed, issues raised within areas of the regulation continue to be monitored and reviewed during ongoing oversight.

CHIRP Comment

This is a comprehensive report covering all of the same issues we have seen in many recent engineering reports received by *CHIRP*. The CAA response, understandably based on standard practice, did confirm that the *CHIRP* report-identified concerns were considered. It is disappointing to know that there are still engineering managers in our industry that fail to realise that breaking the confidentiality process in an organisation's internal reporting vehicle undermines internal reporting for a long time, possibly even years, and reprimanding reporters for raising concerns is certainly against all the principles of Just Culture. On occasion the input from maintenance management is an essential component in the investigation of a maintenance issue. It may moderate the reports record of events but it should not prevent corrective and preventative action to address the facts and under no circumstances should it be received with animosity to the reporter, or confidentiality compromised. As most of us already know, internal reporting is a benefit to safety, identifying deviations from the regulations (designed to promulgate safety) increasing productivity and impacting customer satisfaction.

Report No2 - ATC841 – Lack of controller understanding

Initial Report

At this busy regional airport, I feel that widespread inexperience and appreciation of the task of flying an aircraft is clear and obvious with regard to poor vectoring, lack of appreciation of wind effect, and use of speed control. The aim of the game is safe, efficient, smooth sequencing. Only the first is regularly achieved in my experience. Range checks are inconsistent and, as a result, extra fuel is used and it's very difficult to achieve a CDA onto final. Self-positioning onto final seems shunned when it is quiet, and there's a lack of coordination between tower and approach; the default spacing of 8 miles (to enable departures) is regularly meaningless as more often than not you are vectored/slowed to achieve this gap only to be cleared to land on first contact with the tower, at 8 miles! In a similar vein, being slowed in the radar sequence and then effectively told to fly 'best' speed on final is not uncommon. I believe that the controllers are offered regular jump seat flights; this should be mandatory and would really help to improve things.

CHIRP Comment

There's a lot of inexperience in the overall aviation system at the moment, and this includes the controlling environment so allowances need to be made for inexperienced controllers or trainees. *CHIRP* is of course in broad agreement with the notion that controllers would benefit from flight experience. There are programmes for controllers to do this, but they tend to be done

on an as-and-when basis rather than being a mandatory requirement. Making it mandatory as a formal part of the controller syllabus or roster would probably be hard to achieve due to limited controller availability, but more could be done to encourage controllers to do such trips by providing time within rosters rather than it being done in their own time, which few would be likely to embrace. In order to achieve this, airlines need also to be pro-active in offering jump-seats to controllers, and make it easier to do so at relatively short notice rather than the seeming bureaucracy that currently exists to get authorisation into the cockpit – it's in airlines' own interests to have controllers who have experience of what's going on in the cockpit. Jump-seat flights for controllers tailed off during the pandemic for obvious reasons and so the whole concept needs to be reinvigorated to bring it back to the fore.

Although it may have been the case in this instance, if, as pilots, you don't think you're getting the level of service you expect from ATC then talk to them about the issues afterwards in a considered manner so that feedback can be given. That cuts both ways, and most airfields will have an operational liaison group where concerns from both sides can be raised as necessary. In a similar manner, there are many inexperienced pilots in the system and they should also be encouraged to go to the Tower where possible (particularly during their training) to experience what's going on from the other perspective during busy periods and so enable cross-pollination in both directions.

Report No3 - FC5315/FC5326 – Airport remote car parking

Initial Report

FC5315 Report Text: After another 4 hours of my supposed rest periods this week spent on or waiting for buses to and from the staff car park at [Airport] the following points concern me:

- [Airline 1] crew now routinely report to the car park 30mins before official report time, some earlier because 30mins usually means crew room 0-5 mins before report. On yesterday morning it was a 45min wait.
- On average we get to the car park 30mins after we come off duty so a 12hr rest period is now 11hrs, minus the commute.
- We operate rosters close to and too often beyond max FDP (using Commander's Discretion) and frequently are on legal minimum rest between duties.
- Less than half our flights are on time and so we routinely do several hours a week beyond what is rostered.
- When the early morning buses arrive they frequently have to turn people away at the bus stops because they are so full they cannot physically fit any more people on. If you do get on, every seat is full and there are 20-30 people standing all through the aisle.

- The buses navigate busy roads and multiple 90 degree corners. If there was an accident the chances of getting out any time soon are questionable.
- There's loads of bugs going round and sometimes the bus is like a doctors waiting room with 50 odd people coughing and sneezing away.

FC5326 Report text: [Airline 2] have experienced significant delays from the [Airport] base over the last 2 summers. Many delays are caused by lack of handling resilience, including on first wave departures. This has a knock on effect as these issues magnify with further similar delays on late departures with long duties already scheduled back well into the WOCL. 1-2 hour delays are common on long late duties, due to handling issues, airport deficiencies and slots. Rather than deal with the root cause of the delays, many duties are now rostered as extended FDPs. There is also far greater use of discretion to return to base. Even when discretion is used, significant delays of 40mins or more after arriving on stand and prior to disembarking passengers are encountered due to airfield supplied bus driver shortages. [Airport] have 3 airport bus drivers on duty for around 60 overnight arrivals, with half, and possibly more, of those flights either arriving on remote stands or onto the 'wrong' terminal thus requiring bussing. These post flight delays are not accounted for in FTLs, yet we are still legally responsible for passengers. Even longer delays are required waiting for a company-supplied crew bus. Many crew are arriving up to 40mins early due to car parking and security issues. This is on top of similar delays departing after the previous duty. Thus their actual rest period is below that achieved on paper. These issues have been raised for years with the company and [Airport] and yet nothing has changed.

Airline 1 Comment

Thank you to the reporter for highlighting this concern with regards to staff parking at [Airport]. This was also reported by a number of crew members via our safety and fatigue reporting systems. Fatigue reports from all bases are being closely monitored for parking issues and discussed during our Fatigue Safety Action Group. It is unfortunately a trend for airports to move staff parking further away from the terminal, which is another reason why we are monitoring this closely. Our Nominated Flight Operations has raised this issue directly with [Airport] senior leadership. We are also about to launch a survey to gather further data on this topic, which will again feed into our action groups to ensure follow up actions are conducted within a timely manner. In the meantime we encourage our crew to continue to report their concerns via our reporting system.

Airline 2 Comment

As with the other operators based at [Airport], we have experienced widespread disruption, the vast majority of which is

beyond our control, due to the ongoing development of the infrastructure at the airport. Specifically, amongst these issues, we have experienced lack of stand availability, – particularly at [Terminal] – mixed terminal activity, taxiway closures leading to significant delays in push-back and arrival on stand, ATC delays, lack of passenger buses and baggage system outages. Both Flight and Ground Operations management have, and continue to, engage as much as possible with the airport management in an attempt to find solutions to help mitigate against some of the many issues being experienced by our airline and the adverse effect it has on the duties of not only our Flight and Cabin Crew, but also our locally based ground handling staff.

With reference to the issues experienced, some of which have been listed above, it has resulted in significant delays to our 2nd and 3rd wave departures. These departures, particularly when compared to the 1st wave, have seen huge drops in on-time performance and the obvious knock-on effects to the utilisation of Flight and Cabin Crew. As a result of this, the company has on occasions had to utilise Extended FDP's in order to be able to crew flights and minimise any further delays and disruption to the operations and other Flight and Cabin Crew members. The use of these Extended FDP's are carefully managed and additional fatigue mitigations surrounding these duties are in place which are above and beyond the legal requirements for their use. We have a sound and robust safety reporting and fatigue reporting system which allows any crew concerns to be recorded and investigated accordingly.

Engagement from our management at the very highest level continues, and lessons learned from this year's operation will be taken into next year with us doing everything in our power to reduce disruption to Flight and Cabin Crew rosters and individual duties.

CHIRP Comment

Staff parking at [Airport] changed from its previous location next to the [Terminal] as a result of recent upgrade work and so this was the cause of the problem. Although they are aware, the problem is often largely invisible to the airlines on a day-to-day basis because the onus is on the crews to achieve their report time and so the associated burdens of coping with delays often fall onto them alone. As ever, things often only change when sufficient data is amassed and so crews should report as being unable to meet their report times as a result of the extra delays getting to the terminal rather than simply accepting the extra burden on themselves. It's also not just airline crews who would be suffering from the increased delays in getting to the airport; engineers, controllers and other trades would also be facing increased commute times as a result. Amongst other issues, an ongoing CAA FTL/FDP review is looking at assumptions for commutes and passages to and through airports in general to the report points. *CHIRP* thinks that more AMC/GM is required in this respect so that the burden does not fall solely on the

crews as yet another stressor in their day but is included as part of FDP calculations for each airport situation.

Ultimately, we're encouraged that the airlines are engaging with [Airport] in this case in order to ensure that there are sufficient resources to transport the crews, but the airlines must also take steps to mitigate the reality of what is actually happening as a result of insufficient transport assets and factor that into their rostering calculations until matters improve. For their part, the airport management team should have thoroughly reviewed the situation as part of their project's change management process in the context of considering the impact on all stakeholders (their staff, the airline staff, their commercial customers) and not just the revenue-generating passengers.

Report No4 - FC5309/FC5319 – Unticking MOR boxes in ASRs

Initial Report

FC5309 Report text: There are strong rumours that the company is 'unticking' the MOR box used by pilots in flight safety reports. When questioned, the answer is that the company works closely with the CAA and has a special relationship.

FC5319 Report text: Over many years, it can be common for Flight Ops managers to ask reporters of ASR's to remove the MOR tick, even though the Pilot thinks it should be ticked. Can organisations be reminded that they should not be asking authors of reports to change their minds, and let the CAA make up their own minds.

CAA Comment

The CAA have launched the MOR Industry working group which is engaging with the 10 organisations who are either the largest or represent the largest report volumes. The purpose of the group is to provide a dedicated forum for two-way engagement on MORs. This has come from an internal CAA project and promotes collaboration and feedback between industry and regulator.

CHIRP Comment

Companies 'unticking' MORs is something that we have raised with companies and the CAA before, and so it would be disappointing to see it being done again without justification. That being said, there are circumstances where company/CAA interaction does occur and the box can be unticked by mutual agreement for minor issues but it shouldn't be an habitual action, especially not to hide data, and the boundary between what is mandatory and what is not can be opaque to those who are not familiar with the distinctions.

The CAA receives in the region of 30,000 MORs each year, and many of these are simply logged; they do not have enough resources to investigate them all in detail and so only the specifics of those that represent significant risk are passed on to the investigators and surveyors for further action; the rest are used for statistical analysis and trend identification. For this reason, it is primarily for the companies themselves to deal with the issues raised in ASRs and MORs, ensuring that those that are formally serious incidents or accidents are notified to the CAA. To set the context, UK(EU) Regulation 376/2014 specifies what occurrences are deemed 'significant risk' (see below) and which must be reported to the CAA.

So, the bottom line is that it depends on what is being reported whether the company needs to pass it on to the CAA. Anything that has a safety risk should be considered, but it's for the company, in association with the CAA, to determine which are 'significant risk' and classed as MORs. But it's *CHIRP*'s opinion that there ought to be an open record of how many ASRs have had their MOR boxes unticked by a company so that there is transparency in the reporting process within both the companies and the CAA; at the moment, we understand that there is no such record and so the CAA don't know what they don't know, nor the scale of how many ASRs are being unticked.

Ultimately, if you feel strongly that an issue should be reported to the CAA but your company does not and they untick the MOR box then it's always possible to report issues directly to the CAA, bypassing the company. This can be done either as a VOR (Voluntary Occurrence Report) through the ECCAIRS portal (which can be accessed via the [CAA Occurrence Reporting webpage](#) but is somewhat user-unfriendly), or by whistleblowing via the [CAA whistleblowing facility](#). Although doing so after having previously submitted an ASR may be another unwelcome burden, if you feel strongly that your concerns are not being listened to or presented to the regulator when you think they should be, then these methods at least provide an avenue for direct reports.

Associated reporting regulations

- [UK Regulation \(EU\) 376/2104](#) Article 4 Mandatory reporting:

1. Occurrences which may represent a significant risk to aviation safety and which fall into the following categories shall be reported by the persons listed in paragraph 6 through the mandatory occurrence reporting systems pursuant to this Article:

(a) occurrences related to the operation of the aircraft, such as:

(i) collision-related occurrences;

- (ii) take-off and landing-related occurrences;
 - (iii) fuel-related occurrences;
 - (iv) in-flight occurrences;
 - (v) communication-related occurrences;
 - (vi) occurrences related to injury, emergencies and other critical situations;
 - (vii) crew incapacitation and other crew-related occurrences;
 - (viii) meteorological conditions or security-related occurrences;
- (b) occurrences related to technical conditions, maintenance and repair of aircraft, such as:
- (i) structural defects;
 - (ii) system malfunctions;
 - (iii) maintenance and repair problems;
 - (iv) propulsion problems (including engines, propellers and rotor systems) and auxiliary power unit problems;
- (c) occurrences related to air navigation services and facilities, such as:
- (i) collisions, near collisions or potential for collisions;
 - (ii) specific occurrences of air traffic management and air navigation services (ATM/ANS);
 - (iii) ATM/ANS operational occurrences;
- (d) occurrences related to aerodromes and ground services, such as:
- (i) occurrences related to aerodrome activities and facilities;
 - (ii) occurrences related to handling of passengers, baggage, mail and cargo;
 - (iii) occurrences related to aircraft ground handling and related services.

- Annexes I-V of [UK Regulation \(EU\) 2015/1018](#) go on to amplify this with specific topics for reporting.

- More usefully, [AMC & GM for Reg \(EU\) 376/2014](#) Section 3 talks about which occurrence information organisations should send to the CAA (as the competent authority). Within para 3.1 it says: *“Regulation 376/2014 requires the collection, analysis and follow-up by organisations, as well as the transfer of certain occurrences to their competent authority.”* The document goes on to state at Para 3.7 that only those occurrences that fall within the Mandatory Occurrence Report set (as noted above) must be passed on to the CAA. Those that are not within the MOR list (i.e. Voluntary Occurrence Reports (VOR)) do not need to be passed on to the CAA unless they involve a ‘safety risk’ and so the operator, by inference, has the option to ‘untick’ the MOR box in these cases. The associated Diagram 3 shown is from para 3.7.

Diagram 3. Information flow related to the occurrence initial notification



Note: for the purpose of simplification, the scheme indicates that the reporting by individuals is made to the organisation while it is recognised by Regulation 376/2014 that individuals may report directly to the competent authority. See Section 2.8 for more information on the various reporting channels.

Key principle
Organisations are required to report to their competent authority (Article 4(8) and (9)) all mandatory reportable occurrences they have collected i.e. those contained in Regulation 2015/1018 when reported by a person listed in Article 4(6) (see Sections 2.2 and 2.3).
Occurrences collected under VORS are not all reportable to the competent authority. Indeed, only those that may involve an actual or potential aviation safety risk (Article 5(5) and (6)) shall be reported to the competent authority.

The prose within Para 3.7 goes on to say that:

“It is understood that organisations shall discuss with their competent authorities to determine what types of occurrences are considered involving an actual or potential aviation safety risk. This should ensure an alignment between the occurrences that the organisation intends to transfer from the VORS and the ones that the competent authority expects to receive. It should also ensure harmonisation among all organisations reporting to the same competent authority.

Regulation 376/2014 gives Member States the possibility to request their organisations to transfer them all occurrences they have collected under their VORS (Article 5(6)).

It is also understood that when an occurrence is reported to an organisation, this organisation might need to assess whether or not it falls under MOR or VOR and therefore what the applicable notification obligations are. In a situation where a reporter has transferred the report under

VORS, the organisation may reclassify it into MOR and vice-versa.”

Report No5 - FC5327 – Interpretation of FTLs

Initial Report

I filed a Fatigue Report because the OM-A minimum Table 6 Recovery was not allocated between a rotation crossing 4 or more Time Zones and simulator duties. The report was closed and I was advised that simulators could be scheduled in rest periods because they were ground duties to which FTLs do not apply. I believe this is incorrect under the definition of “Duty” from our OM-A Chapter 7:

“Duty” means any task that a crew member performs for the operator, including flight duty, administrative work, giving or receiving training and checking, positioning, and some elements of standby;”

The operator is already rostering close to minimum Table 6 Recovery Days and this interpretation is further limiting crews’ recovery opportunities.

The crux of my concern is not the Table 6 recovery periods themselves, but more their interactions with other duties. My understanding is that Table 6 recovery must be “free of all duties” but the response to my Fatigue Report was that I could be rostered a sim duty during Table 6 Recovery which I would suggest is not within the definitions of Recovery, Rest and Duty.

CAA Comment

Where post-FDP or post-rotation rest periods are expressly required in the regulations, the rest period (as defined) is not specified in set hours but in number of local nights at home base as stated in the associated table. There are no set hours for the rest period because it is the number of local nights that are needed for recovery to reset the body clock, not a number of hours. Once the required number of local nights has been achieved, the rest period is complete, and duties can be rostered accordingly.

The definition of rest requires that the company cannot roster duties during the day in these rest periods until the number of local nights has been achieved. Because the crew member is unacclimatised during rest periods, it makes no sense to say they are ‘rested’ during the day because the person’s circadian rhythm is not adjusted to local time and therefore their bodies don’t know what ‘day’ is; they need the normal sleep opportunity in the local time WOCL to get back to where their body could be said to be on local time.

We have initiated a post-implementation review of all of the assumptions within the UK rostering and FTL/FDP regulatory set to determine whether there are any areas that could be better defined, harmonised or re-evaluated now that we are no longer part of the EASA regulatory regime. Rest periods will be included as part of this review.

CHIRP Comment

The report contained specifics that required interpretation within the company FRMS but the key issue was whether rest should be considered as rest, or whether the company could schedule simulators within that 'rest period'. The CAA comments are clear in that no duties should be rostered until the required number of local nights have been achieved so that peoples' body clocks can acclimatise to local time. Philosophically, companies are at risk of undermining the value and quality of the simulator task and any associated recurrent training if they schedule simulators within rest periods because the point of rest periods is to ensure that crews are sufficiently recovered from previous flight duties to operate effectively. By definition, they would not be considered 'sufficiently recovered' to fly until the end of the rest period and so scheduling a simulator in a rest period thereby asks crews to conduct simulated flight operations when not rested. Since they are not 'rested' how can crews be expected to perform to the required 'flying' standard in the simulator? Taken to extremis, people are in the simulator to demonstrate their flying ability or be trained and so, what if a simulator assessment was failed by a crew member who was not properly rested? Arguably, simulator flights are more demanding than normal flying due to, for example, the injection of emergencies and poor-weather conditions and so they demand even greater levels of alertness and ability to perform.

The fundamental question is whether 'rest periods' should be free of all duties including simulators (see ORO.FTL.105 para (21) definition below) or are simply a device to ensure that crews have sufficient local nights in bed to recover from flying rosters and so crews can be allocated duties when not in bed. The CAA's answer is unequivocally that rest periods should be free of all duties until the required number of local nights has been achieved.

As background context, relevant definitions from [ORO.FTL.105](#) are below. Note that the definition of 'rest period' at (21) makes no distinction between flying and ground duties, and requires that the 'rest period' should be "...free of all duties...", with 'duty' defined at (10) as "...any task...".

(10) 'duty' means any task that a crew member performs for the operator, including flight duty, administrative work, giving or receiving training and checking, positioning, and some elements of standby;

(11) 'duty period' means a period which starts when a crew member is required by an operator to report for or to commence a duty and ends when that person is free of all duties, including post-flight duty;

(21) 'rest period' means a continuous, uninterrupted and defined period of time, following duty or prior to duty, during which a crew member is free of all duties, standby and reserve;

(22) 'rotation' is a duty or a series of duties, including at least one flight duty, and rest periods out of home base, starting at home base and ending when returning to home base for a rest period where the operator is no longer responsible for the accommodation of the crew member;

[ORO.FTL.235](#) covers rest periods, specifying at its para (d):

(d) Recurrent extended recovery rest periods Flight time specification schemes shall specify recurrent extended recovery rest periods to compensate for cumulative fatigue. The minimum recurrent extended recovery rest period shall be 36 hours, including 2 local nights, and in any case the time between the end of one recurrent extended recovery rest period and the start of the next extended recovery rest period shall not be more than 168 hours. The recurrent extended recovery rest period shall be increased to 2 local days twice every month.

[CS FTL.1.235](#) also covers rest periods with respect to time zone differences and this is the source of 'Table 6' in the company OM-A as referred to by the reporter. Its para (b) states:

(b) Time zone differences

(1) For the purpose of ORO.FTL.235(e)(1), 'rotation' is a series of duties, including at least one flight duty, and rest period out of home base, starting at home base and ending when returning to home base for a rest period where the operator is no longer responsible for the accommodation of the crew member.

(2) The operator monitors rotations and combinations of rotations in terms of their effect on crew member fatigue, and adapts the rosters as necessary.

(3) Time zone differences are compensated by additional rest, as follows:

(i) At home base, if a rotation involves a 4 hour time difference or more, the minimum rest is as specified in the following table.

Minimum local nights of rest at home base to compensate for time zone differences

Maximum time difference (h) between reference time and local time where a crew member rests during a rotation	Time elapsed (h) since reporting for the first FDP in a rotation involving at least 4 hour time difference to the reference time			
	< 48	48 – 71:59	72 – 95:59	≥96
≤6	2	2	3	3
≤9	2	3	3	4
≤12	2	3	4	5

(ii) Away from home base, if an FDP involves a 4-hour time difference or more, the minimum rest following that FDP is at least as long as the preceding duty period, or 14 hours, whichever is greater. By way of derogation from point (b)(3)(i) and only once between 2 recurrent extended recovery rest periods as specified in ORO.FTL.235(d), the minimum rest provided under this point (b)(3)(ii) may also apply to home base if the operator provides suitable accommodation to the crew member.

(4) In case of an Eastward-Westward or Westward-Eastward transition, at least 3 local nights of rest at home base are provided between alternating rotations.

Report No6 - FC5332 – Fitness to fly

Initial Report

In recent months I have had to offload crew members on 3 occasions due to being unfit to fly, both pilots and cabin crew. On all occasions it was due to cold symptoms, which whilst weren't that obvious at report time, manifested themselves throughout the subsequent sectors leading to an offload part way through the day. There are 3 issues I feel need addressing;

- 1. Commanders responsibility for crew members fitness to fly.** Assessing a crew members fitness is subjective, as a cold can vary in severity and can be hidden well during the briefing. Asking the crew member if they are fit will inevitably lead to a 'yes' – and as captains are not doctors it is difficult to make a judgement. We need clear guidance from the Company that the Commander's decision will be final and non-punitive to both parties.

- 2. Perceived pressures from the Company.** While the Company says it has a sickness policy and crew will be paid, cabin crew in particular will not receive sector pay or commission if they are sick – and this was quoted to me as a reason for not calling sick for the duty as 'they didn't have many hours that month as it was and couldn't afford it'. There is also the threat of an interrogation from management depending on the individuals sickness record. The Commander is then under considerable pressure and may have to argue with a crew who may consider themselves fit even when they are clearly not – but as before this is subjective.

- 3. Inadequate education of crew on the risks of flying while unfit.** In the case of the pilot offload, he was unaware that flying with blocked ears could have serious consequences when it comes to burst eardrums etc. I feel that time should be spent during initial training/induction establishing the company culture re sickness and how various ailments that might be mild on the ground can be very different in the air.

The Company often stays quiet on such matters as they obviously don't want to 'encourage' sickness, but I have seen a definite trend of crew reporting when unfit and offloads during the duty, which creates additional problems.

CHIRP Comment

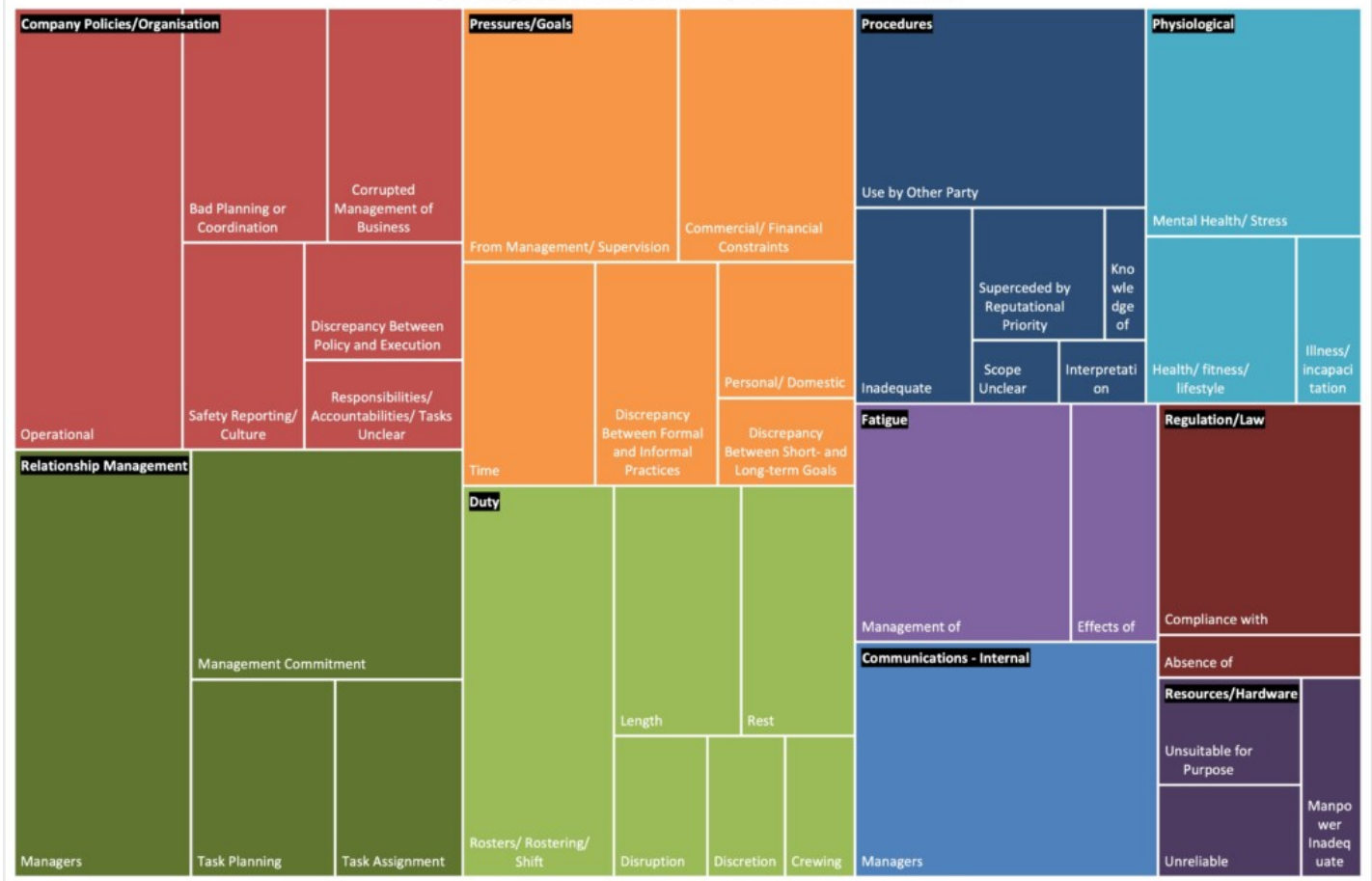
Although fitness to operate is a personal obligation, as the ultimate arbiter for the safety of the flight, **CHIRP** feels that captains clearly have an operational and moral responsibility as the final barrier not just for the safety of the operation but also to save people from themselves or deal with situations when they don't realise they are unfit to operate – ultimately, peoples' fitness to operate has relevance not only to the flight's safety if they can't conduct their duties but also for their personal safety and well-being. That being said, captains offloading crew members if they suspect they are unfit to fly must be done circumspectly given that captains are not specifically qualified to make such decisions for others. If someone is clearly not functioning well enough then that's one thing, but if someone is just a bit 'under the weather' or has a minor ailment that they are happy to continue with but the captain is not, there is potential for all sorts of disputes about medical judgements. In this respect, it's important that captains are supported by medical help and guidance. There are various third-party medical services that airlines subscribe to depending on their chosen provider, and these are important sources of professional assistance in supporting the decisions made by captains so that they don't have to shoulder the burden themselves when things may not be clear-cut.

Aeromedical physiology is an element of pilot education and licencing so we're genuinely surprised that a pilot would not know about the risks of flying with a cold. Cabin Crew are not licenced and their aeromedical training varies from company to company but, although they might perhaps not have the same level of knowledge, they should also be well aware of the risks of flying with colds etc. A minor snuffle might not be a significant risk, but operating with a heavy cold would of course

not be a good idea. Ultimately, we acknowledge that there are huge financial and perceived adverse company policy pressures on crews to fly if they are unfit and so third-party oversight from captains is appropriate in applicable circumstances and must be supported by the companies.

Flight Crew reporting themes in 2023

Top-10 Flight Crew Key Issues reported to CHIRP in 2023





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