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Air Safety Reporting

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William Dean
Air Transport Programme Manager

Safety reporting – why is it so important?

During the month of September, I had the opportunity to present to three different aviation organisations about the role played by CHIRP in promoting air safety, and in particular, the importance of having an independent and

confidential Human Factors reporting system for the commercial air transport sector in UK. The organisations I spoke to included two that are involved in flight safety promotion and the third is a company at the forefront of the exciting, yet still embryonic, Advanced Air Mobility (or "Urban Air Taxi") sector in the UK.

Building on the theme of my previous editorial titled “Safety Culture” in FEEDBACK 155, I thought that for this edition I would discuss the role played by safety reporting in a well-functioning Safety Management System (SMS) and how it can make a significant difference to how organisations learn from near misses, incidents and accidents, as well as help prevent such instances from occurring in the first place. The latter can only take place if management are sufficiently aware of potential hazards and process flaws in advance and then, having received the reports, have the right systems in place to make proper use of the information provided. Such systems require adequate resource and fully engaged commitment from the very top of the organisation.

When an individual submits an internal / company Air Safety Report (ASR) they are starting an important process of information flow, from the operational level to the management level. In a well functioning organisation, the ASR will trigger a number of events, namely, a review by subject matter experts from safety, quality and operations, to assess the severity of the issues raised by the ASR, and to assign ownership of the report to ensure that there is accountability for the containment actions that may need to be carried out, sometimes immediately. Then, a decision should be made as to whether a local or wider investigation is required to obtain more information to assist in determining potential causes as well as the subsequent hazard / risk mitigations. Even if the ASR is deemed of low or medium severity, or perhaps is used to inform management of a hazard or safety concern rather than an incident, it will inform and add to the data available regarding the issue – so, if in doubt, submit an ASR and add to the data available.

All well and good. Why is it then, if the reasons for submitting an ASR are clearly so advantageous, in theory at least, to everyone involved in flight operations, that some employees of companies involved in commercial air transport do not use their internal ASR system and feel they have to report to CHIRP instead? The individual reasons provided to us – and we do ask! – are, as you’d expect, many and varied, but a common theme is culture. Aviation professionals are very well trained and knowledgeable regarding safety in general, and SMS in particular. However, we here at CHIRP find, all too often, that our reporters do not believe that any subsequent interviews or meetings based on their ASR will be held fairly, and probably most worryingly, many state that they don’t *trust* the leadership to be impartial about the issues raised. This should worry organisations because, if they are denied receiving safety reports based on fear or reprisals, they then lose the ability to be pro-active with safety, and will always be on the receiving end of, at best, near misses, and worst, accidents that may have been prevented if safety mitigations had been put in place. If a Just Culture is in place at an organisation then, by definition, employees will feel safe in the knowledge that they can submit a report without then being blamed or shamed.

My challenge to Accountable Managers and other senior aviation managers reading this is to ask themselves “how can I measure culture in my organisation to know it is, in fact, as ‘Just’ as I want it to be?”

Please contact us here at CHIRP and give us your views on the best way to objectively assess safety culture within an organisation. Without a doubt, this is one of the most difficult air safety nuts to crack!

William Dean

**Air Transport (AT) & Advanced Air Mobility (AAM)
Programme Manager**

For all CHIRP Aviation Team, see [CHIRP bios](#).

Engineering Editorial

Since joining CHIRP earlier this year, one of the issues I’ve pondered on is the perceived low level of safety reports raised within Aircraft Engineering – both within organisations and those directly to CHIRP.

The barriers to reporting are not unique to Engineering, but some may be more significant than others. In my conversations with industry professionals, three themes consistently get mentioned: the complexity of the reporting process, the fear of retribution, and the belief that nothing will change. Tackling each in turn:

- **Complexity of the reporting process**

During my own career, I’ve certainly been confronted with reporting forms that appeared too complex and hence time-consuming to complete. Safety reporting needs to be simple, intuitive and fast. Recent developments in AI, together with mobile technologies and intuitive Apps, offer significant opportunities to further simplify the process. This should help ensure that only relevant data is captured and to the required level of detail for investigations to start and for action to be taken.

- **Fear of retribution**

Engineers might worry that reporting a mistake will get them into trouble, damage their reputation, or make them look incompetent. Equally, if colleagues believe that the organisation “shoots the messenger,” they will not be inclined to deliver the message. To address this, I feel organisations need to adopt a true just culture approach: honest mistakes must be treated as learning opportunities, with genuine human errors being met with understanding, not punishment. In addition, the use of confidential reporting systems within organisations, and CHIRP of course, are other options to highlight concerns without fear of blame or punishment.

• Belief that nothing will change

The thinking goes: “Why bother reporting? Nobody listens anyway.” Stories spread, and when engineers share their experiences in crewrooms of raising a report with no action taken, this can deter others from acting. To counteract this, it is vital that organisations undertake suitable investigations and provide timely feedback to those raising reports. Just as importantly, organisations should tell the stories of past successes; widely publicising cases where safety reports have resulted in genuine change are essential.

I’m sure the reader can identify many other reasons why colleagues are not reporting safety concerns, but it is incumbent on everyone involved that these barriers are understood and addressed. It remains critical that those doing the work are actively encouraged to raise their concerns to those empowered to do something about them. As Alan Mulally, a former CEO of Boeing once said, “you can’t manage a secret.”

Kuldeep Nothey

Engineering Programme Manager

Feedback on FEEDBACK

What do you think? We’d love to get your views on the topics covered in FEEDBACK. We don’t claim to have all the good ideas, and we may have missed something that relates to a report so please do contact us and give us your views. You never know, your thoughts might inspire the next editorial or perhaps give us more context for when we contact organisations and companies. Please send any comments to mail@chirp.co.uk for the attention of CHIRP Air Transport Programme Manager and we can start a conversation.

Comment on FEEDBACK 155

Firstly, thank you for another very useful and informative edition of CHIRP Air Transport FEEDBACK. There are several entries which provide very succinct reminders of the common ‘unseen’ or ‘unheard’ threats in commercial aviation. I would like to make a specific query regarding Report No6 – FC5393 – Sickness mobbing.

Although I was slightly shocked to see this level of poor communication from a regulated commercial airline to its flight crew, I am, as many others will be, unsurprised by it. Although at the airlines where I have worked, communication regarding sickness has sometimes been less than supporting, it has never quite bordered on this level of unprofessionalism. My enquiry is

this: what action is being taken by CHIRP, or the CAA, to address instances like this? Although as pilots we are trained to be emotionally resilient, this can’t always be the case, and the impact on the individual could have been significant. No doubt this will be one of many similar examples of the letter in question. This simply cannot be tolerated in a professional airline environment. Of course, I appreciate that airlines must balance operational efficiency with human factors and safety, but examples like this stray, in my opinion, too far across the line and put undue pressure, as well as a subconscious feeling of guilt, on flight crew for legally justified sickness. Action must be taken to express to airlines by the Authority that this example does not reflect a just and proper safety culture, and that if this is sanctioned by their sickness policy, it must immediately be changed. While the response from CHIRP was in line with this understanding, I don’t believe it went far enough to deal with addressing it. Does CHIRP provide reports to the CAA on safety concerns such as this? Or is the onus on the individual reporter to make the authority aware that such practices are commonly being used by their airline?

Thank you for your attention to this matter and for your continued work toward a safer aviation culture.

CHIRP Response: Yes, absolutely, CHIRP has regular and effective dialogue with the CAA and, with the consent of the reporter, these meetings provide current information about issues of concern. Where it is appropriate to do so, we also seek to hold airlines and the regulator to account. However, whilst CHIRP does have considerable influence and will always seek to change behaviours to improve safety, we have no statutory power (therefore, “carrots, not sticks”). CHIRP’s strength is that it is independent and impartial. Thus, we achieve our aims partly through our close, collaborative links with CAA, but as importantly, through the independent body of critical thinking and breadth of different experience represented across our voluntary advisory boards.

Report to CHIRP!

Have you had an incident or a near miss? Could CHIRP help or offer advice on a safety concern?

Perhaps you’ve experienced or observed something with a human factors angle that you think the wider aviation community could learn from. Why not report it to CHIRP?

Every report helps raise awareness of safety issues, highlights emerging trends and shares valuable lessons with others. Report by report, we can all contribute to making aviation safer – as our strapline says:

“You report it, we help sort it.”

Reporting to CHIRP is simple and quick using either our [website](#) portal or the CHIRP App (scan the relevant QR code or search for 'CHIRP Aviation', but watch out for the birdsong apps!). The portal presents a series of fields for you to complete, but not every field is mandatory – just tell us as much as you can. The more detail you provide, the more helpful we can be.

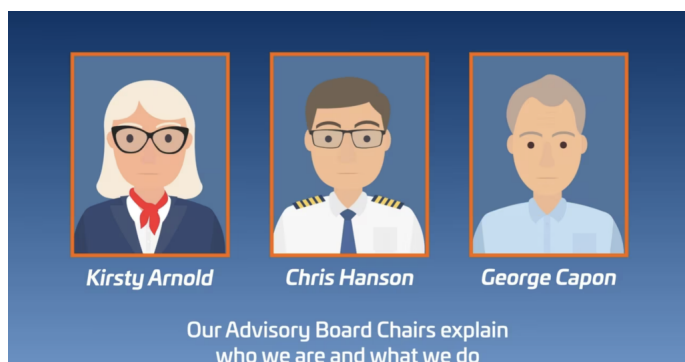
Although you'll be asked for an email address to access the system (to screen out bots and spam), your personal information is held securely within CHIRP's independent systems and is never shared outside the organisation. Importantly, nothing that could identify a reporter is included in any report we progress or publish. We liaise with you at every stage and no information is passed on without your express consent.

So rather than 'fly and forget', please consider working with CHIRP to help make the skies safer for everyone. However, it's important to note that reporting to CHIRP is not a substitute for submitting a Mandatory Occurrence Report (MOR) when required, for example, when there has been a significant risk to safety, or an event that could have endangered the aircraft, its occupants, or others. MORs should be submitted via the CAA's [ECCAIRS 2 portal](#).



CHIRP, what's it all about?

Just a reminder that we've recently produced our latest short video (10mins) explaining what CHIRP does, voiced-over by 3 of our Advisory Board Chairs. Why not click on this [link](#) to have a look and find out what we're all about?



I Learnt About Human Factors From That

Older pilots, better pilots?

Recently, Capt. Chesley "Sully" Sullenberger posted on social media the question: ***Are older pilots less effective in the cockpit of a modern commercial aircraft than younger pilots?***

CHIRP was intrigued by this Human Factors question from Captain Sullenberger, aiming as it does at human performance limitations, and probing the pilots in his network to consider it too. Let us know your thoughts on Sully's question. You never know, they might get published in the 'Comments on FEEDBACK' section of a future ATFB!

An AI-based search on the topic / subject came up with the following – **Note:** that this is not the CHIRP view necessarily:

"Older pilots are not necessarily less effective; experience, judgement, and wisdom gained over time can outweigh minor age-related declines like slightly slower reaction times. While younger pilots might have quicker reflexes, older pilots can draw on a vast knowledge base to adapt and solve problems, with some research even showing older pilots improving traffic avoidance skills over time."

The advantages of experience include:

Wisdom and Judgment:

Longevity in the cockpit builds crucial experience and judgment, which is considered a pilot's most important asset.

Problem-Solving:

An experienced pilot can adapt past knowledge and apply it to new or unfamiliar situations, demonstrating wisdom that training alone cannot provide.

Real-World Application:

Over a career, pilots incrementally gain experience, allowing them to handle unexpected situations with greater skill and insight.

Mitigating the risk of mid-air collision:

Research has shown that older pilots have better traffic awareness compared to younger pilots.

The disadvantages of longevity in the cockpit or the potential age-related factors include:**Reaction Time:**

While reaction times may slightly decrease with age, studies suggest that the accumulated wisdom of an older pilot can compensate for this, at least until the mid-60s.

Let us know your thoughts on Sully's question, and whether you agree with the statements above.



WE NEED YOU!

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 - ATC868 – Slipping Safety Standards

Initial Report

Report Text (summary): Safety is paramount in aviation however over recent years more and more emphasis is placed upon proving beyond reasonable doubt that an issue is unsafe before some [Air Navigation Service Providers (ANSP)] will actually address the issue. Addressing safety issues is often difficult particularly given the commercial pressures that different companies place upon the safe operation of air traffic sectors. Staff can raise issues, leading to situations where everyone is aware of the problem and yet the problems are not addressed unless incontrovertible proof is available to justify taking action. The burden of proof should be that we have to prove that a situation/procedure is safe, which ensures that we fail safe, not to ignore experienced staffs genuine concerns while we wait for the evidence for controllers to prove that a situation is unsafe.

NATS is without doubt an impressive ANSP with many redeeming features and a genuine desire make safety a priority. Subtle cultural changes have slowly led to changes in the ways in which safety is dealt with, which often considers safety as an

inconvenience that is best left to chance. I say this despite having an excellent and determined safety department and a highly professional staff. I suspect that over the next few years that we will find ourselves in situations that could have been avoided and that were completely foreseeable, if not already foreseen! Furthermore, given that staffing is increasingly tighter that possibly this could exacerbate things further.

I would stress that the staff and operational leadership are exceptional on the whole. However, at times genuine safety concerns are ignored. We cannot continue to assume that something is safe until proven to be unsafe. By then it could be too late.

NATS Comment

NATS welcomes the opportunity to respond to the report and highlight some of the areas where we feel that there are sufficient safety checks and reporting lines to assuage the fears of the reporter. Whilst we are not entirely certain of the specific procedures or projects that the reporter is concerned about, we do reemphasise that safety is paramount in the industry and as such we do not take reports like this lightly. We do have a robust reporting process with a proactive approach to risk management, and we believe that all employees are aware of this through various safety initiatives undertaken throughout the year.

From an operational point of view, at our centres we have watch-based safety reps and safety managers that can be approached independently of any reporting process in order to discuss issues and concerns, as well as an entire Centres Safety Improvement Team (CSIT) who proactively monitor the operation to identify trends or issues and lead on necessary changes. In our tower operations we also have safety teams working to ensure the ongoing success of any changes that are made. In our wider programmes and projects, we have embedded safety professionals that carry out bow-tie reviews, hazard analyses etc, leading to safety reports and risk categorisation and mitigations, that need senior management approval before a system/airspace change is deployed into the operation. I have been asked by the highest level of our Safety Management Team to pass on the offer of a direct conversation/interaction in order to share the concerns and discuss any possible changes that may be needed in their eyes. We respect the anonymity of the reporter and therefore ask that you pass on this offer. Should you receive any further comments on this issue then please pass them on straight away so that we can again provide feedback.

CAA Comment

Reg 2017/373 requires Air Navigation Service Providers to have procedures in place to identify hazards associated to its services based on a combination of reactive, proactive and predictive

methods of safety data collection. A process that ensures analysis, assessment and control of the safety risks associated with identified hazards and a process to ensure that its contribution to the risk of aircraft accidents is minimised as far as is reasonably practicable. Assured by Safety performance monitoring and measurement processes verifying the safety performance of the organisation and validating the effectiveness of the safety risk controls. Data collected via mandatory or voluntary occurrence reporting should form part of this feedback loop.

CHIRP Comment

This report generated a detailed discussion between the ATC members of CHIRP, and it was agreed that the report itself was raising a philosophical point rather than a specific hazard or notifying CHIRP of a specific situation, such as a near miss. The reporter, having filed the report and received a prompt response from NATS's senior management of an offer to engage, facilitated by CHIRP involvement, decided to decline the offer. The issue raised could be evidence of a practical drift of attitude in the organisation – that is, a possible example, using Hollnagel's framework, of "work as done versus work as prescribed".

Report No2 - FC5392 – Company's expectation of captain's use of discretion

Initial Report

Report Text (summary): Rostered an E1 extension to Flight Duty Period (FDP). Scheduled on-blocks time 14:00 hrs. The max allowed using E1 extension. Absolutely no "fat" in the planned FDP time before having to consider use of Captain's Discretion to be able to operate the return flight. The Operational Flight Plan (OFP) for the return leg was only available to us (flight crew) once we arrived in [Airfield]. We arrived at [Airfield] 28 mins ahead of schedule and despite departing 3 mins ahead of schedule both outbound to [Airfield] and 16 mins on the return inbound to [Airfield], as well as flying faster than OFP planned Mach No. we (flight crew) still went into Captain's Discretion by 5 mins.

Given the planned flight times and STDs this duty was never going to be achievable without the use of Captain's discretion, even at the planning stage. Whilst 5 mins is minimal, it highlights the preposterous policy currently seemingly in force to plan these flights with an expectation that discretion will be required and granted in order to complete the planned duty. Captain's discretion is not a given – and should not be planned to be granted – to accommodate poor planning.

Reports filed and sent to the company – no response – hence writing this report to CHIRP.

Additional Correspondence from Reporter: This practice is not uncommon at [Airline] for [Canary Islands route]. We are frequently rostered FDPs close to the max allowable under E1 extension. These duties invariably involve turnaround flights from [UK location] to the Canary Islands and often result in Fatigue Reports / use of Captain's discretion. In my case it was rostered the max allowable; and my guess is that they knew the planned FDP would exceed 14hrs but of course cannot roster a duty exceeding the AT limit and as such simply published it as 14 hrs to be legal for dispatch.

Airline Comment

Initial Airline Comment:

We have noted a recent confidential report from a pilot raising concerns about rostering practices perceived to push duties close to the maximum allowable limits under E1 extensions, potentially requiring the use of commander's discretion. We strongly encourage all crew members to continue submitting fatigue reports, as these are critical to enhancing our safety and fatigue management processes. Each report is meticulously reviewed by our Fatigue Risk Management specialists to fully understand the circumstances and ensure appropriate follow-up. This thorough analysis may occasionally result in response times of up to 30 days, as we prioritize a detailed understanding of each case over rushed replies. We value your input and are committed to addressing all concerns while maintaining the highest standards of safety and compliance with EU 965/2012 Annex III ORO.FTL.205. (d).

Additional Airline Comment:

We have decided to send out some of our SMS trainers around the bases to train staff up in fatigue management and safety/fatigue reporting to improve understanding of the regulations and the quantity and quality of reports. This includes [discussing that managing fatigue] is a shared responsibility.

CHIRP Comment

This is an excellent report which is being published to help encourage others to use internal ASR, including Fatigue Reports, to highlight areas where, in the opinion of company flight crew, what is being planned and flown is not as written down in company manuals or in line with the intent of regulation. CHIRP believes that although the reporter raises a clearly valid concern regarding use of Commander's Discretion, with specific instances in support, there was no mention of fatigue as a result, which is the main safety implication of a company that expects captains to use discretion beyond what is regulated for FDP. Ultimately, Commander's Discretion is exactly what it indicates, and captains should always feel able to refuse its use if there are good reasons for doing so, such as fatigue or other human performance implications. Use of discretion is an exceptional

tool, not for routine use, and requires the commander to consult with the crew to assess their fitness for duty before making the decision. If individual captains do not feel able to do this without fear of retribution, then this is an indication of a toxic culture, where safety decisions are being influenced by concerns of a negative response from management. CHIRP acknowledges the airline's prompt and proactive response to our enquiry about the report and in particular its decision to instigate a communications effort to inform crews, using base SMS teams, as well as email, of relevant company policy, and to encourage use of fatigue reports to highlight issues arising due to use of Commander's Discretion.

The following link will take you to an open letter, provided by CAA for use on the CHIRP website, to explain the regulator's view on Commander's Discretion, based on the frequency of reports received in recent years – [Commander's Discretion – CHIRP](#).

Report No3 - FC5403 – Split duties and lack of rest

Initial Report

Split duties at [Airline] for short haul, for example operating to [UK Airport] landing at 22:30, by time check out and get to hotel at least 23:30, but scheduled to be picked up 04:20 the next morning to be on duty at 04:40 and depart at 05:40. So less than 5 hours in a hotel, not sure how it is legal, it's only 1 leg there and then back but I just don't see how this is safe to operate on that rest, and the company keep reiterating it is safe and legal. It's not like a night flight you could prepare for and sleep through the day but this one you have to be prepared to sleep but then it's not enough rest. It just doesn't seem safe.

CHIRP Comment

Split duties often result in long and tiring duties with low actual flying hours, followed by an early start the next day. For this reason, they are not popular with crews if rostered often, or at short notice. Split duties are still very much a feature for some airlines and have associated fatigue risks associated with them.

The CAA's FTL Review, which is expected to cover split duties, is ongoing.

Report No4 - FC5412 – Electronic Flight Bag iPad Mounts

Initial Report

Report Text (summary): I am reporting a serious and ongoing safety concern regarding the Electronic Flight Bag (EFB)

mounting systems fitted to [number] of aircraft in our fleet. These mounts differ from those used on the rest of the fleet and introduce significant operational hazards.

The EFB holders obstruct flight controls, particularly during landing, where precise and unobstructed control inputs are critical – especially in windy or adverse conditions. Additionally, they interfere with the captain's access to the nosewheel tiller, making taxiing more challenging and increasing the potential for ground handling issues. The company's safety department was made aware of the problem and responded by issuing a survey to flight crew. The response was overwhelmingly negative, highlighting widespread dissatisfaction. At a flight safety meeting, the safety manager briefly mentioned [Aircraft OEM] prefers this new style of mount – an assertion that is especially worrying given our concerns about its safety. We certainly do not want the rest of the fleet fitted with this design. Despite a Flight Crew Instruction being issued to use the [EFB devices] in landscape mode rather than portrait to reduce obstruction, the mounts remain problematic. Some crews have resorted to removing the EFB from the mount during flight and only using it on the ground. While this workaround is safer in practice, it leaves flight crews without ready access to digital charts during flight and violates company procedures introduced with the new mounts.

I have spoken to many captains, and there is a shared concern about these mounts. For example, I was made aware of a recent incident at an anonymised airport where the Flight Data Monitoring detected a near runway excursion. The event was reported to the chief pilot via WhatsApp shortly after it occurred. The involved captain – who wishes to remain anonymous – indicated a difficulty in accessing the tiller during rollout contributed to a loss of control. If not addressed, it could contribute to a serious incident or accident.

I am submitting this report to CHIRP because internal feedback has not led to a satisfactory resolution, and flight crew remain deeply concerned about the current course of action.

CAA Comment

Following on from a CHIRP request for the CAA to look into the issue of the EFB mountings, and after a previously planned CAA audit at [Airline], as well as other correspondence between the CAA and the operator, [Airline] has now identified a replacement EFB mount, which will eliminate the potential for control restriction. This is currently working through the airworthiness aspects [needed prior to consideration for approval].

CHIRP Comment

As the reporter describes, they were extremely concerned that the views of flight crew were not being acknowledged and considered highly enough by the airline and, despite submitting

internal reports and speaking to flight ops management, they still felt compelled to contact CHIRP. CHIRP's role was to act as the bridge between the reporter and the CAA who coincidentally carried out a planned audit of the airline shortly after CHIRP's intervention. The CAA used the information contained in the CHIRP report to inform their enquiries about the EFB mount, and the result can be read in the CAA comment above. This will be a good news story when the newly designed EFB mounts are in operation to the satisfaction of all flight crew.

A recent fatal accident of a Chinook helicopter involved an iPad that fell into the footwell and became jammed against the pedal, thus making the aircraft uncontrollable. This accident highlights the importance of electronic systems being properly secured and with no risk of interference with the controls. The NSTB report can be accessed [here](#).



Report No5 - FC5398 – Aircraft doors and slides

Initial Report

At the operator with whom I am employed it is common practice for dead-head rated, and not-rated on type crew (i.e. non-operating crew who are positioning to, or from a station) to offer help with the arm/disarm and close/open of the aircraft doors, and in rare instances, to complete exterior inspection. [As] they are not on duty, and it might be, that their headspace and operational arousal level might differ from that of an operating crew member. The CHIRP report is then to establish if a type rated, yet non-FDP off duty, yet on company time crew member, can reasonably or legally take part in such safety critical functions such as the exterior inspection walk-around and/or the arming disarming opening/closing of aircraft doors. My concern rests with the liabilities and fallout should an injury so result from a slide deployment, of a not on duty crew member carrying out the tasks, of an on duty crew member such as an exterior inspection and or an inadvertent potentially lethal slide deployment and how this might develop legally in the case of the regulator, or legislation, or a court of law. I thank you for your time and guidance.

CHIRP Comment

Most colleagues, most of the time, will try and be helpful in such circumstances, particularly when close knit airline teams are involved. However, it's important to emphasise that agreeing to help other colleagues isn't always the right decision. There are clear implications regarding liability if a non-operating crew member carries out safety of flight duties, such as operating doors or undertaking walk round pre-flight checks, and something was to go wrong. However, in contrast, there is nothing to stop an airline asking a non-operating crew member, who happens to be on board for positioning for example, to be formally called in on duty to help the operating crew. CHIRP believes that the flight should be able to be operated safely with the assigned operating crew on board and not need the assistance of positioning crew. This report was a good example of how normalisation of deviance can erode safety margins. Non-operating crew trying to be helpful will, over time, result in operations shifting towards non-standard or procedures contrary to regulations. And if this happens, where now is the boundary?

The airline was not contacted at the behest of the reporter.

Report No6 - FC5400 – Duty times not amended to collect new company devices

Initial Report

My airline is currently issuing replacement iPads (and new company phones) to all pilots. As part of the rollout, we are all required to book an appointment, which should last no longer than 15 minutes, to collect our new devices. Inevitably, this appointment will have to be immediately before or after a Flight Duty Period for almost all of us. However, [Airline] are refusing to amend on-duty times for anyone reporting early to collect their devices. They have amended a small number of off-duty times (which makes no practical difference to them), but the Director of Flight Ops has told me in an e-mail that this [should not have happened]. [Airline] do not consider this time as duty and claim that the CAA agrees with them. I arranged an appointment 15 mins before a non-limiting duty (the FDP had 2 hours in hand). But, in the event of a delay, I would have been at work for 15 minutes extra, purely on mandated company business. Common sense would dictate that this has to be accounted for in the time we can physically work – and I believe that the definition of duty would also require this. Ultimately, if an incident occurs at the end of a limiting FDP, after we have actually come in early to collect a company device, where do we (the licence holders) and the company stand? This is now the 4th such rollout, and [Airline] has consistently refused to acknowledge these appointments as duty. I am extremely uneasy about the concept of having to come in early on company business yet then pretend that my day is starting at

the normal time. It was only 15 minutes for me; with limited numbers of appointments, it will have been 30 minutes or more for others. We as pilots have a duty to manage our own FTLs, and to arrange such appointments so as to minimise any risk of subsequent disruption. But surely [Airline] is also obliged to accept that, if they require us to extend our day at either end, this must be accounted for?

CAA Comment

If the ground duty was assigned at a specific time, or if it must be carried out adjacent to a Flight Duty Period (FDP), then it should be detailed as part of the duty for that day. If the time to carry out the task is at the discretion of the individual, then the duty time should be recorded at some point during the period allowed for completion.

CHIRP Comment

CHIRP has seen similar reports from pilots at this airline which is consistent with increased use of company provided personal devices that need regular updating with the latest security capabilities which can involve collection of new hardware versions. CHIRP believes that the crux of the issue seems to be that FDPs are now invariably longer and more fatiguing than in the past and as a result crews are less willing to be flexible and use their own time for such tasks, even if, as in this case, the time taken was not longer than 15 minutes. The report is a symptom of a greater problem, where crews are reluctant to sacrifice rest periods and time available before start of duty to fulfil administration tasks for the benefit, as the reporters see it, of the airline.

Report No7 - FC5405 – Fuel trucks parked at runway end

Initial Report

I am an [Aircraft Type] captain based at [Airport]. Following the awful crash in Korea where an aircraft overran the runway and hit a concrete wall, I am concerned that we have a similar hazard at [Airport]. Three fuel trucks are parked right next to the ILS localiser antenna at the end of runway [XX]. I have raised this concern with airline management who have made enquiries of the airport management about what risk assessment has been carried out. I have not received a response as yet. Much is made of the Engineering Materials Arresting System (EMAS) system that has been installed at the runway end which is supposed to bring an aircraft to a halt, in the event of an overrun of the runway. All well and good! But the fuel trucks are parked only yards away from the end of EMAS! Surely there's a safer place to park them?

Airport Comment

Thank you for passing this over for comment. You have correctly informed the reporter to raise their concerns in our electronic reporting system; their airline has all the links required for this. However [the issue raised] is factually incorrect. The only vehicles parked anywhere near the end of the runway (and these are beyond the EMAS installation) are airport busses (a maximum of 4) when closed and a maximum of 2 during operational hours. EMAS installation, as you state, will provide the stop for all aircraft types that are permitted to use the airport, and this is installed at both ends of the runway. The LRST provides a briefing with all airlines twice a year, and I would suggest that if the reporter still believes this to be of concern, then they should raise it through their own Safety Manager and/or Chief Pilot who are both in attendance. If the reporter has seen a fuel tanker in this area it is again well beyond the EMAS and will be while providing services to the aircraft parked at the Private Jet Centre. Finally, it should be stressed that while the airport operates with very tight margins due to its location, it completely complies with all legislation, CAA and international.

CHIRP Comment

[Airport] runway has been cleared for use by the CAA and therefore deemed safe from a regulatory compliance point of view, and with EMAS in place. CHIRP has suggested that the reporter put a similar report in via the airport SMS as well as the airline which should trigger a response from [Airport] HSE team. It also might result in the Local Runway Safety Team (LRST) becoming aware of the issue which, if they were unaware, would be useful. LRSTs are dedicated groups within an airport that focus on preventing runway incursions and excursions by identifying specific local safety issues, implementing targeted solutions, and conducting awareness campaigns for airport users. LRSTs are composed of representatives from the aerodrome operator, air traffic control, and airlines thereby providing a vital part of an airport's overall safety management system. Informing the LRST should also result in the issue being considered for entry in the [Airport] SMS hazard log if not already entered.

Report No8 - FC5424 – Forcing the check of delayed reports

Initial Report

In a recent memo to all crew via our Pilot Base Manager, we were reminded of the company's new policy on delayed reports. 2 hours before our report time we are now expected to check and confirm any delayed report times. This therefore places a requirement on us to interrupt our rest period regularly in summer months [when we are having] minimum rest to check

for a delay. With no delay this has now reduced our rest period by 2 hours and effectively increased our duty by 2 hours. Additionally, it is stated that if we do not check at 2 hours and we report for work at the correct report time and there was a notification, we MUST accept the delayed report or be placed N/A. This constitutes a punitive measure and threatening stance by the company to force a change that is against the FTL policy. Delaying a report time [and communication of this] is solely a crewing function in which they are required to get hold of us. [They should not] rely on an app and force crew to be the custodian of that change. The culture in the airline is such that I feel unwilling to ASR this policy due to [possible] repercussions.

There is a feeling of a bullying culture in general management and training and if you speak out you will then be the next target.

Whilst I accept it is sometimes necessary to delay a report, I do not accept that I have to either reduce my rest period to accept it or be forced to accept it later as I missed it. Simply put on an early shift my alarm goes off inside the 2-hour window. I therefore get up change and head to work. I would not check my phone, iPad or apps at this point. But I may now be forced to accept a significant delay which has not been effectively communicated, pushing me into removing myself from a duty as it would not be possible to complete inside the original duty time length from original report.

CHIRP Comment

CHIRP has received several reports this year from different airlines concerning this issue, namely crews having to check an App during a rostered rest period to confirm if a delayed report time is in place, thereby reducing the time available for rest. The three airlines concerned all use 2 hrs prior to the planned reporting time to require crews to go on-line and check an App for updated information. Some airlines are reported to give a crewmember an N/A code (“was not available for duty”) against their name if they don’t see the App notification and report for duty at the originally promulgated time.

However, notwithstanding the above, CHIRP believes that the onus should be on the airline to contact the employee rather than the employee regularly interrupting rest to check for a potential delay that may not have occurred. It is accepted that airlines will be responding to intense commercial pressure and sometimes feel they must make decisions that are to the detriment of crews, but still reasonable. This is a good example of the challenges to stay within what James Reason called the ‘Safety Space’, safety vs operational efficiency.



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