



EASA
European Aviation Safety Agency

Raising and managing findings on SMS

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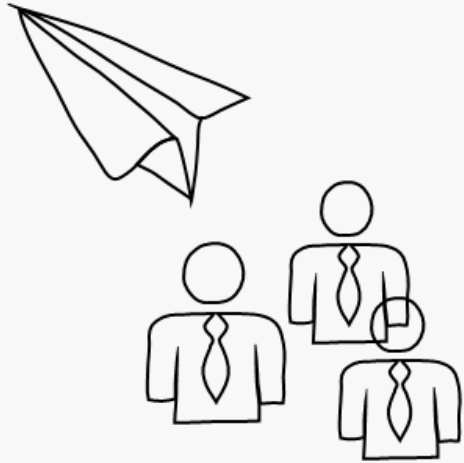




- EASA UT issues
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- Discussion on CAP



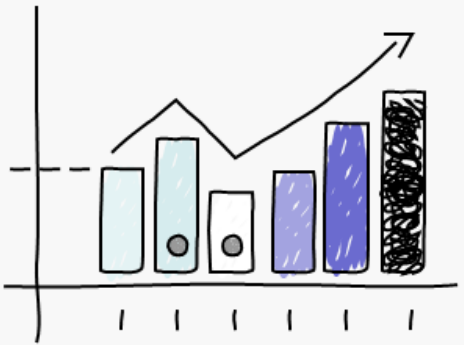
Identified issues by EASA



AIRLINE
MANAGEMENT
UNWILLINGNESS
TO TAKE REAL
SAFETY
ACCOUNTABILITY



POOR SAFETY
MANAGER
QUALIFICATION &
COMPETENCE
(AND LINE
MANAGERS)



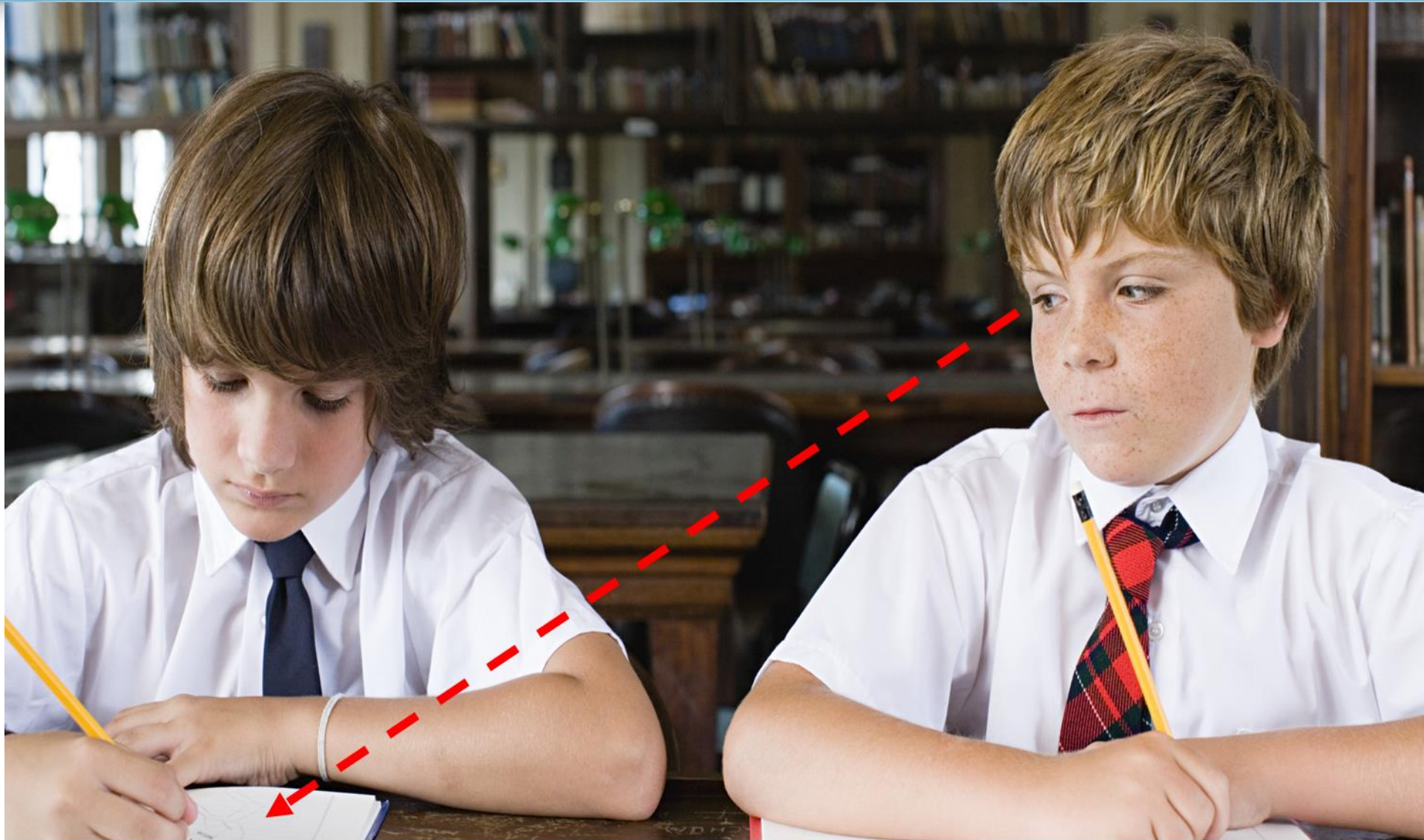
INADEQUATE RISK
MANAGEMENT
PROCESSES,
LEADING TO
QUESTIONABLE
ASSESSMENTS



INADEQUATE
MONITORING or
LACK OF RISK
MITIGATIONS



Manuals and procedures





SRB meeting results





Identified issues by NAA

- SRA's exist but **isolated** in MS Excel spreadsheet library
- Risk Assessments conducted unilaterally, **not 'cross domain'**
- Risk Mitigations listed which already exist in the organisation
- Risk Mitigations which have not been carried out post op launch
- Risk Assessments filed away and **not updated / revisited**
- Repeated Risk Assessments on similar Risks
- Hazard Register – does such a process exist?
- If so, is the Hazard Register **relevant** to the organisation?



Identified issues by NAA

- The operator identifies the aviation safety hazards entailed by its activities, evaluates and manages the associated risks, **BUT does not take actions to mitigate the risks and does not verify their effectiveness,**
- The operator does not manage the safety risks related to a change;
- Some hazards presented in the hazard log are not specific to the nature of the organisation and the complexity of its activities;
- The mitigation measures used to further mitigate the risk were already existing defences but not identified as such.



Challenges in raising findings

SUBSTANTIATING THE FINDING WITH ENOUGH EVIDENCE

ARO.GEN.350 VS PSOE GRADING SYSTEM

LEGAL REFERENCE IR VS AMC

**ACCEPTABLE FOR FINDINGS TO BE RAISED AGAINST
INTERNAL PROCEDURE IN THE MANUAL**



EXAMPLES



EASA UNC example

When reviewing the management system, the following non-compliances were identified:

- the newly appointed Safety Manager (July 2017) had not received any formal training on SMS or Risk Assessment and she did not have any previous experience in the function;
- there was no evidence of training delivered to the personnel involved in the risk assessment and management process;
- the operator had recently introduced two new aeroplane types to the fleet; however, there was no evidence of risk assessment for their introduction;
- the hazards and mitigations identified during the management of change process for the introduction of NAT operations were not appropriate to the scope of change;
- there was no evidence that the operator was monitoring the implementation of actions taken to mitigate risks;
- the mitigations determined during the risk assessment process and discussed during the sampled SRB were not adequate to demonstrate the reduction of the identified risks to an acceptable level;
- the hazard identification was reactive only (not pro-active).



The operator could not demonstrate its ability to understand the identified hazards and their consequences on its operations. Moreover was not able to identify, implement and track the mitigation measures as evidenced by:

- The sampled risk assessment
- Two sampled SRB where no evidence of implementation of any proposed mitigation was available
- The management and content of the hazard log



NAA finding

The operator was unable to demonstrate that all required safety training had been completed in accordance with Sections 11.2.1 and 11.13.2 of the Corporate Safety and Security Manual (CSSM), as evidenced by:

- Training records for Safety Investigator [Name of staff member] indicated that he had not undertaken the following training:
 - Human Factors Training (relevant to discipline) (Scheduled Dec 2018).
 - Interviewing Techniques (relevant to discipline) (Scheduled Jan 2019).
 - Risk Assessment Training (Scheduled Jan 2019).
 - Aircraft Accident Investigation Training (Not Scheduled).
 - Fatigue Awareness Training (Scheduled Jan 2019).
- There was no record of the Accountable Manager having undertaken SMS training since 16 March 2012, whereas the CSSM required this training to be completed every 5 years.

The operator may wish to consider reviewing its list of required training for key safety personnel, indicating which training is essential and which may be undertaken after appointment to role. They should also review the process by which safety training is scheduled and its completion tracked.

Level 2, AMC1 ORO.GEN.200(a)(4)



NAA finding

The operator could not demonstrate a fully effective safety management system. For example:

- A significant number of relevant operational hazards/risks, identified as ‘Safety Cases’ within [the IT system], had been ‘closed’ and were no longer being reviewed or monitored. For example, ‘Loss of Control’, ‘Runway Excursion’ and ‘Airborne Conflict’.
- A significant number of ‘Risk Assessments’ had been created, but formal risk assessment had not yet been completed and/or were annotated as “In Progress”. For example, ‘Ground Ops – System Errors’, ‘Ground Ops – Loss of Operational Control’, ‘Flight Ops – Succession Plan’ and ‘Flight Ops – Updating Operations Manuals – having enough administration staff’.
- The ‘Safety Heatmap’ was not configured to provide the operator with meaningful data regarding incident trends and risks, particularly in the area of flight operations. For example, incidents could only be classified as ‘No Classification’, ‘Airworthiness Incidents’, ‘Aircraft Defects’ or ‘CAM Errors’ and root cause trending (e.g. Human Factors) was not possible.
- The Management Manual had not been updated to reflect the recent [IT system] upgrade. In particular, the new ‘Risk’ module was not described, nor the associated risk management process (in terms of severity and likelihood) for calculating risk.

Level 2, ORO.GEN.200 (a) (3)



NAA finding

The operator could not demonstrate a fully effective Safety Management System. For example:

- Documentation to support the hazard identification, risk assessment and mitigation process could not be produced. In particular, the Hazard Log referred to in Paragraph 3.6.3 of the Management Manual could not be provided.
- The internal safety investigation process described in Paragraph 3.7 of the Management Manual was not consistently applied. In particular, Ground Occurrence Reports (GORs) were not discussed at the Safety Action Group and, on some occasions, the investigation into GORs did not include 'Follow up Procedures and Actions Taken' and/or a record of the corrective and preventative action taken (e.g. GOR/85 and GOR/86).
- The management of change process detailed in Paragraph 3.10 of the Management Manual had not been utilised to assess and mitigate the risks associated with significant changes to the operation. For example, no documentation could be provided to support the establishment of a sales team in Paris, the transition from the LEON system to Openjet and the upcoming introduction of a new aircraft type.
- The process to ensure that all personnel receive training for their safety responsibilities, as described in Paragraph 3.12.1 of the Management Manual, had not been achieved. In particular, the Flight Safety Officer had not yet received safety training commensurate with his duties and responsibilities.

Level 2, ORO.GEN.200



NAA finding

The operator could not demonstrate a fully effective process to record that risks assessed as 'Unacceptable' had received "Urgent action...regarding the elimination or reduction to exposure of the hazard and/or reduction of the risk", as required by Paragraph 3.2.2 of the Safety Management System Manual. In particular, the following deficiencies were noted within GRO-11 B, 'XYZ poor culture & untrained staff working around company aircraft':

- The post-mitigation score remained at an unacceptable level (15) and it was not clear from the Risk Register that additional mitigations were proposed and when these would be complete.
- There was no evidence that the Board had 'accepted' the risk, as required by the Safety Management System Manual.
- A number of mitigations, such as an increased level of turnaround oversight by company staff, had not yet been included in the Ground Operations Risk Register.

Given the potential severity of an 'unmitigated' risk, the operator should ensure that the safety management system can demonstrate that these risks are being adequately managed, both in the short and long term.

Level 2, ORO.GEN.200 (a) (3)



Considerations for CAP and follow-up actions

1

OPERATOR MAY NEED MORE THAN 90 DAYS TO EFFECTIVELY ADDRESS THE ISSUES RAISED

2

KEY PERSONNEL MAY NEED TO BE TRAINED/CHANGED

3

FOLLOW UP ACTIONS NEED TO BE MONITORED/ASSESSED

4

OVERSIGHT SCHEDULE MAY NEED TO BE ADAPTED



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European Aviation Safety Agency

Thanks for your attention

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