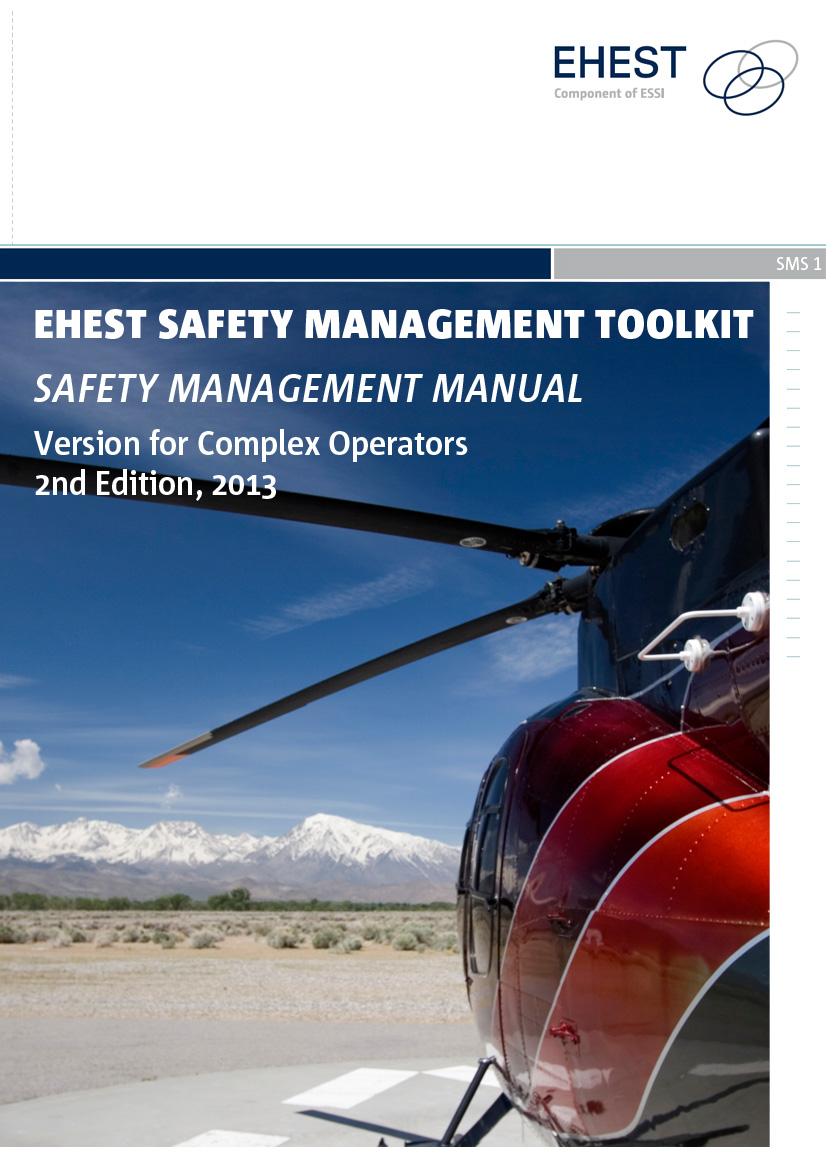
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***European Helicopter Safety Team***

**Safety Management Manual**

*A Template for Industry*

**Edition 2**

10 May 2013

## ABOUT THIS MANUAL

This Company Safety Management Manual (SMM) has been created by the Specialist Team Operations & SMS of the European Helicopter Safety Team (EHEST). The EHEST is the European component of the International Helicopter Safety Team (IHST) and the helicopter branch of the European Strategic Safety Initiative (ESSI).

The SMM Version 2 has been developed with consideration being given to Annex III of the EU regulation on Air Operations, Part ORO Subpart GEN Section II ‘Management System’ and the relevant AMCs and GM. Version 2 is based on Version 1. The changes made were aimed at aligning the manual with the rules, AMCs and GM published in October 2012.

This SMM targets Complex Operators with little experience of running a Safety Management System (SMS).

The criteria defining a Complex Operator is set out in AMC1 ORO.GEN.200(b) Management System as follows:

“(a) An operator should be considered as complex when it has a workforce of more than 20 full time equivalents (FTEs) involved in the activity subject to Regulation (EC) No 216/2008[[1]](#footnote-1) and its Implementing Rules.

(b) Operators with up to 20 FTEs involved in the activity subject to Regulation (EC) No 216/2008 and its Implementing Rules may also be considered complex based on an assessment of the following factors:

(1) in terms of complexity, the extent and scope of contracted activities subject to the approval;

(2) in terms of risk criteria, whether any of the following are present:

(i) Operations requiring the following specific approvals: performance-based navigation (PBN), low visibility operation (LVO), extended range operations with two-engined aeroplanes (ETOPS), helicopter hoist operation (HHO), helicopter emergency medical service (HEMS), night vision imaging system (NVIS) or dangerous goods (DG);

(ii) Different types of aircraft used;

(iii) The environment (offshore, mountainous area, etc.).”

The Safety Management Manual (SMM) is the key instrument for communicating the approach to managing safety within the Company. The SMM documents all aspects of safety management, including the safety policy, procedures and individual safety responsibilities.

The SMM may be contained in (one of) the manual(s) of the operator. GM1 ORO.GEN.200(a)(5) Management System – Management System Documentation – General mentions the following:

“(a) It is not required to duplicate information in other manuals. The information may be contained in any of the operator manuals (e.g. operations manual, training manual), which may also be combined.

(b) The operator may also choose to include some of the information required to be documented in separate documents (e.g. procedures). In this case it should be ensured that manuals contain adequate references to any document(s) kept separately. Any such documents are then to be considered an integral part of the operator’s management system documentation.”

This SMM has been created by a team of professionals from within the EHEST whose experience covers a variety of different backgrounds including EASA, National Aviation Authorities, manufacturers, operators, helicopter associations, operator and pilot associations, etc.

This SMM is a sample manual designed to assist an operator in creating their own manual. It contains explanatory notes and instructions marked in italic.

The SMM must be adapted to appropriately reflect the operator’s organisation and needs and should not be applied ‘just as it is’.

The user must also understand that having a compliant SMM does not mean that they have an SMS in place. The SMM is solely a reference document that describes and documents the SMS. The SMS must then be created through an adequate implementation plan that requires commitment from the management and the personnel within the Company.

The plan includes an assessment of the Company’s organisation and method of managing safety prior to implementing the SMS (gap analysis), the creation, implementation and revision of relevant procedures and documentation, and safety training. It should also include the initial identification of hazards and an assessment of the safety risks faced by the operator in its various operations.

To assist with this task, the EHEST Safety Management Toolkit provides example registers of some of the typical helicopter hazards and risks developed by the Safety Department of Eurocopter. These registers of hazards and risks are a unique feature made available by the EHEST to the helicopter community. It must however be taken into account that risks will differ depending on the operator, nature of operations and any existing barriers in place.

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***Insert here Company Name and Logo***

**Safety Management Manual**

Initial issue

*Insert date*

##### Distribution and Control

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| --- | --- | --- | --- |
| **Copy Holder** | **Copy No** | **Format** | **Responsibility** |
| National Aviation Authority | 1 | A4 | CAA |
| Accountable Manager | 2 | A4 | AM |
| Safety Manager | 3 | A4 | SM |
| Compliance Manager | 4 | A4 | CM |
| Flight Operations Manager | 5 | A4 | FOM |
| Crew Training Manager | 6 | A4 | CTM |
| Ground Operations Manager | 7 | A4 | GOM |
| Maintenance Manager | 8 | A4 | MM |
| SRB member 1 | USB key 1 | Electronic | SRB member 1 |
| SRB member 2 | USB key 2 | Electronic | SRB member 2 |
| Auditor 1 | USB key 3 | Electronic | Auditor 1 |
| Auditor 2 | USB key 4 | Electronic | Auditor 2 |
| Accident investigator 1 | USB key 5 | Electronic | Accident investigator 1 |
| Accident investigator 2 | USB key 6 | Electronic | Accident investigator 2 |
| OCC | 15 | A4 | SM |
| Crew Briefing Room | 16 | A4 | SM |
| Instruction Room | 17 | A4 | SM |
| Maintenance Planning Room | 18 | A4 | SM |
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| Issue | Modified Section | Description of the Modification |
| V2 |  | Alignment with the rules, AMCs and GM published in October 2012 |
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## Chapter 1 - Definitions

(a) Accident Precursor

Event(s) which, without appropriate mitigation, can result in Undesirable Events, incidents and accidents.

(b) Audit

A systematic, independent and documented process for obtaining evidence and evaluating it objectively to determine the extent to which requirements are complied with.

(c) EHEST SMS Toolkit

EHEST suite of SMS materials, which includes this Safety Management Manual, a database of hazards and risks, an Emergency Response Plan, and a pre-flight assessment tool.

(d) Hazard

A condition, object, activity or event with the potential of causing injuries to personnel, damage to equipment or structures, loss of material, or reduction of the ability to perform a prescribed function.

(e) Inspection

An independent documented conformity evaluation by observation and judgement accompanied as appropriate by measurement, testing or gauging, in order to verify compliance with applicable requirements (incl. procedures, work instruction standards, etc.).

(f) Likelihood

Likelihood is used in this manual as a synonym of probability. It is a measure of how likely something is to happen. Probability / likelihood varies between 0 and 1 and can be assessed using terminology such as ‘very low, low, medium, high and very high’. Note: In the ICAO Doc 9859 AN/474 Safety Management Manual, Third Edition, safety risk probability is defined as the likelihood or frequency that a safety consequence or outcome might occur.

(g) Management of Change

A documented process to identify external and internal changes that may have an adverse (or positive) effect on safety. This process uses the existing hazard identification, risk assessment and mitigation processes.

(h) Mitigation Barrier

Risk control mitigating the outcome (severity) of an incident or of an accident.

(i) Prevention Barrier

Risk control aimed at preventing Undesirable Events and Undesirable Operational States.

(j) Recovery Barrier

Risk control aimed at impeding that Undesirable Operational States result in an accident or, in other words, that incident scenarios escalate into an accident.

(k) Risk

The combination of occurrence likelihood and severity.

(l) Risk Analysis, Assessment and Mitigation

A risk management process ensures analysis (in terms of likelihood and severity of occurrence), assessment (in terms of tolerability) and control (in terms of mitigation) of risks to an acceptable level.

(m) Risk Tolerability Matrix

A matrix (or table) combining Risk Likelihood and Risk Severity.

(n) Safety

The state in which risks associated with aviation activities are reduced and controlled to an acceptable level (ICAO Annex 19, expected to be published in 2013). The publication of Annex 19 is likely to lead to a revision of the ICAO Doc 9859 AN/474, Safety Management Manual, Third Edition, where safety is defined as the state in which the risk of harm to persons or property damage is reduced to and maintained at or below an acceptable level through a continuing process of hazard identification and risk management.

(o) Safety Assurance

Safety assurance is the process of assuring safety. In the ICAO Doc 9859 AN/474 Safety Management Manual, Third Edition, Safety Assurance encompasses the processes of Safety Performance Monitoring and Measurement, Management of Change, and Continuous Improvement of the SMS. Note: The EU regulation on Air Operations, Part ORO.GEN 'Management System' and relevant AMCs and GM do not use the terms Safety Assurance, but addresses the three Safety Assurance processes separately. This approach has been adopted in this Manual.

(p) Safety Management System (SMS)

A systematic approach to managing safety, including the necessary organisational structures, accountabilities, policies and procedures (ICAO Doc 9859 AN/474 Safety Management Manual, Third Edition).

(q) Safety Performance

Safety achievement as defined by the safety performance targets and measured by safety performance indicators.

(r) Safety Performance Indicator (SPI)

A data-based safety parameter used for monitoring and assessing performance (ICAO Doc 9859 AN/474 Safety Management Manual, Third Edition).

(s) Safety Performance Monitoring

The process by which the operator’s safety performance is monitored and assessed against the operator’s safety policy and safety objectives.

(t) Safety Performance Objective (SPO) or Target (SPT)

The planned or intended objective for safety performance indicator(s) over a given period. Objectives and targets are considered synonymous in this SMM.

(u) Safety Risk Value or Risk Index Value

Values in the cells of a Risk Matrix allowing differentiation of risk level for the purpose of risk analysis, assessment and mitigation.

(v) Undesirable Event (UE)

Event leading to a stage in the escalation of an accident scenario (Undesirable Operational State) where the accident can be avoided only through successful recovery measure(s) or by chance.

(w) Undesirable Operational State (UOS)

The stage in an accident scenario where the scenario has escalated so far that the accident can be avoided only through successful recovery measure(s) or by chance.

**Chapter 2 - Acronyms**

ALARP As Low as Reasonably Practicable

AM Accountable Manager

AMC Acceptable Means of Compliance

ASR Air Safety Report

AU Audit

CMM Compliance Monitoring Manager

EASA European Aviation Safety Agency

EHEST European Helicopter Safety Team

ERP Emergency Response Planning or Plan

ESSI European Strategic Safety Initiative

FDM Flight Data Monitoring[[2]](#footnote-2)

GM Guidance Material

ICAO International Civil Aviation Organization

IHST International Helicopter Safety Team

MOC Management of Change

SAG Safety Action Group

SM Safety Manager

SM ICG Safety Management International Cooperation Group

SMM Safety Management Manual

SMS Safety Management System

SOP Standard Operating Procedure

SPI Safety Performance Indicator

SPO/SPT Safety Performance Objective/Target (synonymous terms)

SRB Safety Review Board

SRM Safety Risk Management

SURV Survey

## Chapter 3 – Scope of the Safety Management Manual

**Cf. ORO.GEN.200(a)(5) and related AMCs/GM**

The Safety Management Manual (SMM) is a reference document describing how safety is managed in the Company. The SMM is the key instrument for communicating the Company’s approach to safety to all its personnel.

The SMM documents all aspects of safety management, including the safety policy, objectives, procedures and individual safety responsibilities.

The contents of the SMM include all of the following:

(1) Scope of the SMS;

(2) Safety policy and objectives;

(3) Safety accountability of the accountable manager;

(4) Safety responsibilities of key safety personnel;

(5) Documentation control procedures;

(6) Hazard identification and risk management schemes;

(7) Safety action planning;

(8) Safety performance monitoring;

(9) Incident investigation and reporting;

(10) Emergency response planning;

(11) Management of change (including organisational changes with regard to safety responsibilities);

(12) Safety promotion.

The SMM may be contained in one or more Company manuals.

This SMM will be communicated to the National Aviation Authority and may also be communicated to customers and other parties to demonstrate the willingness and capability of the operator. The SMM will also be distributed throughout the Company to ensure that all employees are fully aware of the system thereby ensuring:

* That safety is a central component in our management system;
* That safety is accounted for in all decisions and actions taken by all in the Company;
* That the needs, requirements and expectations of customers and other parties are fulfilled.

## Chapter 4 – Safety Policy and Objectives

**Cf. ORO.GEN.200(a)(2) and related AMCs/GM**

By means of the Safety Policy, our Company states its intention to maintain and, where practicable, improve safety levels in all its activities and to minimise its contribution to the risk of an aircraft accident as far as is reasonably practicable.

The Safety Policy:

* is endorsed by the Accountable Manager;
* reflects the organisational commitments regarding safety and its proactive and systematic management;
* is communicated, with visible endorsement, throughout the operator; and
* includes safety reporting principles.

The Safety Policy includes a commitment:

* to improve towards the highest safety standards;
* to comply with all applicable legislation, meet all applicable standards and consider best practices;
* to provide appropriate resources;
* to enforce safety as a primary responsibility of all managers; and
* not to blame someone for reporting something which would not have been otherwise detected.

In addition to these general objectives enshrined in the Safety Policy, detailed safety management objectives are addressed in the Section Safety Performance Monitoring and Measurement.

Senior management will:

* continually promote the safety policy to all personnel and demonstrate their commitment to it;
* provide necessary human and financial resources for its implementation; and
* establish safety objectives and performance standards.

An example of a Safety Policy, quoted from the ICAO Doc 9859 AN/474 Safety Management Manual, Third Edition, is provided below:

Safety Policy

Safety is one of our core business functions. We are committed to developing, implementing, maintaining and constantly improving strategies and processes to ensure that all our aviation activities take place under an appropriate allocation of organizational resources, aimed at achieving the highest level of safety performance and meeting regulatory requirements, while delivering our services.

All levels of management and all employees are accountable for the delivery of this highest level of safety performance, starting with the [chief executive officer (CEO)/ managing director/or as appropriate to the organization].

We are committed to:

• Support the management of safety through the provision of all appropriate resources, that will result in an organizational culture that fosters safe practices, encourages effective safety reporting and communication, and actively manages safety with the same attention to results as the attention to the results of the other management systems of the organization;

• Ensure the management of safety is a primary responsibility of all managers and employees;

• Clearly define for all staff, managers and employees alike, their accountabilities and responsibilities for the delivery of the organization‘s safety performance and the performance of our safety management system;

• Establish and operate hazard identification and risk management processes, including a hazard reporting system, in order to eliminate or mitigate the safety risks of the consequences of hazards resulting from our operations or activities to achieve continuous improvement in our safety performance;

• Ensure that no action will be taken against any employee who discloses a safety concern through the hazard reporting system, unless such disclosure indicates, beyond any reasonable doubt, gross negligence or a deliberate or wilful disregard of regulations or procedures;

• Comply with and, wherever possible, exceed, legislative and regulatory requirements and standards;

• Ensure that sufficient skilled and trained human resources are available to implement safety strategies and processes;

• Ensure that all staff are provided with adequate and appropriate aviation safety information and training, are competent in safety matters, and are allocated only tasks commensurate with their skills;

• Establish and measure our safety performance against realistic safety performance indicators and safety performance targets;

• Continually improve our safety performance through continuous monitoring and measurement, and regular review and adjustment of safety objectives and targets, and diligent achievement of these; and

• Ensure externally supplied systems and services to support our operations are delivered meeting our safety performance standards.

(Signed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CEO/Managing Director/or as appropriate

*The Safety Policy states that the purpose of safety reporting and internal investigations is to improve safety, not to apportion blame to individuals. To this purpose, the last bullet of the Safety Policy can be expanded in a separate statement, called Protection of the Reporters. An example is provided below:*

Protection of the Reporters – Just Culture[[3]](#footnote-3)

The Company is committed to operate according to the highest safety standards.

To achieve this goal, it is imperative to have uninhibited reporting of all accidents, incidents, events, hazards, risks and other information that may compromise the safe conduct of our operations. To this end, every staff member is warmly encouraged to, and responsible for, reporting any safety-related information.

Reporting is free of any form of reprisal. The main purpose of reporting is risk control and accident and incident prevention, not the attribution of blame. No action will be taken against any staff member who discloses a safety concern through the reporting system, unless such disclosure reveals, beyond any reasonable doubt, an illegal act, gross negligence, or a deliberate or wilful disregard of regulations or procedures.

Our method for collecting, recording and disseminating safety information guarantees the protection to the extent permissible by law, of the identity of those who report safety information.

(Signed and dated)

Accountable Manager

***Acceptable and non-acceptable behaviour?***

*The EHEST recommends[[4]](#footnote-4) that clear descriptions of behaviour considered by the Company as acceptable (for instance genuine unintentional errors) and non-acceptable (for instance wilful disregard of procedures, falsification of documentation, sabotage) and of their consequences (disciplinary policy) are set out such that the differentiation between these two types of behaviour are perfectly known and understood by everyone in the Company.*

*It is then of primary importance to apply this distinction in a consistent manner, so that decisions are always interpreted as ‘just’ and that no feeling of injustice could be perceived by personnel which could seriously hamper the continued reporting of safety information.*

**Chapter 5 – Safety Accountability and Responsibilities**

##### 5.1 Safety accountability of the Accountable Manager

***Cf. ORO.GEN.200(a)(2) and related AMCs/GM***

The Accountable Manager bears the safety accountability which means that he, or she, is ultimately accountable for safety in the Company.

He or she endorses the Safety Policy (including a statement on the protection of the reporters); provides the human and material resources necessary for operating the SMS and achieving the safety objectives; nominates the Safety Manager, the Compliance Monitoring Manager, the Safety Review Board and (if one is used in the Company), the Safety Action Group.

The Accountable Manager chairs the Safety Review Board, endorses the safety objectives and the Compliance Monitoring Report.

##### 5.2 Safety Responsibilities of Key Safety Personnel

Our safety management organisation includes the Accountable Manager (AM), a Safety Manager (SM), a Compliance Monitoring Manager (CMM), a Safety Review Board (SRB) and (optionally) a Safety Action Group (SAG).

*Describe here your safety management organisation. An example is provided below:*



Figure 1 – Example of Safety Management Organisation[[5]](#footnote-5)

##### 5.3 Safety Manager

***Cf. AMC1 ORO.GEN.200(a)(1)(a) and GM1 ORO.GEN.200(a)(1)***

The Safety Manager acts as the focal point and is responsible for the development, administration and maintenance of the SMS.

The functions of the Safety Manager are to facilitate hazard identification, risk analysis and management; monitor the implementation of actions taken to mitigate risks as listed in the safety action plan; provide periodic reports on safety performance; ensure maintenance of safety management documentation; ensure that there is safety management training available and that it meets acceptable standards; provide advice on safety matters; and ensure initiation and follow-up of internal occurrence/accident investigations.

The Safety Manager is the focal point for collecting and analysing hazards and maintaining a register of hazards, risks, and risk controls (mitigations).

Depending on the size of the operator and the nature and complexity of its activities, the Safety Manager should be assisted by additional safety personnel for the performance of all safety management related tasks. *State which members of staff have been designated to assist the Safety Manager, if applicable.*

Regardless of the organisational set-up, the Safety Manager remains the focal point as regards the development, administration and maintenance of the SMS.

**Note: It is intended that hazard identification, risk assessment, risk mitigation and risk control become an integral part of day-to-day business. Day-to-day supervision of the operations and therefore safety is the responsibility of the ‘managers’. The Safety Manager is responsible for the supervision and facilitation of the processes to support ‘managers’ in developing processes, procedures and work instructions for the staff under their supervision to perform their activities in a safe manner.**

##### 5.4 Safety Review Board (SRB)

***Cf. AMC1 ORO.GEN.200(a)(1)(b),(c) and (d)***

The Safety Review Board is high level committee that considers matters of strategic safety in support of the Accountable Manager.

The Safety Review Board is chaired by the Accountable Manager and can be composed of heads of functional areas. Please specify who belongs to the SRB.

The Safety Review Board monitors the safety performance against the safety policy and safety objectives; monitors that any safety action is taken in a timely manner; and that the SMS is effective.

The Safety Review Board ensures that appropriate resources are allocated to achieve the established safety performance.

The Safety Manager or any other relevant person may attend, as appropriate, Safety Review Board meetings. The Safety Manager may communicate to the Accountable Manager all information, as necessary, to allow decision making based on safety data.

##### 5.5 Safety Action Group (SAG)

***Cf. GM2 ORO.GEN.200(a)(1)***

A Safety Action Group may be established as a standing group or as an ad-hoc group to assist or act on behalf of the Safety Review Board.

More than one Safety Action Group may be established depending on the scope of the task and specific expertise required.

The Safety Action Group should report to and take strategic direction from the Safety Review Board and should be comprised of managers, supervisors and personnel from operational areas.

The Safety Action Group monitors operational safety; resolves identified risks; assesses the impact on safety of operational changes; and ensures that safety actions are implemented within agreed timescales.

The operator should specify if the Company makes use of Safety Action Group(s). Where they are used, describe the tasks allocated to the groups and how they liaise with the SRB.

##### 5.6 Manager(s)

***Cf. ORO.GEN.210(b)***

The term ‘manager(s)’, also called ‘head(s) of operational areas’ in this manual, is used as per ORO.GEN.210 Personnel Requirements (b), which states that a person or group of persons shall be nominated by the organisation, with the responsibility of ensuring that the organisation remains in compliance with the applicable requirements (regulations, standards, Company’s procedures, etc.). Such person(s) shall be ultimately responsible to the Accountable Manager.

The manager(s) are responsible for ensuring compliance with all applicable requirements, including those regarding the management of safety.

Note: Managers are an important driving force of effective safety management. Managers make sure that safety aspects are considered and properly dealt with in all activities within their remit.

##### 5.7 Personnel

***Cf. ORO.GEN.210(c), (d) and (e)***

(c) The Company shall have sufficient qualified personnel for the planned tasks and activities to be performed in accordance with the applicable requirements, including the SMS requirements.

(d) The Company shall maintain appropriate experience, qualification and training records to show compliance with the above requirement (c).

(e) The Company shall ensure that all personnel are aware of the rules and procedures relevant to the exercise of their duties.

In the context of the SMS, the personnel in charge of operational tasks have the following responsibilities:

* Ensure both their own and the safety of other personnel in the vicinity of the working environment.
* Interrupt or discontinue their work if their safety or that of others is at risk.
* Perform their tasks in compliance with regulations and Company procedures.
* Practice and promote the Company’s safety policy.
* Notify hazards and safety-related events and report any relevant information to the Safety Manager.
* Take note of the lessons learned from incidents and accidents, be mindful of the risks, and take all appropriate measures to protect themselves and the others from these risks in their daily activity.
* Participate in safety briefings, meetings and events.
* Participate, if applicable, in safety analyses.
* Know their role in the Company’s Emergency Response Plan.

Every staff member in the Company has a role to play in the successful implementation of the SMS. This is not only the ‘task of a few’ or an ‘affair of specialists’, in particular, it is the responsibility of everyone in the Company to identify and report hazards. All members of staff are to inform the Safety Manager and their Line Manager of any situation deemed to be hazardous to flight safety and to their own safety or the safety of others both within or out of the Company[[6]](#footnote-6).

All personnel are to be trained in the SMS and know their roles and responsibilities. Refer to the Section Training and Communication on Safety of this SMM.

*In order that each staff member understands their roles and responsibilities within the SMS, it is recommended that roles and responsibilities are defined within the job descriptions.*

##### 5.8 Compliance Monitoring Manager

***Cf. ORO.GEN.200(a)(6) and related AMCs and GM***

The Compliance Monitoring Manager shall ensure that the Company’s activities are monitored for compliance with the applicable regulatory requirements, including those regarding the SMS, and additional Company requirements and procedures, and that these activities are being carried out properly under the supervision of the relevant managers.

The Compliance Monitoring Manager is responsible for ensuring that the compliance monitoring programme is properly implemented, maintained and continually reviewed and improved.

The Compliance Monitoring Manager has direct access to the Accountable Manager, and is not one of the persons referred to in ORO.GEN.210(b)[[7]](#footnote-7).

The independence of the compliance monitoring function shall be established by ensuring that audits and inspections are carried out by personnel not responsible for the function, procedure or products being audited.

In the case where the same person acts as Compliance Monitoring Manager and as Safety Manager, the Accountable Manager, with regards to his/her direct accountability for safety, should ensure that sufficient resources are allocated to both functions, taking into account the size of the operator and the nature and complexity of its activities.

*The Company should indicate whether the Compliance Monitoring Manager also acts as the Safety Manager.*

*The Compliance Monitoring Manager should have the relevant knowledge, background and appropriate experience related to the Company’s activities including knowledge and experience in compliance monitoring as well as access to all parts of the Company and, as necessary, to any contracted operator.*

## Chapter 6 – Compliance Monitoring Organisation and Programme

***Cf. ORO.GEN.200(a)(6) and related AMCs and GM***

The implementation and use of a compliance monitoring function allows an operator to monitor compliance with all relevant requirements, including those of the SMS. In doing so, they should as a minimum, and where appropriate, monitor compliance with the Company procedures that were designed to ensure safe operating activity.

The compliance monitoring programme covers, as a minimum and where appropriate, the scope of approved operations of the operator; manuals, logs, and records; training standards; management system procedures and manuals.

*The Compliance Monitoring Programme may be described in another Manual. (Describe here the applicable part of the compliance monitoring programme that addresses the SMS or, insert a reference to the appropriate Section of the Company Compliance Monitoring Manual.)*

*Specify the basic structure of the compliance monitoring function applicable to the activities carried out. The organisational set-up of the compliance monitoring function shall reflect the size of your Company and the nature and complexity of your activities.*

##### 6.1 Audits and Inspections

The Compliance Monitoring Manager may perform all audits and inspections (definitions in GM4 ORO.GEN.200(a)(6) and in the Definitions Section of this Manual) or appoint one or more auditors by selecting personnel either from within or external to the organisation. Regardless of the selected option, the Company shall ensure that the independence of the audit function is not compromised, particularly in the situation where the individuals carrying out the audit or inspection also have a responsibility for other functions within the Company. *Please specify.*

Auditors (either internal or external) shall have the relevant knowledge, background and appropriate experience related to the activities of the operator, including knowledge and experience in compliance monitoring. The Company’s auditor(s) demonstrate diplomacy, independence, ethics, and possess good verbal and written communication skills.

In the situation where the Company uses external personnel to perform compliance audits or inspections:

* any such audits or inspections are performed under the responsibility of the Compliance Monitoring Manager; and
* the Company retains the responsibility to ensure that the external personnel fulfils all requirements, which include regulation and the Company’s standards, procedures, etc.

The Company retains the overall responsibility for the effectiveness of the compliance monitoring function and, in particular, for the effective implementation and follow-up of all corrective actions.

##### 6.2 Organisational Set-up

*The Compliance Monitoring Manager may be assisted by dedicated personnel and/or an external organisation. Describe here the Company’s Compliance Monitoring organisation and how independence is assured, how audits are planned, how consideration is given to past compliance monitoring, how oversight is carried out by the competent authority and the SRM process.*

##### 6.3 Compliance Monitoring Documentation

The Company shall have in place relevant documentation that addresses the SMS function as part of the Company’s overall management structure. The SMS documents for the compliance monitoring programme shall reflect the following:

* A schedule of the monitoring programme;
* audit procedures;
* reporting procedures;
* follow-up and corrective action procedures; and
* a recording system.

*It shall also include the training syllabus and document control.*

*Please provide information relating to the Compliance Monitoring Documentation or insert a reference as to where this information is recorded and documented.*

##### 6.4 Compliance Monitoring Training

The Company shall ensure that all personnel engaged in managing the compliance monitoring function understand the objectives as laid down in the Company’s management system documentation.

The Company shall ensure that those personnel responsible for managing the compliance monitoring function, the Compliance Monitoring Manager and his/her team, receive appropriate training for this task. This training shall cover the requirements of compliance monitoring, manuals and procedures related to the task, audit techniques, reporting and recording.

*Please provide information relating to Compliance Monitoring Training or insert a reference as to where this information is recorded and documented.*

## Chapter 7 – Documentation Control Procedure

***Cf. ORO.GEN.200(a)(5) and related AMCs and GM***

*The operator’s management system documentation may be included in a separate manual or in one of the manual(s) as required by the applicable implementing rule(s).   
Where appropriate cross references should be included.*

##### 7.1 Document Control, Revision and Configuration Management

*Describe here the Company's procedures for the control of applicable regulations and other reference documents and for their revision, and for configuration management.*

The Manager in charge (please specify) shall ensure that:

* revisions are communicated to all staff concerned and modifications are identified,
* related internal documents and procedures are updated accordingly,
* obsolete/invalidated versions are clearly marked accordingly,
* modified versions are clearly marked, changes are identified and a current version number is incorporated,
* document changes are recorded and kept for traceability purposes.

Revision and configuration management are part of the change management process (see the Section 'The Management of Change' in this SMM):

* Proper revision and management processes ensure that obsolete/invalidated versions, which could create safety risks[[8]](#footnote-8), cease to be used,
* Proposed amendments are risk assessed, and their likely effect on safety established, prior to a revision being introduced.

##### 7.2 Control and Revision of the Safety Management Manual

*Describe here how the SMM is controlled and revised over time and how revisions are disseminated within the organisation.*

*An example table is provided below:*

|  |  |  |
| --- | --- | --- |
| Steps | Consist of | Person(s) in charge |
| Submitting a request for a change | * Identify need to change the SMM * Submit a change request to the Safety Manager | All staff |
| Assess, validate or reject the request for change | * Check relevance * Evaluate related risks * Verify the requested change against:  1. Applicable regulations, standards and norms 2. Other Company documents  * Validate or reject the change | Safety Manager |
| Amend the SMM | * Make the relevant changes in the SMM * Trace the modifications * Update the version number, date of issue and list of effective pages | Safety Manager |
| Record and distribute the revision | * Record/archive the new version * Distribute and publicise the new version, and * Recall the former version | Safety Manager |

##### 7.3 Record-Keeping

***Cf. ORO.GEN.220(b) and related AMC1 and GM1***

An effective system of record-keeping ensures that all records are accessible whenever needed within a reasonable time. These records should be organised in such a way that ensures traceability and accessibility throughout the required retention period.

In order to ensure easy and fast access to information, including access by national authorities, the Company’s records are:

* adequately referenced (author, title, issue date, revision number and date, list of effective pages),
* archived/kept as records for a minimum period of 5 years (see the table below),
* and disposed in a controlled manner after this defined period of retention.

*A sample table is provided below:*

|  |  |  |  |
| --- | --- | --- | --- |
| **Records** | **Person(s) in Charge** | **Recording/ Archiving means** | **Record Keeping period** |
| Safety Objectives and Indicators | Safety Manager | Company IT System (must include backup) | 5 years |
| Safety Review Board reports | Accountable Manager | IT | 5 years |
| Event Reports | Safety Manager | Paper and IT | Permanent |
| Audit Reports including the follow-up of corrective actions | Safety Manager | Paper and IT | 5 years |
| Hazard and Risk Registers | Safety Manager | IT | Permanent |
| Risk mitigations | Safety Manager | IT | Permanent |
| Safety Trainings Register | Safety Manager or Training manager | IT | Permanent |
| Other | To be specified | To be specified | To be specified |

Records are to be kept in a paper format, in an electronic format or a combination of both. Records stored on microfilm or optical disc format are also acceptable, however, no matter which format is employed records must remain legible throughout the required retention period. *Define the retention methods used in the Company.*

Microfilming or optical storage of records may be carried out at any time. The records should be as legible as the original record and remain so for the required retention period. The retention period starts when the record has been created or last amended.

Paper systems should be on a robust material which can withstand normal handling and filing. Computer based systems should have at least one backup system which should be updated within 24 hours of any new entry. Computer based systems must include appropriate safeguards against the possibility of access by unauthorised personnel to prevent tampering with the data.

All computer hardware used for data backup must be located in a different location from that containing the original working data and in an environment that ensures they remain in good condition. When hardware or software-changes take place, special care is to be taken to ensure that all necessary data continues to be accessible throughout at least the full period specified in the relevant implementing rule(s). In the absence of such indication, all records should be kept for a minimum period of 5 years.

**Chapter 8 – Safety Risk Management**

***Cf. ORO.GEN.200(a)(3)***

Safety Risk Management combines the following processes and components:

* Hazard identification, Risk assessment and mitigation processes
* Internal safety investigation
* Safety performance monitoring and measurement
* The management of change
* Continuous improvement
* The Emergency Response Plan (ERP)

A formal risk management process shall be developed and maintained to ensures that analysis, in terms of likelihood and severity of occurrence; assessment, in terms of tolerability; and control, in terms of mitigation of risks to an acceptable level. Additionally, the levels of management who have the authority to make decisions regarding the tolerability of safety risks shall be specified.

**8.1 Safety Risk Assessment**

**8.1.1 Scope of Safety Risk Assessment**

The SMS only addresses the assessment of aviation safety risks. This does not mean that financial, legal, or economic aspects do not need to be considered in the risk assessment process. The organisation should be able to identify all significant influences that may impact aviation safety and/or Health & Safety[[9]](#footnote-9), in particular when determining contributing factors for the analysis of consequences of a hazard, and deciding on risk mitigation measures.

**8.1.2 Elements that Influence the Safety Risk Assessment**

Communication and Consultation

Good communication within the organisation and, where relevant, with external parties (such as customers, partners, or contractors) should help ensure access to all relevant information, and assist in ensuring buy-in from all those that may be affected by the risk assessment conclusions and recommendations. Communication and consultation should take place at all relevant stages of the process.

Regulatory Requirements – Risks Addressed by Regulations

Regulations are generally developed to control common safety risks that stem from specific or general hazards through prescriptive, technical standards in the areas of technology, training, or task performance. Such hazards controlled by regulations do not need to be further addressed in the organisation’s risk assessment unless evidence exists that the regulatory provision is not sufficient. If the regulation is not specific, has several options, or directly calls for a risk assessment, the hazard obviously should be assessed, and the appropriate provision implemented.

Note on Industry Standards and Best Practices

When a Company develops Standard Operating Procedures (SOPs) based on industry standard/best practice it should still perform its own risk assessment to ensure that the SOPs are appropriate and customised to its own activities.

ORGANISATION’S RESOURCES

Available resources are relevant with respect to both capacity and competence:

1. for the risk assessment process itself (see next page); and
2. for the activity being assessed, (aircraft, equipment, personnel, finances, etc.).

The organisation’s current resources in terms of equipment and personnel are normally considered in the risk assessment. One outcome of a risk assessment may be that the operator does not possess the right equipment or personnel for the activity.

**8.1.3 Risk Acceptance Criteria and the ALARP Concept**

Risk acceptance criteria are established on the basis of a Safety Policy and Safety Performance Objectives. Furthermore, management responsibility for the acceptability of safety risks is defined as part of the SMS.

Safety risk acceptance criteria address the following, as applicable, to your Company’s activities - please select the relevant aspects:

* third parties;
* passengers and operational personnel;
* crew members;
* the natural environment; and
* the corporate well-being.

The Company employs the ‘As Low As Reasonably Practicable’ (ALARP) risk acceptance criterion. This ALARP criterion is not exclusively based on fixed risk level targets but is a systematic and documented process to reduce safety risks below the maximum allowed by regulations or standards or when the risk is otherwise considered unacceptable. ALARP means that the safety risk is being managed to as low a level as reasonably practicable whilst at all times staying below the maximum allowed risk.

**8.2 Risk Assessment Process Steps**

**8.2.1 Preparation**

PLANNING

The Safety Risk Assessment should be initiated in time for the results to be available before any decisions regarding the activity concerned have to be made.

SYSTEM DESCRIPTION

The activity to be analysed should be described in terms of systems and processes.

WORKING GROUP

The person responsible for performing the risk assessment shall determine the need for a dedicated working group comprised of suitable subject matter experts and personnel involved in the Company activities.

SELECTION OF METHOD AND DATA BASIS - Guidelines

* Employ EHEST methodology and data base provided in the EHEST Toolkit.
* The Safety Manager decides whether, and what other methods and sources are used to determine hazard causes, likelihood and consequences.
* Progressively extend and personalise the data base.
* The Safety Manager decides whether to use additional data sources.
* Company data base shall contain:
  + information resulting from the investigation of internal occurrences and accidents,
  + reported deviations and proposals for improvement,
  + experience collected from the monitoring of normal operations.
* Company database may be augmented with similar data exchanged with other operators.
* Whenever possible, the process of risk assessment should build upon experience derived from risk assessments carried out previously.

**8.2.2 Hazard Identification**

**8.2.2.1 Hazard Classification[[10]](#footnote-10)**

Hazards could come from different sources, including:

• Natural and environmental: weather, earthquake, wind and sand, sea water, rocks, cliffs, ice structures, rough waters, volcano lava and dusts, etc.

• Economic: competition, production pressure, cost pressure, etc.

• Unsafe conditions: use of unofficial documentation or documents not up to date, poor resources.

• Unsafe acts: errors, violations, negligence, sabotage, excessive/uncontrolled performance variations.

• Physiological: diseases, hypoxia, perceptual illusions, fatigue, sleep deprivation, jet lag, medication, alcohol, intoxication, digestion troubles, etc.

• Technological: design or maintenance related, hazardous material, pollution, explosions, etc.

• Operational or mission specific: obstacles, cables, demanding landing sites (moving platforms/off airfield sites), degraded visual cuing (brown-out and white-out), demanding/overbearing customers (VIPs), etc.

**8.2.2.2 Hazard identification Sources**

Hazards can be identified from different internal and external sources by asking the following question: What elements, in isolation or in combination, may have contributed or could contribute to an incident or accident?

*Internal sources*

*List here all the internal sources used by the Company for hazard identification, such as:*

* Safety assessment of systems and operations
* Air Safety Reports
* Voluntary reports, spontaneous identification
* FDM
* Safety indicator tendencies
* Inspections and audits
* Etc.

*External sources*

*List here all external sources used by the Company for hazard identification, such as:*

* Accident and incident reports;
* Technical publications from manufacturers (for instance Safety Bulletins);
* Safety Information Bulletins, safety alerts and other safety publications from EASA, the European Commission, the National Aviation Authorities, ICAO, Eurocontrol, the FAA and other authorities worldwide;
* Websites such as SKYbrary and Wikipedia;
* Safety publications by national or international associations and safety initiatives such as EHEST and IHST, the Helicopter Association International (HAI), the Royal Aeronautical Society (RAeS), the Flight Safety Foundation ( FSF), etc.;
* Safety publications by industry, research organisations and academia;
* Professional journals, conference proceedings, safety campaigns, helicopter safety days;
* Benchmarks between operators, data aggregated at sector level or by the manufacturers, etc.;
* Etc.

**8.2.2.3 Hazard Consequences Identification Sources**

Hazards are distinguished from hazard consequences. For instance a cumulonimbus constitutes a hazard[[11]](#footnote-11) for a helicopter flying in its vicinity (less than 5NM). Consequences of this hazard can be: heavy turbulence that could induce total loss of the aircraft; lightning that could result in technical damage and/or injury; hail that can damage the structure and the blades; heavy rain that can result in an engine flame out; icing that increases the helicopter mass, affects the aero-dynamical profile, alters the rotor blades profile and may block the cyclic swash-plate; etc.

Consequences can be described based on the hazard information specifying the place, time, extent, nature, etc. of the event as required. Hazard identification also provides a systematic overview of all possible consequences.

For each hazard, the following question should be asked: What were or could have been the possible hazard consequences?

Where information on the consequence of a hazard has been identified for a specific type of activity it should be available directly from data sources (e.g. from reported accidents and occurrences or from results of analysis already documented) such available information should be considered.

**It is also worth noting that the absence of past incidents/accidents does not mean absence of risk.** It is important, therefore, to identify the underlying hazards and to assess the risks. One effective way of doing this is to group similar events to try and identify the underlying hazards.

Aids to the identification of possible consequences include the following:

*List here all sources used by the Company for the identification of hazard consequences:*

* Other risk assessments
* Occurrence and accident reports
* Audits/non-compliance reports
* Internal reviews
* Monitoring results including flight data monitoring information;
* Brainstorming
* Threat assessments
* Standard checklists (origin should be identified if used and the lists assessed and revised as required to suit the purpose).

**8.2.2.4 Hazard Identification Process**

Hazards are identified through the application of a hazard identification processes.

The hazard identification process is the formal means of collecting, recording, analysing, acting on and generating feedback about hazards and the associated risks that affect the safety of the Company’s operational activities.

The hazards identification process features several components:

The **reactive approach** consists of analysing accidents and incidents that have occurred and trying to understand why. Based on the analysis of reported accidents and incidents, the following questions should be asked:

|  |
| --- |
| * What accidents or incidents did happen and why? * For what reasons or did these occur? Because of what causal factors? * What barriers or risk controls[[12]](#footnote-12) failed and which barriers worked? |

The **proactive approach** consists of analysing the conduct of operations to identify potential hazards and assess the associated risks and then to mitigate risks factors before they result in an accident or incident. This approach should trigger the following questions:

|  |
| --- |
| * What accidents or incidents could happen and why? * For what reasons could these occur? * Do we feel enough protected? Any action we should take now to prevent these from occurring? |

Hazard identification also features a **predictive approach**. It consists of conducting a predictive analysis using for instance data extrapolation (estimating for instance the future risk level based on the data collected over the past 3 or 5 years) or statistical modelling (a more complex way). A predictive approach aims to identify and mitigate risks before they become evident (addressing today the risks of tomorrow). This approach poses the following question:

|  |
| --- |
| * What accidents or incidents could happen in the future and why?” * Do we feel enough protected? Any action we should take now to avoid such future risks and occurrences (addressing today the risks of tomorrow)? |

The predictive and proactive approaches are very effective tools for the management of safety, they should build upon the basis of solid reactive processes.

**8.2.2.5 Hazard, Risks and Risk Controls**

The Company is encouraged to use the safety risk control modelling approach recommended by the EHEST[[13]](#footnote-13).

The purpose of this approach is to consider “Undesirable Events” (UEs) as an intermediate step between hazards and risks, and incidents and accidents.

Hazards can, in isolation or in combination, lead to UEs.

UEs trigger a stage in the escalation of an accident scenario, called the Undesirable Operational State (UOS), where the scenario has escalated to the point that the accident can only be avoided through successful recovery measure(s) or by chance.

Risk Controls aimed at preventing UEs and UOS are prevention barriers. Controls that prevent a UOS resulting in an accident are identified as recovery barriers, while controls that mitigate the effect of an incident or accident are called mitigation barriers.

This approach can be illustrated as the 'Safety Bowl' (figure 3) or the 'Bow Tie' (figure 4).



**Figure 3 – The ‘Safety Bowl’ Safety Risk Control Model**

**(Source Dédale and Air France)**

The Safety Bowl model is an intuitive illustration of accidents seen as ‘loss of control’ of the situation. The bowl represents the safe envelop within which operations should be kept, while the position of the UEs represent the departure into either accident or incident scenarios. The model also illustrates the importance of monitoring and managing the risk controls in place and the need to introduce or adapt risk controls when necessary.

This risk control approach can also be represented in the form of a 'Bow Tie' diagram:



**Figure 4 – The ‘Bow-Tie’ Safety Risk Control Model**

**8.2.2.6 Hazard Recording**

The Safety Manager shall maintain a register (or log) of hazards.

*A hazard register template is provided in the Register of Hazards supplied with this EHEST SMS Toolkit.*

See also the Section Conclusions and Documentation, sub-Section Register of Hazards, Risk Assessments, and Risk Controls.

**8.2.2.7 Identification of Undesirable Events and of their Consequences**

*A sample list is provided in the Register of Undesirable Events supplied with this EHEST SMS Toolkit. It can be used to get the SMS started and then adapted and updated through the operation of the SMS.*

**8.2.2.8 Mapping Hazards to Undesirable Events**

*A sample list is provided in the Register of Hazards and Undesirable Events supplied with this EHEST SMS Toolkit. It can be used to get the SMS started and then adapted and updated through the operation of the SMS.*

**8.2.3 Risk Assessment, Description and Evaluation**

Risk combines two dimensions: likelihood of hazard consequences and their severity. Both dimensions have to be assessed.

**8.2.3.1 Analysis of Likelihood**

Assessment of likelihood is based on the following two way process:

* hazard consequences are analysed to establish possible causes, contributing factors and existing barriers
* causes, contributing factors and barriers are then further analysed to determine likelihood of an occurrence.

In the causal analysis of consequence, human and organisational factors are considered for their possible contributing effects. We normally consider direct causes (‘unsafe acts’), workplace factors and organisational factors (‘error provoking or latent conditions’).

The effects of existing likelihood-reducing factors and barriers (See the Section Safety Model) that influence the chain of events are considered and documented, taking into account the following:

* certification requirements;
* maintenance procedures;
* existing normal and abnormal procedures;
* technical measures/equipment;
* training;
* other human and organisational factors.

Causal analysis, supported for instance by 'Bow Tie' type diagrams is performed to the level of detail necessary to establish relevant likelihood values.

Alternatively[[14]](#footnote-14), values can be estimated on the basis of expert judgement, or on the basis of observed or reference frequencies provided for the sector, type of operations, type of machine(s), etc.

Likelihood may be expressed using terminology such as ‘very low, low, medium, high and very high’.

The following table is an example of what a Company may use for determining likelihood:

|  |  |  |
| --- | --- | --- |
| RISK LIKELIHOOD | **MEANING** | **VALUE** |
| FREQUENT | **Likely to occur many times.** Has already occurred in the Company (Freq. > 3 times per year – indicative\*). Has occurred frequently in the history of the aviation industry. | **5** |
| OCCASIONAL | **Likely to occur sometimes.** Has already occurred in the Company (Freq. < 3 times per year – indicative\*). Has occurred infrequently in the history of the aviation industry. | **4** |
| REMOTE | **Unlikely to occur, but possible.** Has already occurred in the Company at least once or. Has seldom occurred in the history of the aviation industry. | **3** |
| IMPROBABLE | **Very unlikely to occur.** Not known to have occurred in the Company but has already occurred at least once in the history of the aviation industry. | **2** |
| EXTREMELY IMPROBABLE | **Almost inconceivable that the event will occur.** It has never occurred in the history of the aviation industry.[[15]](#footnote-15) | **1** |

*\* Indicative: depends on the size of the company and volume of activity. Use figures adapted to your Company.*

Below are examples of methods[[16]](#footnote-16) that the Company may use for causal and likelihood analysis:

* fault tree analysis;
* FMECA (Failure Mode, Effects and Critical Analysis);
* influence diagrams;
* bow-tie diagrams;
* brainstorming.

As the risk assessment progresses, an iterative process may help to identify new factors and barriers. These can then be included in the analysis.

**8.2.3.2 Analysis of Severity**

The severity of all hazard consequences is analysed. The analysis considers both short-term and long-term consequences, such as effects on the natural and work environment.

Consequences are grouped such as loss or damage of life/health, environment, material values/assets, functions and reputation.

The determination of severity is normally of a descriptive (qualitative/ordinal terms) nature, except when relevant calculations (quantitative) can or should be applied. A qualitative analysis describes the chains of events that could follow from the hazard and its possible consequences. Quantitative analysis is used to calculate the extent of damage that could be caused.

Severity can be expressed using terminology like ‘very small, small, medium, large and very large’. The meaning of each term is then expressed in words and/or numbers / ranges.

Below is an example table that the Company may uses for determining severity:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| SEVERITY OF OCCURRENCE | **MEANING** | | | | **VALUE** |
| PERSONNEL | ENVIRONMENT | MATERIAL VALUES & ASSETS | REPUTATION |
| CATASTROPHIC | Multiple fatalities | Massive effects (pollution, destruction, etc.) | Catastrophic financial loss  Damage > 1 M€ (\*) | International impact | **E** |
| HAZARDOUS | Fatality | Effects difficult to repair | Severe financial loss with long term effects  Damage < 1 M€ (\*) | National impact | **D** |
| MAJOR | Serious injuries | Noteworthy local effects | Substantial financial loss  Damage < 250K€ (\*) | Considerable impact | **C** |
| MINOR | Light injuries | Little impact | Financial loss with little impact  Damage < 50K€ (\*) | Limited impact | **B** |
| NEGLIGIBLE | Superficial or no injuries | Negligible or no effects | Financial loss with negligible impact  Damage < 10K€ (\*) | Light or no impact | **A** |

*\* Indicative: depends on the size of the company and volume of business. Use figures adapted to your Company.*

In the analysis of severity of each consequence, human and organisational factors are primarily considered for their possible contributing effects.

The effects of existing recovery controls and barriers that influence the consequence itself or the consequence chain should be considered, as applicable:

* certification requirements (e.g. fire protection);
* existing abnormal and emergency procedures;
* secondary safety measures (e.g. crashworthiness, personal protective equipment);
* technical measures/equipment;
* training;
* human and organisational factors;
* emergency preparedness.

As the risk assessment progresses it is possible that an iterative process may help to identify new factors and barriers. These are then added to the procedure and included in the analysis.

Risk levels may vary over time depending on the nature of the operation(s) (machines and equipment, procedures and documentation, flight environment, personnel qualification, duration of the tasks, etc.). Comprehensive and up-to-date data such as risk assessments and risk descriptions helps in the task of performing good and effective risk assessments.

Risk must be re-assessed, in particular when a change is introduced. See the Section ‘The Management of Change’ in Chapter 8.9 of this SMM.

**8.2.3.3 Risk Description**

The risk description forms the basis for risk evaluation and mitigation. Based on the results of the likelihood and severity analysis, the risk is described as a combination of the likelihood of occurrence and the associated severity.

Depending on the analysis method and the risk acceptance criteria, the description is either qualitative and/or quantitative. The level of detail depends on the level of detail in the likelihood and severity analysis.

One method that can be used for risk description is a risk matrix combining risk likelihood and risk severity. See the next Section.

If a hazard has more than one consequence, the risk may be expressed as a combination of the likelihood and severity for each of the consequences.

Uncertainties in the risk description are to be identified and documented. If the analysis is based on critical assumptions or other conditions that could affect the assessment, these are to be identified and documented (if necessary in the form of a sensitivity analysis).

Risk Description and Analysis at Undesirable Events level

The Company will primarily use the EHEST approach: hazards can lead to Undesirable Events (UEs), which can deteriorate into incidents and accidents. Hazards can contribute to several UEs and are generally related to several Hazards (many-to-many mapping), which all have an associated risk level. The level of risk associated to an UE is, however, not the average of the risk levels associated to the hazards that contribute to the risk. This is why UE’s are also subject to a separate risk rating. See Appendix 9.

Risk rated UEs are then used as an input to Safety Cases. See Appendix 9.

**8.2.3.4 Risk Evaluation**

The results of the risk analysis is compared to the criteria for acceptable risk.

This comparison is documented using a format that can be used by decision makers.

One method that can be used is a Risk Tolerability Matrix combining the analysis results and the risk acceptance criteria.

*An example of Risk Tolerability Matrix is provided hereafter:*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **RISK LIKELIHOOD** | **RISK SEVERITY** | | | | |
| NEGLIGIBLE (A) | MINOR (B) | MAJOR (C) | HAZARDOUS (D) | CATASTROPHIC (E) |
| FREQUENT (5) | **5 A** | **5 B** | **5 C** | **5 D** | **5 E** |
| OCCASIONAL (4) | **4 A** | **4 B** | **4 C** | **4 D** | **4 E** |
| REMOTE (3) | **3 A** | **3 B** | **3 C** | **3 D** | **3 E** |
| IMPROBABLE (2) | **2 A** | **2 B** | **2 C** | **2 D** | **2 E** |
| EXTREMELY IMPROBABLE (1) | **1 A** | **1 B** | **1 C** | **1 D** | **1 E** |

*Completing the matrix ‘mechanically’, i.e. without genuine safety reasoning based on facts and relation between facts, is of limited use. A team analysis among specialists of different domains (Working Groups) relevant to the operation(s) being examined helps in assessing the risk in a realistic manner. The evaluation of risk should be based on a systematic analysis of the operation concerned.*

The red-coloured values indicate unacceptable risk levels, the yellow-coded values are tolerable risk levels and the green-coded values establish acceptable risk levels.

Each risk level calls for a particular action and the levels of management who have the authority to make decisions regarding the tolerability of safety risks need to be specified.

**Unacceptable Risk Level**: the red zone in the matrix: risk is too high to continue operating.

Action required: Prohibit/suspend the operation. Operation may be resumed only when risk level is returned to tolerable or acceptable.

Management levels who have the authority to make decisions regarding risk tolerability:

* For the risk evaluation validation: The assumptions made for the determination of the risk level and its tolerability are to be validated by the Safety Manager.
* For the authorisation of operations: Management level which has the authority to authorise operations at this level of risk: not applicable: operations cannot be authorised.

**Tolerable Risk Level**: the yellow zone in the matrix: the risk level can be tolerated for the operation, providing that appropriate mitigation measures are in place.

Action required: Introduce appropriate mitigation measures.

Management levels who have the authority to make decisions regarding risk tolerability:

* For the risk evaluation validation: The assumptions made for the determination of the risk level and its tolerability are to be validated by the Safety Manager.
* For the authorisation of operations: Management who have the authority to authorise operations at this level of risk: the Accountable Manager.

**Acceptable Risk Level**: the green zone in the matrix below: risk is tolerable and can be accepted for the operation.

Action required: Monitor. Risk is considered sufficiently controlled and no additional risk mitigation measures are required. However, in line with the ALARP concept, actions may still be taken to further reduce the risk level if feasible and reasonable. Additionally, any assumptions used to make an assessment must be monitored to ensure they remain valid.

Management levels who have the authority to make decisions regarding risk tolerability:

* For the risk evaluation validation: The assumptions made for the determination of the risk level and its tolerability are to be validated by the Safety Manager.
* For the authorisation of operations: Levels of management who have the authority to authorise operations at this level of risk: not applicable: no special authorisation is required: the authorisation of activities featuring ‘acceptable risks’ fall within the regular operational control for operations.

**Note: A Company could decide to use more levels of risks and more levels of management who have the authority to make decisions regarding the tolerability of safety risks.**

**8.2.4 Risk Control**

**8.2.4.1 Identification of Risk Control (Mitigation) Measures**

The risk evaluation forms the basis for deciding on risk control (mitigating) measures and in assessing the effectiveness of these measures.

Risk control measures identify the consequences associated with both an unacceptable risk and tolerable risk and where further risk reduction measures are feasible and reasonable.

Identification of possible mitigation is based on the risk description and evaluation, considering in particular any uncertainties identified and critical assumptions made.

Controls that may eliminate the consequence of a hazard, likelihood-reducing measures and severity-reducing measures are identified. The measures should address the human factors (e.g. training and competence), equipment or organisational factors (e.g. procedures).

In the Company, the personnel contribute to the definition of risk control measures in particular where they concern personal equipment (goggles, helmets and other flight equipment), by their acceptance and use.

**8.2.4.2 Risk Control Priorities**

Risk control measures are implemented based on the following priorities:

1. eliminate the consequences of the hazard;

2. reduce the likelihood of occurrence;

3. reduce the severity.

**8.2.4.3 Risk Control Types**

Examples of risk controls include:

* passive technical controls (e.g. system redundancy, firewall);
* active technical controls (e.g. automatic fire extinguishing system).

**8.2.4.4 Risk Control Effect Assessment**

The risk mitigating effect of the controls are assessed with respect to:

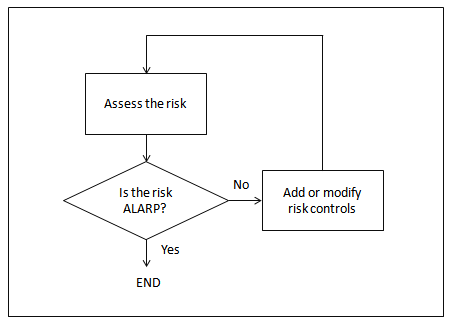
* functionality: Does the measure influence the ability to perform the activity?
* robustness: Will the measure be effective under varying conditions and over time?
* possible other effects such as introduction of new risks.

When identifying risk control measures, any new risks that may arise from the implementation of such measures (‘substitution risks’) should be identified.

Risk is re-assessed considering the effects of the proposed risk control effects, as illustrated in the table below:

|  |  |  |  |
| --- | --- | --- | --- |
| **Risks Assessed** | **Initial Risk Level** | **Risk Control** | **Resulting Risk Level** |
| Risk 1 |  |  |  |
| Risk 2 |  |  |  |
| Risk 3 |  |  |  |

The measures are not necessarily sufficient to bring the risk level back to an acceptable or tolerable level in a first round: if the risk acceptance criteria require further risk reduction, the comparison (iterative process) describes the optimisation process. So new risk controls are added, or existing risk controls are modified, until the risk is as low as reasonably practicable (ALARP).



**Figure 5 – Iterative Risk Reduction Process**

The ALARP concept combines the technical feasibility of further reducing the safety risk and the cost; demonstrating that the safety risk is ALARP means that any further risk reduction is either impracticable or grossly outweighed by the cost.

**8.2.4.5 Cost Benefit Analysis**

The contemplated mitigation measures should be subjected to a Cost Benefit Analysis[[17]](#footnote-17), which helps determine the most appropriate measures. The mitigation considered appropriate should achieve the safety benefits desired and should be economically acceptable.

*An example of Cost Benefit Matrix is provided below:*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **BENEFITS** | | | |
| **COSTS** |  | **High** | **Average** | **Low** |
| **Low** | **1** | **2** | **3** |
| **Average** | **2** | **3** | **4** |
| **High** | **3** | **4** | **5** |

**Figure 5 – A Simple Costs Benefits Analysis Matrix**

**Source: D. Huntzinger, Eurocopter**

Acceptance criteria with regards to the costs of implementing mitigation measures and the expected benefits, these are to be endorsed by the Accountable Manager.

Mention here or in a separate document the acceptance criteria used within your Company.

**8.2.5 Conclusion and Documentation**

Any risk assessment should be documented and contain unambiguous, precise and robust conclusions to enable decision makers to arrive at appropriate control reduction decisions (see the Section Implementation of Risk Control Measures).

Documentation includes references to other documents (when applicable) and points out any need for further work.

**8.2.5.1 Scope**

The risk assessment documentation includes or references, as required, descriptions of the following:

* the purpose of the risk assessment;
* the activity/issue analysed;
* involvement of personnel and other operators with whom we interact;
* context/framework for the activity/issue;
* the assessment of who is affected by the activity/issue and how;
* data used;
* the analysis method;
* the hazard(s);
* the contributing factors and consequences
* uncertainties and assumptions made for the assessment;
* the likelihood and severity;
* the risk mitigation measures;
* the risk evaluation;
* the conclusions.

**8.2.5.2 Register of Hazards, Risk Assessments and Risk Controls**

The Safety Manager shall maintain a register (or log) of hazards, and of the corresponding risk assessments and mitigations. This risk register records hazards per activity and indicates how these have been addressed in the past and are currently being addressed.

Any future risk assessment may then draw upon the information already available.

The information is both communicated and made available to all in the Company with special attention to the managers in charge, depending on the nature of the risks[[18]](#footnote-18).

The register of “Hazards” and “ Hazards and Undesirable Events” (Excel files) are updated at each step of the risk management processes. These registers also record the results of the processes and serve as a basis for risk monitoring, review and improvement.

This procedure is detailed in Appendix 9.

**8.3 Changes that Could Invalidate the Conclusions of a Risk Assessment**

Changes that could invalidate the conclusion of a risk assessment could be:

* significant changes in the preconditions and context;
* new knowledge of risks involved (experience from accidents and occurrences, reporting of safety concerns, research, better risk analysis methods, internal inspections, audits and reviews, hazard reporting);
* significant changes in the underlying data used for the assessment;
* significant organisational changes that could affect the assessment; and
* several smaller changes that together might constitute a significant change.

Depending on the type of activity affected and the nature of the changes, the Safety Manager may decide to reassess the risk.

**8.4 Implementation of Risk Control Measures**

Implementation of the risk control (mitigation) measures may, depending on the nature of these measures, give rise to an implementation plan identifying who is in charge, the resources needed, the deadline, and the stages of implementation. The implementation plan is periodically reviewed until completion or revision.

**8.5 Monitoring, Review and Improvement**

The risk assessment process is monitored for the purpose of:

* analysing and learning from events, changes and trends;
* detecting changes in the internal and external context including changes to the risk itself;
* ensuring that the risk mitigation measures remain effective; and
* identifying emerging risks.

Monitoring and review can be performed through periodic reviews, inspections and audits, risk assessments and the risk management process itself, with the aim to strive for a continuous reduction in the risk level.

**8.6 Occurrence Reporting and Internal Safety Investigations**

***Cf. AMC1 ORO.GEN.160 and related AMC***

The Company reports to the National Civil Aviation Authority all occurrences defined in AMC 20-8, and as required by the applicable rules implementing Directive 2003/42/EC on Occurrence Reporting in Civil Aviation[[19]](#footnote-19).

The operator should report all occurrences defined in AMC 20-8, and as required by the applicable national rules implementing Directive 2003/42/EC2 on occurrence reporting in civil aviation.

In addition to the reports required by AMC 20-8 and Directive 2003/42/EC, the operator should report volcanic ash clouds encountered during flight.

*Mention here the procedure, legal deadline, and forms by which you report your reportable occurrences, serious incidents and accidents to your National Aviation Authority and Accident Investigation Board.*

**8.6.1 Occurrence Reporting Scheme**

***Cf. GM1 ORO.GEN.200(a)(3)***

The overall purpose of the scheme is to make best use of reported information to improve the level of safety performance and not to attribute blame.

The scope of this scheme also includes occurrences not reportable to the authorities.

The objectives of the occurrence reporting scheme are to:

* enable an assessment to be made of the safety implications of each relevant incident and accident, including previous occurrences of a similar nature, so that any necessary action can be initiated; and
* ensure that knowledge of relevant incidents and accidents is disseminated, so that other persons and operators may learn from them.

The scheme is an essential part of the overall monitoring function and it is complementary to the normal day-to-day procedures and ‘control’ systems and is not intended to duplicate or supersede any of them. The scheme is a tool to identify and analyse those instances where procedures appear to have failed or where there was a failure to apply the procedures.

All occurrence reports judged reportable by the person submitting the report should be retained as the significance of such reports may only become obvious at a later date.

The Company’s approach is described as follows.

Every occurrence identified through occurrence reports, voluntary reports or other sources provides the opportunity to draw safety lessons. Learning from experience is only possible if all events are reported and analysed and their causes and factors (technical, operational, or environmental) are determined and analysed.

On a daily basis, occurrences (down to simple malfunctions) may affect any process. Some of these occurrences are defined as accident precursors. Accident precursors are occurrences which, without appropriate mitigation, can result in Undesirable Events or accidents.

The Safety Manager is to record, analyse and monitor these occurrences. Occurrences are recorded in a database and the database is analysed to identify trends and define recommendations to correct possible deviations and avoid accidents (proactive approach).

An occurrence is classified as “technical” when its cause is mainly technical: for instance an in-flight engine failure or any other equipment failure.

An occurrence is classified as “operational” when it is mainly due to one or several “unsafe acts” (unintentional error or voluntary deviation from a procedure) or by one or more “unsafe conditions” (deficiencies in the Company’s organisation) or by a combination of these.

An occurrence is classified as “environmental” when it is mainly due to uncontrollable environment factors, such as weather, volcanic ash, earthquake, etc.

It should be recognised, however, that occurrences can feature more than one of these components.

Several occurrence reporting forms are used in the Company: for instance, the Flight Occurrence Report form is provided at Appendix 1 and the Maintenance Occurrence Report form at Appendix 2.

Occurrences may also be reported verbally, by email or on a simple sheet of paper to the Safety Manager.

Reports may be treated as confidential and/or anonymous at the reporter’s request.

Reporting occurrences is essential for improving safety and is strongly encouraged. In return, the Company guarantees that the reporter(s) will not be punished for reporting safety concerns except in the case of illegal act, gross negligence, or a deliberate disregard for regulations and applicable procedures. See the Section Safety Policy and Objectives of this SMM.

Each occurrence report is analysed, processed and recorded in the file "Database Incidents.xls” by the Safety Manager.

The analysis should focus on assessing the potential impact on flight safety. In addition, it should also include the safety of personnel and of third parties[[20]](#footnote-20). The analysis can also be expanded to assessing the impact on material, the environment, and the Company’s reputation[[21]](#footnote-21).

**8.6.2 Internal Safety Investigations**

The scope of internal safety investigations should extend beyond the scope of occurrences required to be reported to the competent authority.

Investigations consist of collecting and analysing events, determining causal and contributing factors, drawing up conclusions and making safety recommendations as applicable.

Investigations are carried out in particular in the case of:

* accidents and incidents,
* discovery of new hazards and risks,
* recurrent safety risks.

Moreover, the Safety Manager may at any time decide to launch an investigation procedure on an opportune basis. The investigation procedure is detailed in the table shown on the next page.

Investigation procedure

|  |  |
| --- | --- |
| Stage | Remarks |
| Decision to launch an investigation | * Put together an investigating team. |
| Activity Planning | * Define and breakdown the activities. * Define the investigation needs. |
| Data Collection | * Collect evidence about the event. The following relevant sources can be used:   + Physical examination;   + Documentation and files;   + Interviews with the persons involved;   + Observation of actions;   + Simulations;   + Expert consultancy;   + Safety database. |
| Scenario Identification | * Identify/reconstruct the scenario. |
| Scenario analysis | * Analyse the facts, determine the causes and identify the associated hazards. * Integrate all investigation elements. |
| Risk Assessment | * Determine risk level and assess risk acceptability. |
| Risk Control/Mitigation Analysis | * Identify and assess risk controls/mitigations. |
| Correction/Prevention | * Determine corrective/preventive action. |
| Safety Communication | * Communicate the investigation results to all those concerned. |
| Completion of the investigation | * Close and archive the file. |

**8.7 Safety Performance Monitoring and Measurement**

***Cf. AMC1 ORO.GEN.200(a)(3)point (d)(1)***

Safety performance monitoring and measurement is the process by which the Company’s safety performance is verified in comparison to the overall safety policy and objectives.

Safety performance is defined as the level of safety achievement against the Safety Performance Objectives (SPOs), using specific Safety Performance Indicators (SPIs). Safety performance reflects the ability of the Company to effectively manage risks.

**8.7.1 Stepwise Approach to Safety Performance Measurement**

At different levels of maturity of the SMS, the amount of quality safety data available and the issues and actions that are most important for improving safety performance and actions will differ. The Company has, therefore, adopted a step-wise approach to safety performance measurement[[22]](#footnote-22), based on three levels of SMS maturity:

Level 1 of SMS implementation: Present and suitable

At the first level, the SMS will have achieved compliance with the applicable requirements. SPIs should focus on the activities required to maintain basic compliance with the SMS regulatory framework. These can be of a quantitative (numerical) or qualitative (non-numerical) nature:

Quantitative indicators (examples):

* the number of safety reviews performed;
* the number of staff who received training in SMS;
* the number of internal audits performed versus number of audits planned;
* Etc.

Qualitative indicators (examples):

* feedback received from staff on the safety policy;
* feedback received from staff on new procedures implemented in the area of internal occurrence reporting or hazard identification.
* Etc.

Once the SMS is in place and compliance with requirements has been achieved, new level 2 indicators will need to be introduced to achieve improvement of safety performance.

Level 2 of SMS implementation: Operating and effective

At this level, the Company will start to define more specific SPIs on the basis of safety data collected through the hazard identification and internal occurrence reporting processes (see Chapter 8.6 in this SMM).

More specific, objective and reliable leading performance indicators and precursor event indicators are introduced to identify any weaknesses and areas where improvement is required. These can include:

* the number of risk assessments performed following organisational changes;
* the percentage of standard operating procedures that have been subject to hazard identification;
* average lead time for completing corrective actions following internal audit;
* number of additional procedural controls implemented;
* Etc.

At this level of SMS maturity, the Company will be getting a better picture of the risks affecting the operations and the solidity of the risk controls in place.

Level 3 of SMS implementation: Best Practice

Level 3 is the level where the Company will have achieved continuous learning and improvement for all parts of the SMS.

At this maturity level, effective hazard identification and risk assessment processes are established that will allow it to derive a more sophisticated mix of safety performance indicators.

SPIs are focused around local issues identified from the safety data already collected, and from key safety areas identified by the regulator or identified at an aggregate level from within the industry sector.

SPIs allow the risk levels related to occurrences to be monitored, the solidity of any barriers and relationship to any accidents.

Risk mitigation actions focus on those issues that present the greatest risks or offer the greatest potential for improvement.

Quantitative indicators (examples):

* number of high risk occurrences (coded amber and red);
* mean value of risk ratings (over a reference period, e.g. 1 year);
* sum of risk ratings (over a reference period, e.g. 1 year);
* solidity of risk controls (defences) (rated from 0 to 5; over a reference period, e.g. 1 year).

Following the implementation of risk mitigation actions, risks are monitored to ensure that risk controls are effective and are indicative of how these controls could be improved.

**8.7.2 Fixing Safety Performance Objectives**

The process for determining quantitative safety performance objectives for a given period consists of:

1. Measuring the baseline against which safety improvements are to be assessed;
2. Fixing reasonable, yet ambitious targets; and
3. Monitoring target achievement over time and reviewing targets as necessary.

The Safety Manager shall ensure that both the SPO’s and the SPI’s are pertinent and documented.

**8.7.3 Process**

***Cf. AMC1 ORO.GEN.200(a)(3)(d)(2)***

The Safety Manager shall ensure that the process for safety performance measurement is established and implemented.

SPO’s are monitored over time by the Safety Manager and reviewed by the Safety Review Board or by the Accountable Manager with the Safety Manager. *Select or modify as appropriate.*

SPIs are also reviewed following the implementation of a change. See Chapter 8.9 ‘The Management of Change’ of this SMM.

A report is provided annually to the Safety Review Board and the Accountable Manager[[23]](#footnote-23). *Modify this statement as appropriate.*

The process of safety performance monitoring and measurement shall include the following:

Safety Reporting

The Safety Manager collects and centralises the Company’s safety reports and monitors the type and number of reported events over time[[24]](#footnote-24). Additionally, he/ she addresses the status of compliance with the applicable requirements.

Safety Studies

*Safety studies consist of a detailed analysis which is used to target broad safety concerns.*

The Safety Manager shall, whenever appropriate, initiate safety studies addressing subjects of safety relevant to the Company.

Safety studies are aimed at gathering additional information on selected topics which has been identified by safety reports or other means. Safety studies are by their nature larger in scope than the analysis of specific hazards. Safety surveys, for example, belong in this category.

Safety studies can address a variety of subjects such as compliance with Standard Operating Procedures, mission preparation and risk assessment of specific operations such as dealing with deteriorating weather, resisting customer pressure, etc.

Safety studies can make use of information published in technical publications from manufacturers, OEMs, the regulatory authorities, Helicopter Associations and national, European or international Helicopter Safety Initiatives such as EHEST and IHST. This can include a review of journal articles, accident and incident reports, conference proceedings, press releases and other safety information often available on internet.

Safety Studies are logged in the file “Safety Studies.xls”. See Appendix 9 for the procedure.

Safety Reviews

*Safety reviews, including trend reviews, are conducted during the introduction and deployment of new technologies, change or implementation of procedures, or in situations of structural change to operations.*

A safety review should be performed at least once each year by the Safety Review Board and/or by the Safety Manager and Accountable Manager[[25]](#footnote-25) *(select as appropriate)*.

The aim of the major safety review is to assess:

* safety performance against the safety indicators and objectives,
* the effectiveness of Safety Management System, including through an assessment of the effect of the corrective and/or preventive actions,
* procedures and policies,
* Health and Safety[[26]](#footnote-26).

Possible negative trends and deficiencies may be identified, as well as actions taken to correct these deficiencies by targeting their causes. Corrective actions are to be recorded. A Model of a Corrective Action Follow-up File is provided in Appendix 7.

Safety Audits

Safety audits focus on the integrity of the management system and periodically assess the status of safety risk controls.

The Company addresses all audit findings through appropriate corrective actions in an effort to restore and/or improve the effectiveness of the SMS and safety performance. A Model of a Corrective Action Form further to an audit is provided in Appendix 6.

Internal Audits

The Safety Manager shall have responsibility for the internal Safety Audits but may be assisted by another internal or external auditor. *State here the arrangement in place in your Company.*

External Audits

The SMS is audited by the National Aviation Authority and may also be subject to audit by a customer where approved by the Accountable Manager.

Safety Surveys

Safety surveys are dedicated qualitative or quantitative (statistical) studies targeting specific safety subjects.

Safety surveys allow particular elements or procedures of a given operation to be evaluated, such as problem areas in daily operations, perceptions, opinions, satisfaction levels and areas of dissent or confusion. Safety surveys can also be used to gather comments and suggestions.

Safety surveys facilitate consultation with various parties such as operational personnel and customers on selected topics.

Safety surveys can make use of questionnaires in either paper or web format.

**8.8 Emergency Response Planning**

***Cf. AMC1 ORO.GEN,200(a)(1);(2);(3)(5) point (f)***

The Safety Manager co-ordinates and maintains an Emergency Response Plan that should ensure orderly and efficient transition from normal to emergency operations, and the subsequent return to normal operations.

The Company Emergency Response Plan is described in a separate document.

*An example of an Emergency Response Plan developed by the EHEST is provided separately.*

**8.9 The Management of Change**

***Cf. ORO.GEN.200(a)(3) point (e)***

The Company shall manage safety risks related to a change. The management of change is a documented process to identify external and internal change that may have an adverse effect on safety. It makes use of existing hazard identification, risk assessment and mitigation processes.

Changes include organisational changes with regard to safety responsibilities.

The following is a non-exhaustive list of examples of changes that should be considered:

* New regulations,
* Managerial reorganisation,
* Relocation,
* Outsourcing,
* Mergers,
* Change of market structure, development of new markets, etc.,
* Change in economic and financial pressure,
* New operations and/or missions,
* New aircraft type or variant,
* New maintenance procedures, equipment or tools,
* Hiring new personnel,
* New training provider,
* Etc.

Changes may have various positive or negative safety impacts. Any change that may have an adverse effect on safety shall be identified and managed through the Company’s existing processes for hazard identification, risk assessment and mitigation.

A Change Management Form is provided in Appendix 8.

The register of “Hazards” and “ Hazards and Undesirable Events” (Excel files) are to be updated for each internal or external change to be analysed.

Different changes can be grouped in a common Safety Impact Assessment, especially if they are introduced together or if they are inter-related.

The Company’s change impact assessment procedure is described as follows:

Change Impact Assessment Procedure

1. Identify the nature and scope of the change(s).
2. Perform an initial Impact Assessment study covering:
   * The Company’s operational procedures (Operations Manual, Standardisation Manual, Maintenance Training Organisation Exposition (MTOE), etc.),
   * Work organisation (staffing, composition of the teams, scheduling, additional training, etc.),
   * Infrastructure (relocation, parking base, etc.),
   * Maintenance of equipment or the aircraft.
3. Perform a Safety Risk Analysis (See the Risk Management section):
   * Identify hazards related to implementing the proposed change and their possible consequences,
   * Identify existing risk controls and define, as appropriate, additional mitigation measures.
4. Identify key personnel who will assist in implementing the change and the mitigation measures required and involve them in the change management process.
5. Define an implementation plan.
6. Assess related financial costs.
7. Communicate the proposed change to the staff and involve them in the project in an effort to garner their support.
8. Implement the actions as defined in the plan.
9. Check the overall effects through the established Safety Performance Monitoring and Measurement process.

**8.10 Continuous Improvement**

***Cf. AMC1 ORO.GEN.200(a)(3) point (f)***

The Company shall continuously seek to improve its SMS[[27]](#footnote-27) and safety performance.

Improvement of Safety Performance

The Safety Manager shall provide a report[[28]](#footnote-28) on safety performance (risk levels, incident and accident figures, etc.) annually to the Accountable Manager. The report should include a comparison with the levels achieved in previous years. This report can be merged with the one mentioned in the previous paragraph.

Continuous improvement of safety performance should be achieved through:

* proactive and reactive evaluations of facilities, equipment, documentation and procedures through safety audits and surveys;
* proactive evaluation of each individuals performance to verify the fulfilment of their safety responsibilities; and
* a reactive evaluation in order to verify the effectiveness of the system for control and mitigation of risk.

Improvement of the SMS[[29]](#footnote-29)

Continuous improvement of the SMS is achieved through:

* Assessment of how the SMS is functioning;
* Identification and analysis of possible issues/challenges associated with the running of the SMS;
* Implementing changes aimed at improving the SMS;
* Monitoring and reviewing the effects of any changes.

Continuous improvement can also be achieved when the SMS is functioning well, performance of the SMS can always be improved.

Measures that can improve the SMS include:

* Leaner procedures;
* Improved safety reviews, studies and audits;
* Improved reporting and analysis tools;
* Improved hazards identification and risk assessment processes and improved awareness of risks in the Company;
* Improved relations with the subcontractors, suppliers and customers regarding safety;
* Improved communication processes, including feedback from the personnel.

Continuous improvement of the SMS may target any component of the SMS, in other words any subject addressed in this SMM which has the objective of increasing the effectiveness of the system over time.

The Safety Manager performs a review of the SMS (how effectively goals and objectives were met) and he/she provides a report[[30]](#footnote-30) on the SMS (how effectively the SMS works, the stage of implementation, results of audits and review of actions, any issues/challenges and proposals for improvement) annually to the Accountable Manager.

## Chapter 9 – Contracted Activities

***Cf. ORO.GEN.205 and related AMC1 and GM1***

The Company may contract certain activities to external organisations for the provision of services related to areas such as ground de-icing/anti-icing, ground handling, flight support (including performance calculations, flight planning, navigation database and dispatch), training, and manual preparation.

*Insert a separate document or table with your contracted activities and the contracted organisations.*

The ultimate responsibility for contracted activities, i.e. for the product or service provided by external organisations always remains with the Company.

A written agreement signed between the Company and the contracted organisation shall clearly define the contracted activities and the applicable requirements.

Activities performed by sub-contractors may have an impact on safety, therefore, the contracted safety related activities need to be addressed through the Company's Safety Management and Compliance Monitoring programme.

As part of the SMS, a risk analysis is to be carried out on any newly contracted activity as part of the Change Management process. If corrective and/or preventive actions need to be implemented, they are to be submitted in writing to the sub-contractors or suppliers. Effective application of these measures needs to be checked and monitored under the supervision of the Safety Manager.

As part of the Compliance Monitoring Programme, the Company ensures that the contracted organisation has the necessary authorisations or approvals where required, and has the resources and competence to undertake the task. Compliance with applicable regulations, Company requirements and procedures are to be checked and monitored under the supervision of the Compliance Manager.

## Chapter 10 – Safety Promotion

***Cf. AMC2 ORO.GEN.200(a)(5) point (b)(12)***

Safety Promotion is a process aimed at promoting a culture of safety by ensuring that all personnel in an organisation are aware that, at their level and in their day-to-day activity, they are key players in safety and that everyone, therefore, contributes to an effective SMS.

Managers are important actors of the Company’s Safety Management System. In all the activities they manage, they demonstrate commitment to safety and take care of safety aspects. They lead by example and have an essential role to play for safety promotion.

Training and effective communication on safety are two important processes supporting safety promotion. See Chapter 11 of this SMM.

## Chapter 11 – Training and Communication on Safety

Safety training is an integral part of the Company’s training programme, which is documented elsewhere. *Please provide the appropriate reference.*

***Cf. ORO.GEN.200(a)(4) and related AMCs/GM***

**11.1 Training**

All personnel receive safety training as appropriate for their safety responsibilities and adequate records of all safety training provided are to be kept.

All personnel receive training to maintain their competences. This includes notification of any changes to applicable regulations and rules, Company procedures, and safety-relevant technical matters.

There is a link between training and safety risk management as training and competence development is one of the means through which identified risks can be reduced. Other types of risk controls concern equipment or organisational factors (e.g. procedures), which in turn can also be addressed in training.

The safety training programme may consist of self-study via a media (newsletters, flight safety magazines, power point, etc.), class-room training, e-learning or similar training. *Please specify the safety related training methods employed in your Company and/or by external training service providers.*

A table identifies all Company safety training to be provided to each staff member detailing the training provider, the resources used, the duration, and the expiry/renewal date. *Insert a reference to this the table.*

**Note: As the SMS matures, and unless otherwise prescribed by implementing rules, training contents and frequency should be linked to the safety risk management and safety performance monitoring and measurement (dynamic process). The highest risks and those risks where control particularly depends on personnel competence should attract more training resources (longer duration, higher frequency, etc.).**

*The following table is an example of SMS training that can be conducted for new staff members (induction training) and provided as recurrent training:*

| **Contents** | **Training Objectives** |
| --- | --- |
| Safety Policy | Understand the main elements of the Safety Policy. |
| Organisation, roles and responsibilities | Understand the organisation, roles and responsibilities concerning the SMS. Everyone to know his or her own role in the SMS. |
| Safety Objectives | Understand the Company’s safety objectives. |
| Emergency Response Planning (ERP) (reinforced through practical simulations) | Understand the various roles and responsibilities in the Company’s ERP. Everyone to know his or her own role in the ERP. |
| Occurrence and hazards reporting | Know the means and procedures for reporting occurrences and hazards. |
| Safety Risk Management (SRM) process including roles and responsibilities | Understand the Safety Risk Management process. Everyone to know his or her own role in the SRM. |
| Continuous improvement of safety performance | Understand the principles of continuous improvement of safety performance. |
| Compliance Monitoring | Understand the basic principles of Compliance Monitoring. |
| Responsibility when contracting activities | Understand the Company’s responsibilities when contracting activities. Everyone should know his or her own roles and responsibilities regarding this subject. |

**11.2 Communication**

***Cf. ORO.GEN.200(a)(4) and related AMCs/GM***

The Company shall establish an effective communication system regarding safety related matters that:

* ensures that all personnel are aware of safety management activities as appropriate to their safety responsibilities;
* conveys safety critical information, especially related to assessed risks and analysed hazards;
* explains why particular actions are taken; and
* explains why safety procedures are introduced or changed.

Communication also reinforces the commitment of everyone to report hazards and occurrences and provides feedback to the reporters (an essential condition for sustained reporting).

Regular meetings are organised with the personnel to communicate safety matters and discuss information, actions and procedures.

Communication is kept simple and appropriate to maximise effect, involve all personnel, and reinforce personal and team commitment to safety.

Communication is open. It encourages discussion, develops the Company’s Safety Culture and makes the most of the lessons learned from running the SMS.

Different communication means can be used *(various examples are provided below; select as appropriate)*:

* Safety meetings,
* Safety briefings,
* E-mail, postal mail, suggestion boxes,
* Safety information from the OEMs, the authorities, Helicopter Associations and from national and international Safety Initiatives,
* Safety campaigns, safety posters,
* Newsletters, Company journal,
* Flight safety digests, digest of accidents and incidents (appropriately de-identified), from within and outside the Company,
* Digest of safety studies, audit reports, survey reports, and safety reviews,
* Company forum(s) or professional networks (e.g. LinkedIn, Facebook, Twitter, etc.),
* Subscription to publications and journals,

Communication is a two way process, meetings, e-mails and other interactive methods allow for the provision of feedback from the personnel and can generate discussion.

## Appendix 1 – Flight Occurrence Report

**FLIGHT OCCURRENCE REPORT No.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **CLASSIFICATION** | | **□ Technical** | | **□ Operational** | |
| **IDENTIFICATION OF THE AIRCRAFT** | | | | | |
| Type of Aircraft | Version | S/N | Flight hours | Customer | Country |
|  |  |  |  |  |  |
| **CIRCUMSTANCES** | | | | | |
| DATE: | | Place: | | Remarks: | |
| **SELECT THE CATEGORIES CONCERNED** | | | | | |
| **Flight phase:**  □ Towing □ Manoeuvre  □ Pre-flight inspection □ Hover IGE  □ Refuelling □ Hover OGE  □ Start-up □ Descent  □ Translation/Taxiing □ Final Approach  □ Take-off □ Landing  □ Climb < 500ft □ Engine shutdown  □ Climb > 500ft □ Post-flight insp.  □ Cruise | | | **Flight Conditions:**  □ VFR  □ IFR  □ VMC  □ IMC  □ Mountain  □ Over water  □ Day  □ Night  □ Icing cond.  □ Storm | ***Missions:***  □ Training  □ Ferrying  □ Transport of passengers  □ Inspection flight  □ Aerial work  □ Hoisting  □ Lifting  □ Night flight  □ Night flight with NVG  □ Emergency proc. training  □ Auto-rotation training | |
| **DOCUMENTS USED** | | | | | |
| Reference flight manual: | | Revision: | | Language: | |
|  | |  | |  | |
| **FLIGHT CONDITIONS** | | | | | |
| Meteorological Conditions: | | | | | |

**Appendix 1 – Flight Occurrence Report (Cont’d)**

|  |  |  |  |
| --- | --- | --- | --- |
| **DESCRIPTION OF THE OCCURRENCE** | | | |
| Explain how the event occurred, why it occurred and why it did not result in an accident: | | | |
| Actions of the pilot or the crew to manage the event |  | | |
| Proposals to prevent the event from reoccurring or from avoiding that such event result in an accident |  | | |
| **FEEDBACK TO THE REPORTER** | | | |
|  | | | |
| **SIGNATURES** | | | |
| Reporter(s) | | Safety Manager | Line Manager  *(if agreed at Company level)* |

## Appendix 2 – Maintenance Occurrence Report

**MAINTENANCE OCCURRENCE REPORT No.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **IDENTIFICATION OF THE AIRCRAFT** | | | | | |
| Type of Aircraft | Version | S/N | Flight hours | Customer | Country |
|  |  |  |  |  |  |
| **CIRCUMSTANCES** | | | | | |
| DATE: | | Place: | | Maintenance Phases: | |
| **SELECT THE CATEGORIES CONCERNED** | | | | | |
| **Maintenance phase:**  □ Scheduled maintenance □ Towing  □ Unscheduled maintenance □ Refuelling  □ Repair □ Pre-flight inspection  □ Training/maintenance □ Post-flight inspection | | | | | |
| **MAINTENANCE CONDITIONS** | | | | | |
| **Select the relevant area (ATA Chapter 53)** | | | | | |
| □ 21 Air-conditioning system  □ 22 Automatic pilot  □ 23 Communication systems  □ 24 Electrical system  □ 25 Equipment, furnishings  □ 26 Fire protection system  □ 28 Fuel system  □ 29 Hydraulic system  □ 30 Protection against rain and ice  □ 31 Recording/information system  □ 32 Landing gear/skids  □ 33 Lights/lamps  □ 34 Navigation system/flight data  □ 36 Pneumatic system  □ 39 Electrical/electronic equip. and panel  □ 42 Platforms & Modules  □ 45 Maintenance centralisation system  □ 46 Display integration system  □ 49 External power generation system | | | □ 52 Doors and protection covers  □ 53 Fuselage  □ 55 Stabiliser  □ 56 Windshield and windows  □ 62 Main rotor  □ 63 Main rotor controls  □ 64 Anti-torque rotor  □ 65 Anti-torque rotor controls  □ 67 Flight controls  □ 71/72 Electrical installation  □ 73 power supply system  □ 74 Lighting system  □ 76 Engine control  □ 77 Engine indicators  □ 79 Oil cooling system  □ 80 Engine start-up system  □ 85 Optional equipment  □ 88 Electrical harness  □ 93 – 99 Monitoring/weapons | | |

**Appendix 2 – Maintenance Occurrence Report (Cont’d)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Relevant assembly(assemblies)  or component(s) | Description  P/N: | Type of operation | Documentation of maintenance used | | |
|  |  | Type/Ref: | Rev. Nbr: | Version: |
| **DESCRIPTION OF THE OCCURRENCE** | | | | | |
| Explain how the event occurred, why it occurred and why it did not result in an accident: | | | | | |
| Actions taken by the maintenance staff (or another party) to manage the event |  | | | | |
| Proposals to prevent the event from reoccurring or from avoiding that such event result in an accident |  | | | | |
| **FEEDBACK TO THE REPORTER** | | | | | |
|  | | | | | |
| **SIGNATURES** | | | | | |
| Reporter(s) | | Safety Manager | | Line Manager  *(if agreed at Company level)* | |

## Appendix 3 – Voluntary Occurrence Report

**VOLUNTARY OCCURRENCE REPORT No.**

|  |  |  |
| --- | --- | --- |
| *The single aim of the information reported on this form is to improve safety. You are not obliged to give your identity and position in the organisation. However, should you wish to do so, they will not be disclosed without your approval.* | | |
| **Date (optional):** | **Location (optional):** | **Type of operation:**  **□ maintenance**  **□ during flight**  **□ HSE** |
| **Aircraft in question:** | **Documentation (PMV, work card, etc.)** | **Tools:** |
| **Description of the event:** Explain how the event occurred, why it occurred and why it did not result in an accident: | | |
| What are your suggestions to prevent this event from re-occurring or for preventing that such an event could result in an accident? | | |

*TO BE FILLED OUT BY THE SAFETY MANAGER*

|  |  |  |
| --- | --- | --- |
| ADDITIONAL ANALYSIS AND COURSE OF ACTION | Validated by: | Date: |
|  | | |
| Processed by the Safety Action Group  Date: | | |
| Manager: | Open on: | Closed on: |

## Appendix 4 – Occurrence Follow-up Action Form

|  |  |  |  |
| --- | --- | --- | --- |
| **OCCURRENCE FOLLOW-UP FORM** | | | |
| Flight Occurrence Report No.: | Maintenance Occurrence Report No.: | | Voluntary Occurrence Report No.: |
| **1. PRELIMINARY ANALYSIS** | | | |
| Performed by: | | Date: | |
| **The occurrence (Reminder of the facts):**  Reasons why the occurrence occurred - Safety barriers that failed or where inoperative:  Reasons why it did not result in an accident - Safety barriers that were operative: | | | |
| **Classification based on the Safety Risk Matrix** | | | |
| **ACCEPTABLE** | **TOLERABLE** | | **UNACCEPTABLE** |
| **2. ADDITIONAL ANALYSIS BY THE SAFETY REVIEW BOARD or SAFETY ACTION GROUP** (If the risk is not Acceptable) | | | |
|  | | | |
| Validated by: | | Date: | |

**Appendix 4 – Occurrence Follow-up Action Form (Cont’d)**

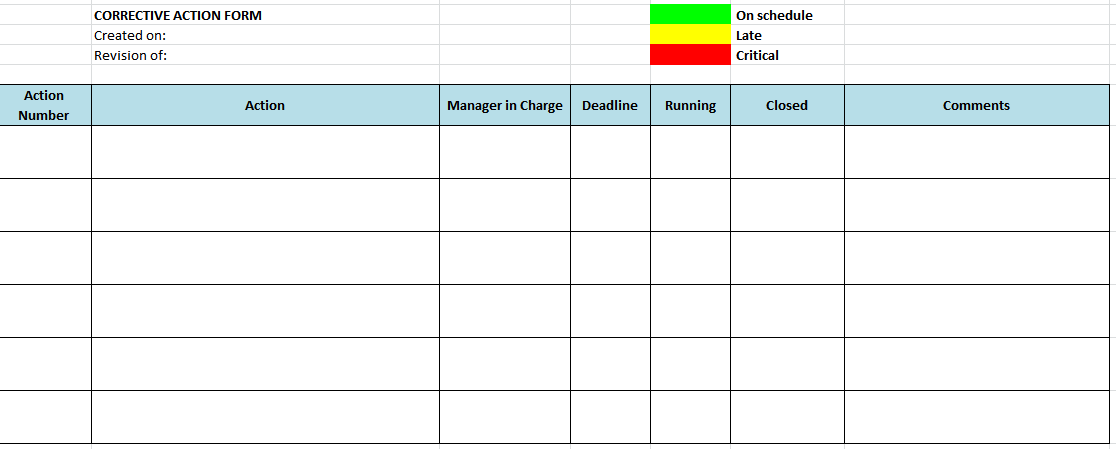
|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **3. CORRECTIVE ACTIONS** | | | | | | | |
| Action No. | ACTION | | Manager | Started | Closed | | Comment |
|  |  | |  |  |  | |  |
| **4. CLOSING THE EVENT** | | | | | | | |
| Feedback transmitted to the personnel concerned on: | | | | | | | |
| MANAGER: | | SIGNATURE: | | | | DATE: | |

## Appendix 5 – Safety Study Support Form

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Study Title** | |  | | |
| Assessed by: | |  | | |
| Revised on (date) | **Hazard** | Likelihood | Severity | **Risk** | **Risk Controls (Defences)** | Likel. | Severity | Risk | RC in place on (date) | Doc.  Reference | Additional Measures or Comments |
|  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |

## Appendix 6 – Example of Corrective Action Form further to Audit

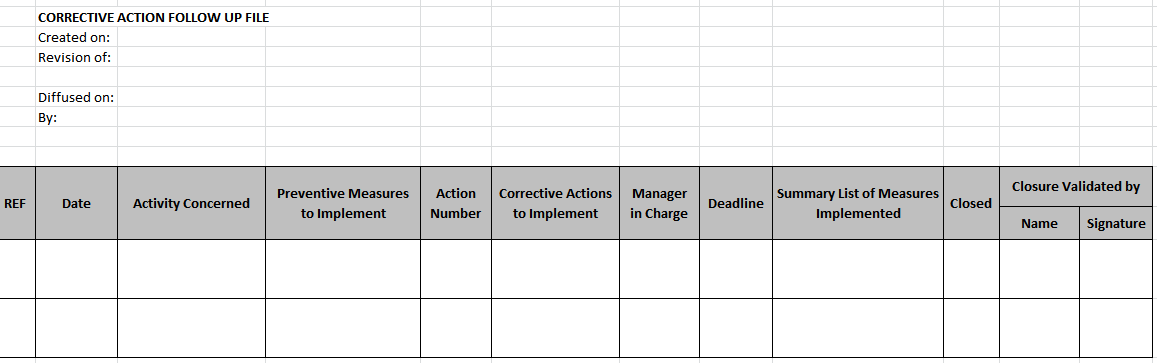
**EXAMPLE OF CORRECTIVE ACTION FORM FURTHER TO AUDIT**



Note: The form can also be used for preventive actions by replacing the term ‘corrective’ by ‘preventive’.

## Appendix 7 – Model of Corrective Action Follow-up File

**MODEL OF CORRECTIVE ACTION FOLLOW UP FILE**



Note: The form can also be used for preventive actions by replacing the term ‘corrective’ by ‘preventive’.

## Appendix 8 – Example of Change Management Form

**EXAMPLE OF CHANGE MANAGEMENT FORM**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Change Assessed** |  | | | | | **Type of Change** | |
| **REF:** | **Project Leader** | |  | | | Permanent □ | Temporary  From to |
| **Affected Hazards or New hazards** | **References added** | | | **Hazards and Undesirable Events identification Registers updated on:** | | **Signature of Safety Manager** | |
|  |  | | |  | |  | |
|  |  | | |  | |  | |
|  |  | | |  | |  | |
| **Summary of Actions to be Carried Out** | | **Manager** | | | **Started on** | **Closed on: Date and Signature  of Manager in Charge** | |
|  | |  | | |  |  | |
|  | |  | | |  |  | |
|  | |  | | |  |  | |
| **End of Process Statement - Summary of actions carried out** | | | | **Project Leader** | | **Date and Signature** | |
|  | | | |  | |  | |

## Appendix 9 – Procedure for Running the Safety Database

The *Company’s* Safety Database is the tool used within the SMS to keep track of Safety Events and the corresponding hazards, associated risk levels, and safety risk controls.

This procedure details the different steps for integrating all safety information in the safety database.

Using a database helps when the number of safety data occurrences becomes substantial. A database can also help to structure the relationship between different types of data. For instance, each **Safety Event/Occurrence** can point to several **Hazards** which in turn can be linked to other Occurrences and/or to **Safety Studies**. Furthermore, every Hazard has its own **Risk level** and is addressed by one or many **Safety Controls/Defences/Mitigations**.

The database is composed of five files:

* “**Safety Database.xls**” – This file logs the **Safety Events/Occurrences** reported through the event reporting system. Two worksheets are provided:
  + Flight Occurrences
  + Maintenance Occurrences

The Safety Manager inserts all the Flight and Maintenance Occurrences in the corresponding worksheets. Every Occurrence can reveal one or more **Undesirable Events**, which did happen or could have happened.

Every Undesirable Event is inserted in a different record (line).

Undesirable Events can be chosen from the list of already defined Undesirable Events or be inserted as new entry in the “**Undesirable Event List.xls**”.

In the “**Corrective Actions**” worksheet, the Safety Manager inserts all the corrective actions deemed necessary to prevent the Undesirable Event from occurring or re-occurring.

* “**Undesirable Events.xls**” – Every Undesirable Event logged in the “Undesirable Event.xls” worksheet is also logged in the “Undesirable Events” file. A new entry is created as required and a new worksheet is then created and named with the Event reference number. Each worksheet is used to study one particular Undesirable Event.
* The Undesirable Event is screened for **Hazards**, i.e. factors that, alone or in combination, could contribute to the escalation of the event into an accident. Hazards are selected from the existing file “**Hazard List.xls**” or new entries are created when appropriate. Each Hazard is risk assessed, the result being marked in the **Risk Level** field.
* **Safety Controls/Mitigations** are then examined with the objective to bring ‘Unacceptable Risk’ down to ‘Tolerable Risk’ or ‘Acceptable Risk’ or to keep ‘Tolerable Risk’ under appropriate control. Mitigations are recorded as **Corrective Actions** when approved by the Management.
* The analysis of Safety Controls/Mitigations can also result in **Safety Recommendations**. Safety Recommendations are suggestions for safety improvements that could result in Corrective Actions. Undesirable Events are generally related to several Hazards (many-to-many mapping) which all have an associated risk level. The level of risk associated to an UE is however not the average of the risk levels associated to the hazards that contribute to it. That is why UE’s are also subject to a separate risk rating.
* “**Safety Studies.xls**” – This file logs all the **Safety Studies** and the issues that have been discovered by the Safety Assurance programme. Safety Studies are of the following types:
  + Safety Cases (SC)
  + Audits (AU)
  + Management of Changes (MOC)
  + Safety Surveys (SURV)
  + Flight Data Monitoring (FDM)

Each Safety Study is inserted in the “**Risk Analysis.xls**” worksheet with its own reference number. A new worksheet is created and named with the corresponding reference number. Each subject is analysed and hazards and controls are identified. **Hazards** and **Controls** can be selected from the existing lists or added as new entries.

* “**Hazard List.xls**” – This file contains all the hazards identified through the analysis of Occurrences and of Safety Studies (see above) or through any other source. Certain hazards can contribute to different incidents and accidents. Correct identification, risk assessment and mitigation of Hazards is therefore essential for safety. All hazards are assigned a reference number and are recorded on a dedicated worksheet in the “**Undesirable Event List.xls**” file for the reported Occurrences or in the “**Safety Studies.xls**” file for the Safety Studies.
* “**Follow-up.xls**” – This file contains a list of follow-up actions taken after completing the analysis of an Occurrence or of a Safety Study and issuing Safety Controls/Mitigations or Safety Recommendations.

General Principle – The system described above is fully integrated. Whatever the source of information (reports, occurrences, studies, etc) whenever new hazards are identified they are logged into the “Hazard List.xls”, analysed and further processed.

## Appendix 10 – Safety Performance Indicators and Objectives

|  | Item | Objectives | Year 20XX Performance | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| Qtr1 | | | Qtr2 | | | Qtr3 | | | Qtr4 | | |
| 1st Half | | | | | | 2nd Half | | | | | |
| Level 1 of SMS implementation: Compliance | | |  |  |  |  |  |  |  |  |  |  |  |  |
| Quantitative indicators | number of safety reviews performed, |  |  |  |  |  |  |  |  |  |  |  |  |  |
| number of staff who received training in SMS, |  |  |  |  |  |  |  |  |  |  |  |  |  |
| number of internal audits performed versus number of audits planned, |  |  |  |  |  |  |  |  |  |  |  |  |  |
| number of voluntary safety reports per staff member per year, |  |  |  |  |  |  |  |  |  |  |  |  |  |
| number of safety reports raised by customers per year. |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Qualitative indicators | feedback received from staff on the safety policy, |  |  |  |  |  |  |  |  |  |  |  |  |  |
| feedback received from staff r on new procedures implemented in the area of internal occurrence reporting or hazard identification, |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Level 2 of SMS implementation: Improvement | | |  |  |  |  |  |  |  |  |  |  |  |  |
|  | number of risk assessments performed following organisational changes, |  |  |  |  |  |  |  |  |  |  |  |  |  |
| percentage of standard operating procedures that have been subject to hazard identification, |  |  |  |  |  |  |  |  |  |  |  |  |  |
| average lead time for completing corrective actions following internal audit, |  |  |  |  |  |  |  |  |  |  |  |  |  |
| number of suggestions for safety improvements, |  |  |  |  |  |  |  |  |  |  |  |  |  |
| frequency and effectiveness of safety briefings, |  |  |  |  |  |  |  |  |  |  |  |  |  |
| number of additional procedural controls implemented. |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Level 3 of SMS implementation: Learning | | |  |  |  |  |  |  |  |  |  |  |  |  |
| Quantitative indicators | number of high risk occurrences (coded amber and red) |  |  |  |  |  |  |  |  |  |  |  |  |  |
| mean value of risk ratings (over a reference period, e.g. 1 year) |  |  |  |  |  |  |  |  |  |  |  |  |  |
| sum of risk ratings (over a reference period, e.g. 1 year) |  |  |  |  |  |  |  |  |  |  |  |  |  |
| solidity of risk controls (defences) (rated from 0 to 5; over a reference period, e.g. 1 year) |  |  |  |  |  |  |  |  |  |  |  |  |  |

1. Regulation (EC) No 216/2008 of the European Parliament and of the Council of 20 February 2008 on common rules in the field of civil aviation and establishing a European Aviation Safety Agency, and repealing Council Directive 91/670/EEC, Regulation (EC) No 1592/2002 and Directive 2004/36/EC. OJ L 79, 19.3.2008, p. 1. [↑](#footnote-ref-1)
2. Throughout this document the term FDM is used. However an alternative term used in the helicopter industry is HOMP (Helicopter Operational Monitoring Programme). [↑](#footnote-ref-2)
3. Just culture is a culture in which front line operators or other members of staff are not punished for actions, omissions or decisions taken by them that are commensurate with their experience and training, but where gross negligence, wilful violations and destructive acts are not tolerated. A just culture facilitates reporting, as staff do not fear of being blamed for the facts they report. [↑](#footnote-ref-3)
4. Not in the EASA AMC. [↑](#footnote-ref-4)
5. A more complex organisation example (not including the CMM) is described in Figure 8-2, page 158, of the ICAO Doc 9859 AN/474 Safety Management Manual, Second Edition. [↑](#footnote-ref-5)
6. Not in the EU regulation on Air Operations. Please check applicable national regulations on Health and Safety SMS. [↑](#footnote-ref-6)
7. In the case of a non-complex operator, this task may be exercised by the Accountable Manager provided he/she has demonstrated having the related competence as defined in AMC1 ORO.GEN.200(a)(6)(c)(3)(iii)(5). In the case the same person acts as Compliance Monitoring Manager and as Safety Manager, the Accountable Manager, with regards to his/her direct accountability for safety, should ensure that sufficient resources are allocated to both functions, taking into account the size of the operator and the nature and complexity of its activities. [↑](#footnote-ref-7)
8. For example, where a maintenance procedure is changed by the manufacturer continued use of the obsolete procedure could create a safety risk. [↑](#footnote-ref-8)
9. Not in the EU regulation on Air Operations, just optionally. Check with your National Authority for possible SMS requirements regarding Health and Safety. [↑](#footnote-ref-9)
10. The classification of hazards in this manual is adapted from the ICAO Doc 9859 AN/474 Safety Management Manual, Second Edition, Chapter 4-4. This classification is used in the Excel file "Hazards Identification.xls" supplied with the EHEST SMS Toolkit. [↑](#footnote-ref-10)
11. And a threat in the sense of the Threat and Error Management (TEM) model.  
    See for instance:

    <http://www.skybrary.aero/index.php/Threat_and_Error_Management_(TEM)>. [↑](#footnote-ref-11)
12. Definition in Section 8.2.4. [↑](#footnote-ref-12)
13. Not in the EASA AMC. [↑](#footnote-ref-13)
14. Not in the EASA AMC. [↑](#footnote-ref-14)
15. Note however that even extremely improbable events may occur. [↑](#footnote-ref-15)
16. Consult for instance SKYbrary or Wikipedia for a description of these methods. [↑](#footnote-ref-16)
17. Not mentioned as such in the EASA AMC, but a CBA approach is relevant to the ALARP concept mentioned in the AMC. [↑](#footnote-ref-17)
18. Not in the EASA AMC. [↑](#footnote-ref-18)
19. Directive 2003/42/EC of the European Parliament and of the Council of 13 June 2003 on occurrence reporting in civil aviation OJ L 167, 4.7.2003, p. 23–36. Note: This Directive is currently being revised and will be replaced by a regulation. Please check applicability on <http://eur-lex.europa.eu/en/index.htm> [↑](#footnote-ref-19)
20. Not in the EU regulation on Air Operations. Check with your National Authorities for possible SMS requirements regarding Health and Safety. [↑](#footnote-ref-20)
21. Annex III to the EU regulation on Air Operations, Part ORO.GEN(a) (1);(2);(3);(5) Management System only address aviation safety. [↑](#footnote-ref-21)
22. Not in the EASA AMC. [↑](#footnote-ref-22)
23. Not in the EASA AMC. [↑](#footnote-ref-23)
24. Not in the EASA AMC. [↑](#footnote-ref-24)
25. Not in the EASA AMC. [↑](#footnote-ref-25)
26. Health & Safety (Occupational Safety) requirements are national requirements. Please check with your National Authorities. [↑](#footnote-ref-26)
27. The AMC only mentions continuous improvement of the safety performance   
    (the output of the SMS), not improvement of the SMS. [↑](#footnote-ref-27)
28. Not in the EASA AMC. [↑](#footnote-ref-28)
29. Not in the Implementing Rules and the EASA AMC. [↑](#footnote-ref-29)
30. Not in the EASA AMC. [↑](#footnote-ref-30)