Occurrence Reporting

UK CAA Flight Operations

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Do the right thing

Never stop learning

Build collaborative relationships

Respect everyone

Why are we here?

Continuously maintaining or improving safety performance

Common Goal

CAA

State Safety Programme

RSMS

Operators

Adaptation of State Safety Objectives

SMS

PDCA

Applicable for both the CAA and Operators

UK Civil Aviation Authority

"JUST" REPORTING CULTURE

PDCA	What do we need to do
PLAN	Define our risk picture
DO	Risk Management through appropriate risk mitigation action plans
CHECK	Monitor SPIs and define whether acceptable level of safety is achieved
ACT	Re-define safety risk action plan and organisational risk picture

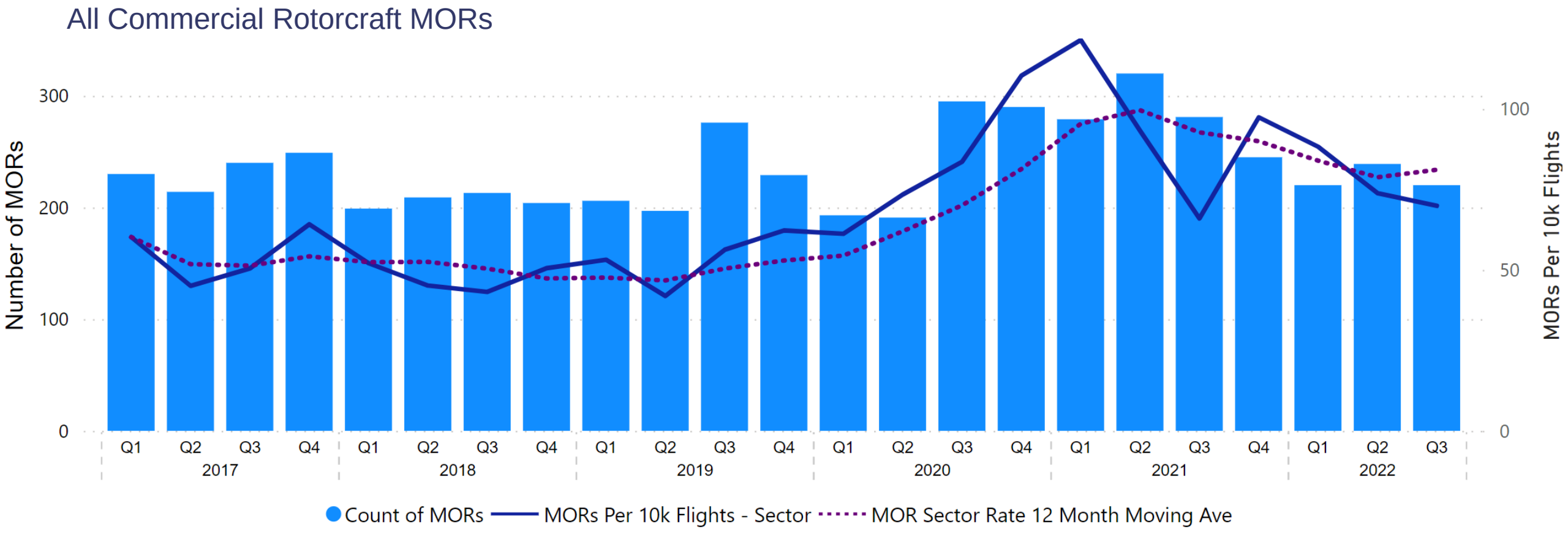
Measuring Safety Performance
The dilemma

0 report →

1000 reports →

Is it really that simple?

MOR Trend


All Commercial Rotorcraft MORs
Number of MORs
300
200
100
0
100
50
0
MORs Per 10k Flights
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3
2017 2018 2019 2020 2021 2022
Count of MORs
MORs Per 10k Flights - Sector
MOR Sector Rate 12 Month Moving Ave

Measuring Safety Performance
What sort of events are being reported?

UK Civil Aviation Authority

THE 2 KEY WORDS ARE:

OCCURENCE REPORTING

Not because you have to – compliance with "MOR" criteria

Right thing to do to increase operational and safety performance – OCCURENCE REPORTING (MOR AND VOR)

Do we invest enough time/resource/effort to investigate either or both?

Our common mistakes

We do not follow the advise from...?

“Better to travel well than arrive”

Common Traps

1. Rushing to conclude - No “real “ root cause

- The objective of root cause analysis is to identify the cause of a breakdown in your organisational system, which has resulted in an undesired event, to ensure that repeat occurrences are minimised.
- We should seek to investigate **all aspects** of the process, procedures, environment, human performance and any mitigating circumstances surrounding an event to identify what caused the underlying problem (root cause).

Common Traps

2. Think the “EVENT” = REAL root cause

- The reported event could be a symptom of a wider system issue
- Correcting the event itself may not stop future reoccurrences.

Common Traps

3. Corrective action plan does not address the REAL root cause

- Immediate corrective action plan for quick fix is common.
- Timely delivery of a corrective, step by step approach considering the human in the system.

Common Traps

4. Safety 2 approach?

- Generally, the tasks would have been carried out many times before without incident, but on this occasion something changed.
- What can we learn from the “good” to correct the bad?

Any Questions?

Thank you

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