ASTRAL AVIATION CONSULTING

Civil Aviation Authority Commissioned Independent Review of the Roles and Responsibilities for Safety Management at UK Civil Flying Display Events

Final Report

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No substantive amendments have been made to the evidential record, analytical methodology, findings, conclusions, recommendations or statistical outputs contained within the report.

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Document Information

Title	Civil Aviation Authority Commissioned Independent Review of the Roles and Responsibilities for Safety Management at UK Civil Flying Display Events – Final Report
Produced by	Astral Aviation Consulting Ltd
Produced for	UK CAA
Date of release	31 July 2026

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1. Executive Summary

1.1.1. This report provides an integrated review of Safety Advisory Groups (SAGs) that support multiple event types throughout the UK. It provides analysis of UK Civil Flying Display SAGs and subsequent comparative benchmarking against wider events as well as presenting the overall conclusions and evidence-based recommendations for improving the consistency, and clarity of safety governance for UK Civil Flying Display events.

1.1.2. Aviation risk is qualitatively different from other outdoor event risk and is already subject to an explicit regulatory framework under CAP 403: Flying Displays and Special Events: Safety and Administrative Requirements and Guidance[1] and Article 86 of the Air Navigation Order[2]. Part of the safety process for Civilian Flying Displays is the provision of appropriate SAG advice. The quality of this advice depends on the clarity of SAG roles, knowledgeable experts on the SAG itself, and disciplined interfaces between advice and governance.

1.1.3. Subjective evidence[3] gathered from stakeholder interviews and questionnaires, and objective evidence, including document reviews, show that SAGs are critical for safety at Civilian Flying Displays, providing advice on ground safety and emergency planning. Based on the subjective evidence, they are generally perceived to be more effective for larger events. However, that same evidence combined with objective analysis of documentation has shown that SAGs are inconsistent across the UK. Most align with the Purple Guide to Health, Safety and Welfare at Outdoor Events (The Purple Guide)[4], although some do to a lesser extent. This introduces ambiguity and variability in terms of stakeholder perception of SAG effectiveness, which is supported by objective evidence from post hoc enquiries and audits. Comparative benchmarking against other major UK events demonstrated these challenges are not unique to flying displays and identified the characteristics of more mature governance arrangements, providing an evidence-based framework for defining good practice and informing the recommendations within this report.

1.1.4. Another recurring system issue is a lack of clarity between key governance and advisory boundaries within UK Civilian Flying Displays. Evidence has shown that there are many differing approaches including advisory responsibility, legal accountability, pseudo-assurance provision, and perceived approval authority. Ambiguity was noted in the interface between the Flying Display application form and CAP 403 guidance: applicants certify that events “will” be organised in accordance with CAP 403, while CAP 403 uses “should” language regarding SAG engagement; this creates space for inconsistent interpretation, and approach. Comparative benchmarking reinforced this finding demonstrating that good governance is consistently underpinned by clearly defined advisory boundaries, disciplined governance arrangements, and a shared understanding of roles and responsibilities.

1.1.5. Drawing on evidence from Flying Display Directors (FDDs), Event Organisers (EOs), SAG Chairs and members, SAG challenges appear to stem from inconsistent interpretation of roles, uneven behaviours, contradictory guidance, and misaligned expectations at the interfaces between aviation activity, the overall event itself, and advisory fora. The recommendations therefore focus on clarifying accountability, re-enforcing the advisory function of SAGs,

[1] https://www.caa.co.uk/data-and-publications/publications/documents/content/cap-403/
[2] https://www.legislation.gov.uk/uksi/2016/765/article/86
[3] In this report, subjective evidence refers to information based on expert opinion rather than objective evidence, which are independently verifiable facts. Subjective evidence is presented by a qualified professional and relies on their personal judgment, evaluation, and specialised experience. Subjective Matter Expert (SME) evidence helps to bridge gaps between work-as-imagined and work-as-done, as well as to interpret grey areas, such as appropriate SAG engagement for differing flying display events.
[4] https://www.thepurpleguide.co.uk

improving proportionality, induction, and chairing practice, clearer guidance, defined boundaries, and access to independent aviation expertise[5].

1.1.6. Where stakeholders expressed differing concerns, such as calls for escalation ability, the recommendations deliberately address underlying concerns (clarity, confidence, appropriate challenge) without introducing inappropriate liability/accountability, assurance, or additional regulation. Additional considerations the Civil Aviation Authority (CAA) could implement within their own control are also considered.

1.1.7. Overall, the proposed recommendations are considered to strengthen the advisory nature of the SAG and its interface with the flying display by aligning behaviours and expectations across the system while preserving established legal responsibilities and enabling proportionate, practical implementation.

[5] It is acknowledged that human behaviour will always introduce variation into all activities, however clearer guidance and defined boundaries may provide a suitable level of detail which can reduce that variability to a suitably low level.

2. Introduction and Scope

2.1. Background

2.1.1. This report meets the requirement to provide the CAA with a report on the conduct of an independent review of the roles and responsibilities for safety management at UK Civilian Flying Display Events. It has not examined the effectiveness of the CAA nor the effectiveness of FDDs, the flying displays themselves, or the associated governance structures that support the safe delivery of UK Flying Displays.

2.2. Definition

2.2.1. To ensure a common understanding, it is worth defining what a SAG is. SAGs are multi-agency advisory forums used by local authorities to support the planning and safe delivery of a range of public events from town fairs and festivals to flying displays. In the flying display context, SAGs should interface with EOs to provide advice from local authorities, emergency services, and other agencies, but remain focused on the ground events and possible emergencies, not the flying display itself[6]. This should be borne in mind when considering the findings and recommendations drawn out in this report.

2.3. Objectives

2.3.1. The objectives of the report are to:

- Examine the structure, functioning, and working arrangements of SAGs across a representative range of civil flying displays
- Review the inter-relationships between FDDs, EOs and SAG members, including Local Authorities, emergency services, and other statutory bodies
- Determine how responsibilities are coordinated, how decisions are made and assured, and how safety and risk management controls are applied in practice
- Analyse the existing safety control measures employed collectively by SAG stakeholders, including the identification of overlaps, gaps, or pinch-points in responsibility and accountability
- Consider how roles and responsibilities interface at key boundaries, particularly between the EO, the FDD and the wider SAG membership
- Determine variations in practice between different SAGs
- Provide an overall benchmark for SAG ‘best practice’ in relation to UK Civilian Flying Displays
- Compare UK civil flying display events with small, medium, and large-scale non-aviation events to provide an analysis of flying display vs non-aviation SAGs
- Provide findings and suggest recommendations to better enable SAGS to provide appropriate advice and guidance to EOs.

2.4. System Interfaces

2.4.1. UK Civil Flying Displays operate under a tripartite safety structure governed by CAP 403. The system relies on clear functional mapping: the EO manages the ground up to the crowd line, where the FDD takes total operational command and control of the display area and airspace.

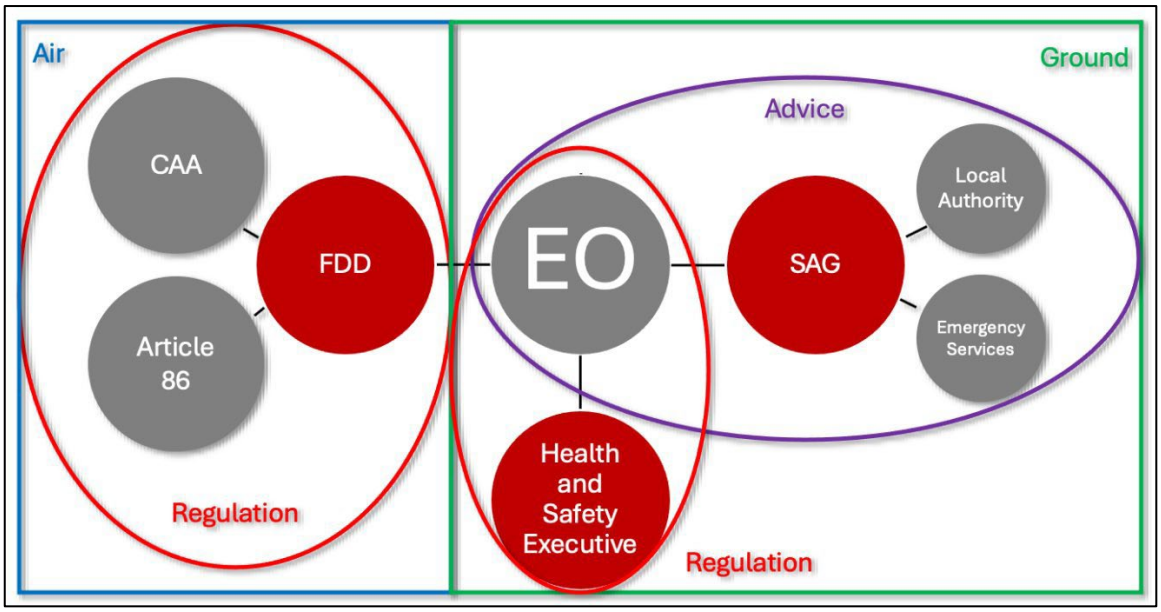
2.4.2. **FDD**. The FDD controls the **Air Safety** system boundary. Duties include CAA permitting, pilot briefings and flight-path enforcement. The FDD holds absolute functional primacy for the flying display.

[6] Flying Display Directors may attend a SAG but are not required to.

2.4.3. **EO**. The EO controls the ground event and **Public Safety** system boundary. Duties include managing ground infrastructure, ticketing, and emergency access. The EO owns the overall event footprint but must yield to FDD aviation directives if required.

2.4.4. **SAG**. The SAG acts as an **External Advice Body**. This multi-agency body (Police, Fire, Ambulance) scrutinises plans and manages off-site regional risks. They hold no veto power but advise on public safety.

2.4.5. The diagram below depicts the boundaries between the air and ground domains, regulation, and advice across the main elements of the system.



2.5. Report Scope and Boundaries

2.5.1. The scope of this report covers relevant documentation together with external individuals and organisations involved in SAG activity for civil flying displays, and other large, medium and small events, including local authorities, emergency services, SAG members, EOs, FDDs and relevant advisory bodies. It also includes available SAG documentation for non-aviation-related events, particularly Terms of Reference (TORs) and Emergency Management Plans (EMPs) together with documentation from relevant organisations and SAGS. In addition, several enquiries and audits were analysed to provide a post-hoc perspective on SAGs alongside a review of relevant national guidance.

2.5.2. This work does not seek to redesign the statutory responsibilities of the CAA, EOs, or FDDs. It focuses on the role, contribution, and limitations of SAGs as part of the wider safety management system.

2.6. Methodology Overview

2.6.1. The methodology combined subjective evidence, captured through stakeholder perspectives (questionnaire analysis and structured stakeholder interviews), with objective evidence (documentary review and comparative benchmarking with other non-airshow UK events and existing guidance). This enabled triangulation between formal guidance, stated practice, and lived operational experience across different event types and scales.

2.6.2. The methodology employed was structured into a series of interlinked phases aligned to the overall delivery plan, reporting milestones, and programme timetable. Each phase built progressively on the outputs of preceding activities, ensuring evidence was gathered, analysed, collated, and reported in a coherent, proportionate, and traceable manner. Key Task (KT) 1 included phases 1 to 4, KT2 phase 5 and KT 3 phase 6 as defined below.

2.6.3. **Phase 1: Mobilisation and Scoping**. The review commenced with a structured mobilisation and scoping phase to confirm objectives, scope, priorities, and governance arrangements. This included confirmation of success criteria and CAA reporting expectations; agreement of the representative sample of up to nine Tier 1, 2 and 3 flying display events and SAGs; finalisation of stakeholder engagement plans and structured lines of enquiry; and establishment of progress reporting and review cadence.

2.6.4. **Phase 2: Baseline Evidence Review**. A baseline review of relevant documentation was then undertaken to establish an initial, evidence-based, objective understanding of the current operating environment (full details of documents reviewed can be found at Appendix A).

2.6.5. **Phase 3: Stakeholder Engagement and Data Collection**. Structured engagement (individual questionnaires and one-to-one interviews) was conducted with a representative cross-section of external stakeholders, including EOs, FDDs, and SAG representatives. Engagement activities were designed to explore how roles and responsibilities were understood and exercised in practice; how decisions were made, challenged and assured; and where stakeholders perceived strengths, weaknesses, overlaps or gaps to be.

2.6.6. **Phase 4: System-Level Analysis of Roles, Responsibilities, and Controls**. Evidence gathered was then analysed using a system-level perspective, focusing on how safety controls operated collectively across organisations. This analysis examined interfaces at key boundaries, between EOs, FDDs and SAGs; assessed coordination, perceived effectiveness, and proportionality of controls; and identified duplication, dilution of accountability, or unmanaged gaps.

- **KT1 Report**. The KT1 Report established an initial evidence-based understanding of SAG operation in the flying display context. It identified recurring themes including variability in the quality of SAGs, inconsistency in national and local guidance, and a lack of clarity at key interfaces between advisory input and legal accountability. While SAGs were consistently recognised as potentially valuable, particularly in supporting multi-agency coordination and emergency preparedness, their contribution was found to be inconsistent and highly dependent on local capability, governance maturity, and the behaviours of individual participants rather than any consistently applied national model.

2.6.7. **Phase 5: Comparative Benchmarking.** Findings from the flying display review were then benchmarked against a range of non-aviation events, festivals, sporting venues, public events, enquiries, audits, and national guidance documents. This phase built on the inductive themes developed in KT1 and examined governance maturity, inter-agency coordination, planning arrangements, competence, assurance processes, proportionality, and regulatory frameworks to identify common themes, transferable lessons, and examples of good practice from across the wider event safety sector.

- **KT2 Report**. The KT2 Comparative Benchmarking Report confirmed that the challenges identified within flying display SAGs are not unique to aviation. Issues relating to role definition, documentation quality, governance maturity, assurance processes, and behavioural execution were found to be consistent across sectors, indicating that the underlying challenges are systemic rather than domain specific.

The KT2 report also noted, aligned to the Cynefin framework[7], that in a complicated system, such as event management safety, identifying transferable good practice while allowing for local flexibility proportionate to event risk, size, and complexity was likely to be the most successful approach.

2.6.8. **Phase 6: Synthesis and Recommendation Development.** Subjective and objective evidence from the documentary review, stakeholder engagement, system analysis, and comparative benchmarking was synthesised to identify recurring themes, systemic issues, and areas of good practice. This phase developed the final findings, established a good-practice framework for SAG operation, and generated proportionate recommendations intended to improve clarity, consistency, governance, and safety management within the existing regulatory framework.

[7] The Cynefin framework is a sensemaking model created by Dave Snowden that categorises situations into five domains, clear, complicated, complex, chaotic, and disorder to help leaders make context-appropriate decisions. More details are at para 8.1.1.

3. Methodology and Evidence Base

3.1. Introduction

3.1.1. The approach included an objective review of baseline evidence, followed by identifying key stakeholders. These stakeholders were approached to complete a questionnaire, and a representative cross-section was then interviewed. The approach deliberately sought subjective views from those involved in planning, approving, advising, and delivering flying display events. This included FDDs, EOs, SAG members, local authority representatives, individuals providing military liaison, and independent SAG chairs.

3.2. Data Sources

3.2.1. To provide the required evidence, several data sources were utilised. These were:

- Available SAG documentation and relevant national guidance (see appendix A)
- A list of stakeholders
- An AAC-generated stakeholder questionnaire (see Appendix B for summary of results)
- One-to-one interviews (see appendix C for interviewees and comparisons)
- Attendance at in-person events involving key stakeholders or key activities (see para 3.3.5)
- Comparative benchmarking data derived from major events, festivals, sporting venues, SAGs, the SGSA, post-event enquiries, audits, emergency management plans, and Terms of Reference (TORs)
- Post-event enquiries and audits
- Recognised good-practice guides from the wider UK event sector

3.3. KT1 Baseline Evidence Review

3.3.1. A baseline review of relevant documentation (at Appendix A) was undertaken to establish an initial, evidence-based understanding of the current operating environment.

3.3.2. Each document and guidance source reviewed during the baseline assessment was analysed against a consistent set of comparative categories (The Purple Guide) to allow structured benchmarking across national guidance and local authority SAG arrangements. The assessment framework considered:

- Overall event safety management arrangements
- Multi-agency coordination and stakeholder involvement
- The role and function of SAGs
- Event Safety Plan content and completeness
- Command and control structures
- Emergency planning arrangements
- Crowd-management considerations
- Medical provision planning

3.3.3. Within the above categories, specific criteria included risk assessment processes, emergency response planning, site planning, crowd management measures, traffic management, agency liaison arrangements, communication systems, evacuation planning, casualty handling, and wider control and coordination arrangements. This comparative framework enabled side-by-side assessment of each of the sources. Full details can be found in Appendix D, along with analysis of the data in section 7.

Questionnaire and Stakeholder Interviews

3.3.4. Building on the baseline evidence review, stakeholder engagement was undertaken to explore how the system operates in practice. Stakeholder engagement was conducted through an emailed structured questionnaire and one-to-one online follow-up interviews. The questionnaire was able to provide a dataset with which to compare each response, thus allowing conclusions to be drawn from the raw data.

3.3.5. Semi-structured interviews were used to explore themes emerging from questionnaire responses, including role clarity, SAG remit, aviation competence, proportionality, governance, and perceived good practice.

3.3.6. The interview analysis framework assessed each interview against a consistent set of comparative criteria derived from the project objectives and emerging themes identified within the questionnaire dataset. These criteria included:

- SAG structure, composition and working arrangements
- Role clarity and understanding of advisory boundaries
- Governance maturity and use of TORs
- Escalation and accountability arrangements
- Aviation competence and the interface between aviation and wider event safety management
- Emergency preparedness and exercising
- Proportionality and scalability of SAG engagement
- Communication and organisational learning
- Management of secondary spectators
- Wider human factors and organisational themes including authority gradients, shared situational awareness, cognitive load, governance consistency, and areas of overlap, gaps, or pinch-points in responsibility and assurance

3.3.7. The framework also examined differing stakeholder perspectives on standardisation, regulation, independent aviation assurance, and the interaction between aviation-specific and non-aviation public safety responsibilities. This comparative approach enabled inductive thematic analysis across FDDs, EOs, SAG Chairs, emergency services personnel and military representatives, allowing both common trends and significant areas of divergence to be identified against the study objectives. The full comparison of interviews can be found at Appendix E. A summary of questionnaire results is at Appendix B with analysis in section 7.

In Person Events

3.3.8. In-person events were also attended to provide a greater depth and breadth of exposure to SAGs, EOs and FDDs, and to facilitate subsequent 1-to-1 engagement. The team attended:

[redacted]

Analysis Methodology

3.3.9. **Thematic Analysis**. Thematic Analysis (TA) is a research method used to identify, analyse, and report patterns, or 'themes' within qualitative data, such as the questionnaires. Unlike quantitative methods, TA focuses on narrative, and the latent meaning and nuances of participant responses from which themes are generated. For this research, inductive thematic analysis was used to allow key themes to emerge directly from stakeholders' questionnaires and interviews, rather than imposing pre-existing assumptions or theoretical categories onto the data.

3.3.10. **HFACS**. The Human Factors Analysis and Classification System (HFACS) is a diagnostic framework originally derived from the 'Swiss Cheese'[8] model to identify systemic failures behind aviation accidents. It moves beyond blaming individuals to examine the underlying narrative of the entire organisation. When analysing qualitative research, HFACS categorises narrative data into four hierarchical levels:

- Organisational Influences: Identifies high-level gaps
- Unsafe Supervision: Identifies failures in oversight
- Preconditions for Unsafe Acts: Captures 'mental models' and environmental factors
- Unsafe Acts (Latent): Pinpoints specific hidden systemic vulnerabilities, which may need to be considered

3.3.11. By mapping qualitative feedback to these levels, researchers can provide evidence as to where the unsafe structures are within the system being studied, from the data collected.

3.3.12. **Critical Discourse Analysis**. Critical Discourse Analysis (CDA) is a qualitative research approach that examines how power, authority, and inequalities are established and maintained through language. In this research, CDA looked beyond what was said to analyse how the language used by stakeholders, such as EOs, FDDs, and SAG members, shapes the "truth" of aviation safety.

3.3.13. The methodology was further strengthened through a programme of comparative benchmarking, which formed the central component of the KT2 phase. This involved analysing safety governance arrangements across a wide range of non-aviation events, including major festivals, sporting venues, and large public gatherings, as well as reviewing post-event enquiries and independent audits. Document sets such as TORs, Emergency Management Plans (EMPs), and emergency planning frameworks were assessed using a consistent criteria-based approach derived from established guidance. This allowed direct comparison of governance maturity, documentation quality, inter-agency coordination, and assurance processes across different sectors. Additionally, national guides and guidance were analysed for themes and ideas for good practice.

Limitations and Assumptions

3.3.14. There was a lack of engagement from some stakeholders. Therefore, because of limited feedback despite repeated requests to complete questionnaires, the evidence base is weighted towards FDD and aviation practitioner perspectives. SAG member engagement was lower than desired, and this should be considered when interpreting the findings.

[8] Developed by Professor James Reason in 1990, the model illustrates how accidents/incidents may occur when multiple layers of defence fail: https://thedecisionlab.com/reference-guide/management/swiss-cheese-model.

However, this limitation has been mitigated using multiple data sources, including document review and comparative benchmarking, as well as the consistency of themes identified across independent strands of evidence.

3.3.15. Findings should therefore be treated as indicative of strong recurring patterns rather than as a statistically representative national survey of all relevant safety specialists.

3.3.16. AI was used to support the analysis due to the volume of data collected throughout the project. The project remained researcher-led throughout, and where AI was used, its outputs were interrogated iteratively and verified before being incorporated into the analysis. Multiple AI models were used, including ChatGPT, Microsoft M365 Copilot, and Google Gemini.

3.4. KT2 – Comparative Benchmarking

3.4.1. The comparative benchmarking analysis, including the analysis of the post hoc reports, provided the primary empirical foundation, using an inductive thematic framework spanning governance maturity, inter-agency coordination, planning quality, risk management, competence and assurance. The availability of evidence did present a challenge. For example, the SGSA audits are not publicly available, which would have provided useful comparison. Additionally, for some organisations and events, TORs were readily available but EMPs weren't always published. This, therefore, is worth noting as a challenge to the overall analysis.

3.4.2. Ratings across multiple SAGs, event types, audits, and enquiry case studies were reviewed to identify patterns of strength and weakness, as well as systemic failure modes. This was supplemented by additional qualitative evidence from enquiry findings and audit commentary, which provided insight into how structural deficiencies translated into real-world outcomes, particularly in relation to unclear roles, weak challenge, and poor information integrity.

3.4.3. The NAA and UKCMA guidance, alongside the KT1 Report, were then used as interpretive and normative frameworks. The NAA/UKCMA material provided established principles of good practice, including lifecycle safety management, system-led governance, and the importance of human factors, while the KT1 Report contextualised these within the specific legal and operational environment of UK civil flying display events. By integrating these sources, the methodology ensured that recommendations were not only evidence-based but also directly applicable to the current operating document sets and environment (The Purple Guide, SGSA, Local Authority SAG guidance and processes etc).

3.5. KT3 – Conclusion of Work

3.5.1. Once KT1 and KT2 were complete, the amalgamation of respective findings and recommendations provides the data and evidence base for the full and final perspective for KT3.

4. Results from Key Task 1

4.1. Introduction

4.1.1. The baseline evidence review identified significant variation in SAG documentation, governance arrangements and integration of aviation-specific material. The Purple Guide, HSE and local authority guidance are commonly used, but the quality is variable and, in many cases, experienced SAG members use their personal knowledge to fill in any gaps.

4.1.2. There is no national standardisation leaving local authorities to manage the balance between regulatory requirements (HSE, Civil Contingencies Act) and available guidance (Good Practice Guide for Working with SAGs 2019 edition, the Purple Guide) which resulted in a wide variety of approaches. Whilst multiple Local Authorities were broadly undertaking SAGs in a similar manner, there was a wide variation in standards and practices available, which proved frustrating to EOs when trying to engage appropriately.

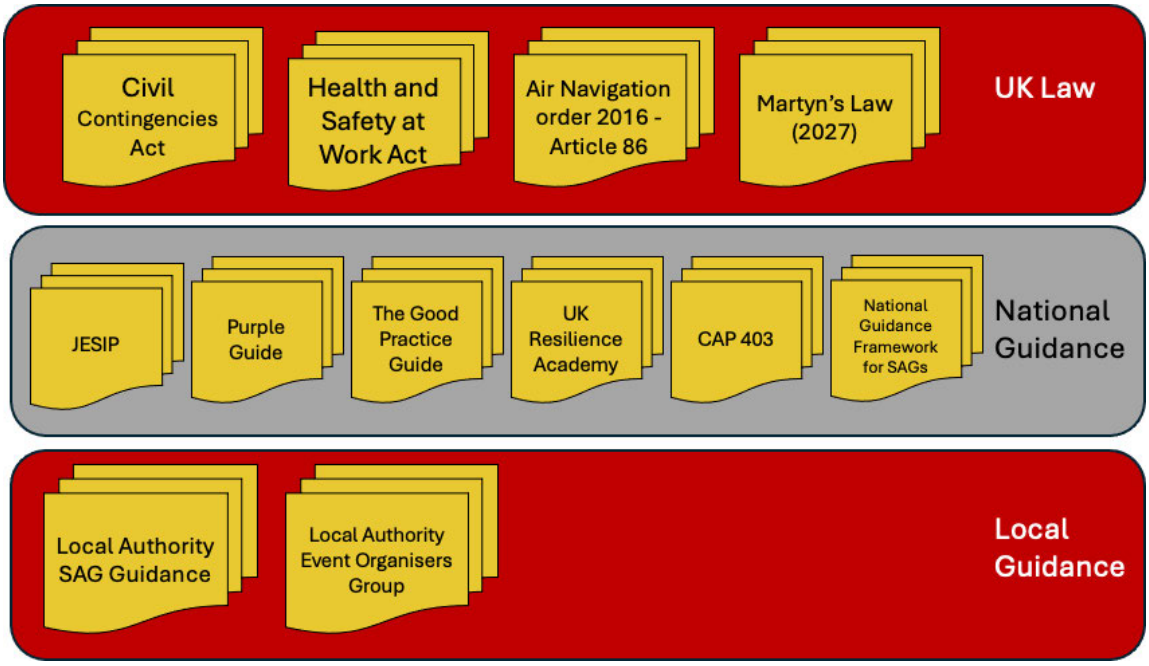
4.1.3. Importantly, the variability identified during the baseline review became a key line of enquiry for the wider study. Subsequent stakeholder engagement, system-level analysis, and comparative benchmarking were therefore used to determine whether these issues were unique to flying display events or reflected broader challenges across the UK event management environment. This provided an evidence-based foundation for assessing the maturity and consistency of SAG arrangements both within aviation and across other event sectors.

4.2. Hierarchy of Legislation and Guidance

4.2.1. At the highest level, the system is underpinned by legislation, most notably the Health and Safety at Work Act 1974, the Civil Contingencies Act 2004, and the Air Navigation Order. These instruments establish the primary legal responsibilities for safety, defining the duties of key actors within the system.

4.2.2. Beneath this legislative layer sits a broad body of guidance material that informs how these responsibilities are interpreted and implemented in practice. Key sources include CAP 403, which provides aviation-specific guidance for flying displays, the Purple Guide, which sets out good practice for outdoor event safety and the Good Practice Guide for SAGs. These documents collectively provide a non-mandatory framework for planning, coordination, and risk management.

4.2.3. At the operational level, there are Local Authority Event Organisers Group and Local Authority SAG guidance. It should be noted that there is no direct thread between the law and, for example, local authority SAG guidance; everything below the level of the law is guidance and, as such, there is no mandate for its use.



4.3. HSE Event Guide

4.3.1. EOs have a legal duty under the Health and Safety at Work Act 1974 to ensure, as far as is reasonably practicable, the health, safety, and welfare of employees, volunteers, contractors, and attendees. This includes conducting risk assessments, implementing safety plans, and maintaining site safety during build-up, the event itself, and dismantling.

4.3.2. Based on the current Health and Safety Executive guidance[9], SAGs:

- Provide independent advice; they are not a decision-making body and do not "approve" events
- Bring together the local authority, emergency services, and other relevant bodies to share information
- Primary task is to review and challenge the organiser's Event Management Plan.
- Should ideally be chaired by a senior local authority officer independent of the event planning process
- Help ensure a consistent approach to safety across different types of events in a region
- Act as a central point for agencies to flag concerns, such as traffic impact or public health risks
- Should provide reasonable advice and not place an undue burden on lower-risk events
- Should keep formal minutes and action points to serve as a public record of the safety consultation process

4.3.3. Note that HSE guidance states that **not all events need a SAG**; involvement should be based on the scale, complexity, and risk profile.

[9] https://www.hse.gov.uk/event-safety/managing-an-event.htm

4.4. Civil Contingencies Act

4.4.1. The Civil Contingencies Act 2004 establishes the statutory framework for emergency preparedness, inter-agency cooperation, public warning and informing, and emergency planning arrangements within the UK. These arrangements underpin the multi-agency planning and resilience structures commonly utilised for public event safety management, including Local Resilience Forums and SAGs. Whilst not direct legislation that pertains to events, it establishes local arrangements for civil protection by placing duties on:

- Police
- Local authorities
- Ambulance services
- Fire services
- NHS bodies
- Transport operators
- Airports
- Harbour authorities

4.4.2. Although the Civil Contingencies Act 2004 applies across the UK, Scotland operates its own resilience framework, guidance, governance arrangements, and responder structures. This is done through bodies such as the Scottish Resilience Partnership and Regional Resilience Partnerships. It means that emergency planning and multi-agency coordination for Scottish Flying Display Events such as the [redacted] are delivered under a distinct Scottish implementation model despite being founded on the same primary legislation.

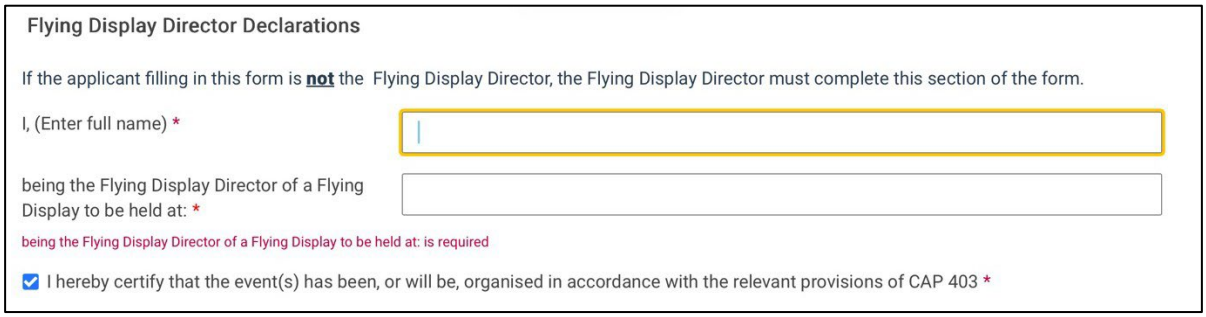
4.5. CAP 403 and Article 86

4.5.1. Article 86 of the Air Navigation Order[10] pertains to the organisation and safe conduct of Flying Displays and Special Events. It creates the legal basis for CAA flying display permissions and CAA oversight of FDDs as it is the FDD who is issued the permission for a Flying Display to be undertaken and who is therefore responsible for the safe conduct of that flying display. Article 86 does not reference EOs or SAGs.

4.5.2. CAP 403 recognises the importance of early liaison with local authorities and emergency services and refers to notification to the local SAG as a means of enabling early guidance and support. However, SAGs remain advisory in nature and do not themselves replace the responsibilities of the EO, FDD, regulator or other statutory bodies.

4.5.3. Article 86 which is the law, does not require any interaction from the SAG, however, the flying display application requires the FDD to state that the display has been organised in accordance with CAP 403[11], a guidance document which mandates that the FDD should liaise with and contact emergency services at the start of the planning phase. This can be an issue if no liaison is possible as the FDD would either have to contravene CAP 403 for the display to go ahead or cancel the display.

[10] https://www.legislation.gov.uk/uksi/2016/765/article/86
[11] CAP403 Chapter 7 para 7.6.


Flying Display Director Declarations

If the applicant filling in this form is **not** the Flying Display Director, the Flying Display Director must complete this section of the form.

I, (Enter full name) *

being the Flying Display Director of a Flying Display to be held at: *

being the Flying Display Director of a Flying Display to be held at: is required

I hereby certify that the event(s) has been, or will be, organised in accordance with the relevant provisions of CAP 403 *

4.6. The Purple Guide to Health, Safety and Welfare at Outdoor Events

4.6.1. The Purple Guide to Health, Safety and Welfare at Outdoor Events (The Purple Guide) contains a dedicated aviation-specific section: Chapter 43 - Air Displays. It contains guidance for the safe planning, management and delivery of civil flying display events. It covers:

- Regulations
- The FDD
- Collaboration and Communication
- Risk Assessment Process
- Suitable Sites
- Weather
- Timing
- Human Factors
- Military Participation
- SAG and Emergency Services Liaison
- Risk Assessment

4.6.2. However, as this is not legislation, there is no requirement for local Authority SAGs to adhere to it.

4.7. The Good Practice Guide to Working in Safety Advisory Groups (2019)

4.7.1. The Guide provides comprehensive, albeit slightly dated, guidance on how SAGs support safe event delivery through multi-agency collaboration. It outlines SAG purpose, structure and processes, emphasising their advisory (non-statutory) role in quality assuring event safety, promoting risk-based decision-making and clarifying that organisers retain responsibility. It also details the legal framework affecting events, highlighting that while SAGs have no direct powers, member agencies apply legislation (e.g. licensing, health and safety, fire safety) to protect the public. The guide also provides practical examples, including risk assessment, procedures, and information sharing. Its aim is to promote proportionality, consistency, early engagement, and collaborative working to enable safe events. An updated version is in production.

4.8. The National Guidance Framework for SAGs: Principles, Roles and Practice

4.8.1. This is expected to be published in 2026 as umbrella guidance for SAGs. It is anticipated to provide a unified national approach to how SAGs operate across the UK defining the core principles of advisory practice, the roles and responsibilities of SAG members and chairs, and standardising operational processes such as risk assessment, meeting structures, and escalation pathways. The framework is expected to address some of the challenges and inconsistencies identified through this review by formalising governance arrangements, including conflict-of-interest management and links with local

resilience forums. It is also expected to introduce enhanced training requirements, particularly for SAG chairs, to improve capability and the quality of decision-making. The guidance is understood to have been developed with input from the UK Resilience Academy, central government, regulators, and the emergency services, and aims to reinforce the advisory nature of SAGs while strengthening accountability and coordination in response to findings from recent inspections and reviews.

4.9. Joint Emergency Services Interoperability Principles (JESIP)

4.9.1. JESIP is a UK framework designed to help the main emergency services work together more effectively during major incidents. It supports the CCA by providing the 'how'. The CCA says that responders must co-operate, JESIP explains how to do it and operates in 5 key principles:

1. Co-locate. Responders should work together at the scene when possible
2. Communicate. Share information clearly and consistently
3. Coordinate. Align actions and decisions across services
4. Jointly understand risk. Assess threats together and agree on priorities
5. Shared situational awareness. Build a common understanding of what's happening

4.10. Martyn's Law

4.10.1. Martyn's Law, formalised in the Terrorism (Protection of Premises) Act 2025, received Royal Assent on 3 April 2025 and is expected to come into force no earlier than April 2027.

4.10.2. The law will require venue and event operators to assess and mitigate terrorist risks through proportionate security measures, staff training, and clear response plans for controlled-entry events with 200 or more attendees (there is also an enhanced tier for events with 800 or more attendees). For qualifying civilian flying display events, its application means the EO would need to provide structured risk assessments addressing crowd density, site access, and potential hostile threats, alongside existing aviation safety controls. Organisers would need coordinated emergency procedures, communication strategies, and liaison with police and local authorities. By embedding counter-terrorism awareness within event planning and operations, Martyn's Law aims to strengthen public protection and resilience at events, including airshows, while building on existing regulatory frameworks rather than duplicating them.

4.11. Local Authority SAG Guidance

4.11.1. The guidance available was variable in quality. In some cases, the guidance was robust and included TORs, in others, the guidance pointed to the Purple Guide. Some material was in a consolidated format, for example a downloadable PDF, others were web-based consisting of several webpages. Finally, many guidance documents contained contact details for SAG members which were out of date, so whilst an attempt to be comprehensive had been made, as the documents had not been updated, they were, in effect, out-of-date.

4.11.2. The SAGs analysed were: [redacted]. To provide an objective assessment against a benchmark and against each other, each was compared against the respective sections of The Purple Guide to determine their alignment and adherence to National level guidance with the following results:

Local Authority / Organisation	% of alignment with the Purple Guide
[redacted]	[redacted]

4.11.3. Full details can be found at Appendix D. Whilst non-contextual data, this dataset was informed by wider discussion, questionnaire responses and one-to-one interviews with key stakeholders; as such, this dataset formed the baseline for the wider event SAG comparison exercise.

4.12. Terms of Reference

4.12.1. The review also identified that formal TORs did not exist in higher level documentation (Health and Safety Executive event guide and Purple Guide) but were in effect in some Local Authority guidance. Even when TORs were referenced, they were not always consistently accessible or standardised and, as highlighted during one-to-one interviews, were not always well understood or consistently applied by all participants.

4.13. Review Results

4.13.1. The results of the review, whilst thought provoking, were not conclusive and as such supported the methodology of gaining subjective evidence from key stakeholders via a structured data set (a questionnaire) and more subjective feedback via one-to-one semi-structured interviews.

4.14. Stakeholder Engagement

4.14.1. To engage the required people and gain data around the understanding of legislation, boundaries, and responsibilities, a questionnaire was emailed to all relevant stakeholders, starting with Flying Display Directors (FDDs) whose contact details were available through the CAA. This in turn allowed the team to gain access to additional stakeholders at the SAG level[12]. During the period 9 March to 30 April, a total of 93 Questionnaires were sent out to stakeholders. However, AAC only received a total of 35 returns, breakdown below[13]:

	FDDs	EOs	SAG members	Other	Total
Number Sent	27	8	55	3	93
Number returned	16	6	11	2	35
% return	59%	75%	20%	66%	37%

Note that of the 35 returned, 9 were returned anonymously.

4.15. Engagement levels by cohort

4.15.1. Engagement was stronger from FDDs and aviation-facing stakeholders than from local authority SAG members. This represents a limitation, but the pattern itself is relevant to

[12] Note that whilst the CAA maintains a list of FDDs and their contact details, there is no such list for SAG chairs or members, hence a cascade from FDD to EO to SAG was required to allow the team to gain access to and engage at the SAG level.

[13] It should be noted however that the industry standard survey response rates generally range between 10-30%, with 20-25% typical for email surveys and over 30% considered excellent.

the review because it reflects the practical difficulty of accessing and engaging the SAG system nationally.

4.15.2. It should be noted at this point that as mentioned above in para 3.3.7.1, this limitation is mitigated by document review, the quality of interviews, and the consistency of themes across different evidence sources.

4.16. Questionnaire Findings

4.16.1. The recurring themes found from the questionnaires are shown below (for full summary of results see Appendix B):

- 82% of respondents stated that they understood their responsibilities within the safety structure of their flying display
- 53% of respondents were very confident in their ability to fulfil their safety role on their SAG
- 14% considered that their SAG was not a suitable size for their event (7% said ‘no’, 7% were ‘unsure’
- SAGs were considered to be very well supported across the following functions: Police, Fire and Rescue, Ambulance / Medical, Local Council, Highways and Transport
- 70% of respondents stated that their SAG operated under a formal set of TORs
- TOR definition was more variable however with only an average of 55% agreeing that the TORs were very clearly defined across all categories
- 73% stated that where TORs were in effect, they were adhered to
- When asked however, only 17% of respondents were able to provide a copy of their TORs
- Of note, only 27% of people who responded to the questionnaire stated that the roles of the individual SAG members were clearly defined
- Finally, 53% of respondents stated that the boundary between SAG advisory responsibility and legal accountability was very clearly understood, with 23% stating that it was not very clearly understood.

4.17. Semi-structured Interviews

4.17.1. A total of 15 follow-up semi-structured interviews were conducted with stakeholders. These interviews provided greater fidelity around the SAG engagement and advice process. This allowed the team to understand the interactions from both the FDD/EO side of an event and from the SAG perspective.

4.17.2. The main interview themes that emerged are as follows:

- **The FDD is frequently relied upon to explain aviation principles and terminology to SAG members,** while also being part of the plan being reviewed. This creates structural tension, particularly if no independent aviation expertise is available.

- **Several FDDs expressed frustration at SAG disorganisation** and lack of aviation awareness and suggested that there might be a way for SAGs to gain aviation input without it coming from the already busy FDD, thus freeing up that individual to concentrate on the flying display. Options put forth by stakeholders to resolve this included aviation awareness training provided by the CAA and the provision of independent aviation advice.

- **Stakeholders consistently reported variation in SAG practice**. SAGs that were the most comprehensive were associated with experienced chairs, repeat events, mature local authority systems, small group tabletop exercises, and pro-active emergency service participation. Weaker examples were characterised by unclear authority, limited aviation understanding, poor accessibility, unconducive environments to challenge in, or disproportionate or incomplete processes.

- **Interviewees broadly supported the value of SAGs** but repeatedly distinguished between the value of multi-agency coordination and the more limited ability of SAGs to advise about aviation-related considerations within the ground element of an event.

4.17.3. The full interview mapping and comparison matrix can be found at appendix E.

4.18. Stakeholder Results Analysis Process

4.18.1. The responses and themes identified in the questionnaires and interviews were combined and analysed through Thematic Analysis, a Human Factors Lens, and using Critical Discourse Analysis.

4.18.2. **Thematic Analysis**. In the context of this research, inductive thematic analysis was used which allowed themes to emerge from stakeholders' questionnaires and interviews. This involved several distinct stages:

1. **Familiarisation and Coding**. Researchers studied the raw questionnaire and interview responses of individual participants to understand broad themes and assign identifying codes to any repeating themes. Themes were coded into 7 overarching themes such as "1. Safety Governance and Structures", with 30 sub themes such as "1.1 Role Clarity & Boundaries".

2. **These were then used to map agreement and divergence,** particularly highlighting "fault lines," such as the strongly opposing views regarding whether SAGs should possess aviation knowledge.

3. Finally, themes were then synthesised across all participants, producing a structured matrix to compare experiences across the spectrum of SAG, FDD, and EO participants at Appendix E.

4.18.3. **Human Factors Analysis & Classification System (HFACS)**. When analysing the collected data, HFACS categorised the narrative data into four hierarchical levels:

1. **Organisational Influences**. In our research, this manifested as ideas like the lack of a "shared national SAG identity" or an over-reliance on specific professional experts, rather than stable SAG structures.

2. **Unsafe Supervision**. In our research this is highlighted in ideas such as "undefined or unused" escalation pathways for stakeholders to highlight safety concerns; and request for enhanced training for FDDs especially regarding interaction with SAGs.

3. **Preconditions for Unsafe Acts.** This analysis helped capture the 'mental models' and environmental factors involved, including the high cognitive load placed on FDDs when they are required to compensate for weak or disengaged SAGs, or when they are expected to provide aviation expertise beyond both their own responsibilities and the advisory remit of the SAG.

4. **Unsafe Acts (Latent)**. In our data, these specific hidden systemic vulnerabilities included "friction in emergencies" during misdirected tabletop exercises or the "over-assertion" of authority by SAG members who are unfamiliar with aviation.

4.18.4. **Critical Discourse Analysis (CDA)**. In the context of our collected data on UK civilian flying displays, CDA identified how power and authority was understood by participants. For instance:

1. **The Power of Framing.** Describing a SAG as "fundamentally advisory" versus possessing pseudo-assurance or "quasi-approval" reveals a struggle over who is perceived as holding the authority.

2. **Authority Gradients.** In our research, CDA uncovers how the authority of the FDD is reinforced through professional discourse, potentially (and possibly necessarily) making up for poorly engaged SAGs.

3. **Ideological Fault Lines.** The philosophical divide we noted in the responses from FDDs regarding aviation knowledge in SAGs was analysed. The spectrum in opinion could potentially be viewed as a discursive move to protect the FDD's professional boundary from external interference or misunderstanding.

4.18.5. In this research, CDA highlights the lack of shared understanding of what a SAG is, or should be, as well as the discrepancies in expectation of aviation knowledge within SAGs. This stems from conflicting institutional languages and understanding of SAG purpose, rather than just personal disagreement.

4.19. Summary of KT1 Results

4.19.1. The baseline evidence review confirmed that, while the system is often described in formal terms, there is a notable distinction between "work as imagined" (TORs, EMPs, etc) and "work as done" (Questionnaire and interview evidence). In principle, the system is designed to operate through clearly defined interfaces between EOs, FDDs, and SAGs. In practice, however, these interfaces are frequently interpreted differently across contexts.

5. Results from Key Task 2

5.1. Introduction

5.1.1. After extensive review and comparison of the events, organisations, audits, enquiries, and stadium documents highlighted below, results were able to be drawn to then allow a comparison with KT1 results (see section 6 for details). This allowed deeper analysis of both work-as-imagined (TORs, Event Management Plans, A-guide etc), and work-as-done (post hoc enquiries and audits), which provides a useful balance between what is envisaged or expected, and what happens in moments of tension.

5.2. Events/Organisations

5.2.1. The following events/organisations, enquiries, stadiums[14] and guides were analysed:

- [redacted]
- SGSA Guidance
- National Arena Association A-Guide
- UK Crowd Management Association – "Safer Crowds ... " Good Practice Guide

[14] Stadiums (operate under SGSA).

[15] Scottish law sets out different requirements for event safety management than English law. Edinburgh's approach to events is shaped by Scotland's distinct legal and regulatory environment, particularly differences in local authority powers, policing structures, and licensing frameworks which results in a different governance construct. As such direct comparison is challenging, albeit useful for flying display events in Scotland.

5.3. Results

5.3.1. The full results in the dataset can be found at Appendix F. This simple comparison provides background and objective comparative data from which to objectively understand the organisation or event operating model but requires additional review to provide a fuller picture.

5.4. Analysis of Results

5.4.1. Using the dataset and reviewing each organisation, event, stadium, audit, enquiry, or guide against the objective assessment, the following results were drawn:

- **Role definitions**. Comparative benchmarking identified widespread inconsistency in the definition of roles, decision-making authority, escalation routes, and accountability across SAGs, with many systems lacking clear TORs or operating with poorly defined boundaries.

- **Formal Structures**. The Maccabi enquiry demonstrated that although formal structures existed, unclear role definitions led to advisory bodies effectively acting as decision-makers, blurring the distinction between advice and accountability and resulting in ‘advisory creep’ and weak challenge. Similarly, the Manchester Arena (Kerslake) report identified confusion between command and coordination functions, particularly where leadership and coordination roles were not clearly distinguished, leading to delayed and limited decision making.

- **Audit**. Evidence showed weak audit trails and inconsistent documentation. Event safety plans were variable in quality as were emergency procedures, crowd modelling, and wider governance paperwork. This is supported by evidence from NAA/UKCMA guidance emphasising the importance of validated inputs.

- **Event Lifecycle**. A key theme that emerged from the evidence was the idea of the full lifecycle of an event, from initiation of planning to debriefing and implementation of lessons identified. While aviation more routinely adheres to a cycle, the KT1 report found this to be inconsistent across the sector; the same was found during the KT2 benchmarking exercise.

- **Risk Assessment and Communication Failures**. Evidence showed failures in structured challenge and balanced risk assessment processes. This is due to bias and lack of willingness to challenge along with evidence of communication failures. Robust NAA/UKCMA guidance on dynamic decision-making is available, but evidence suggests this guidance is inconsistently followed.

- **Disproportionate Governance**. Comparative benchmarking demonstrated that systems currently apply governance unevenly, with some low-risk events subject to disproportionate advisory burden, while higher-risk or complex events may not receive sufficient scrutiny or structured oversight. This inconsistency is reflected in the absence of clearly defined thresholds for escalation, engagement, or enhanced governance, with several cases noting unclear criteria for referral to, or involvement of, SAGs. Useful post-hoc evidence from audits and enquiries reinforces the

consequences of this imbalance. The South Ribble audit identified a lack of defined criteria for SAG engagement, leading to unclear ownership, inconsistent participation, and gaps in oversight across events of differing size and risk levels. Similarly, the City of York SAG audit highlighted a weak definition of roles and engagement expectations, compounded by reliance on individual coordinators rather than a scalable system approach, based on event size and risk level. While not the subject of an audit, the best documentation within the benchmarking dataset (Portsmouth and Bath) demonstrated structured and proportionate engagement, where governance intensity was required to increase in line with event complexity, including more frequent meetings, enhanced documentation and greater multi-agency involvement.

- The NAA and UKCMA guidance provide a clear normative framework for proportionality, emphasising that safety management systems must be adaptable to the size and risk profile of each event, and that resources, planning effort, and oversight should be aligned accordingly. These guides highlight that both under and over-governance introduce risk while insufficient oversight may fail to identify critical hazards. Disproportionate processes which overly focus on the size of an event but take no account of the relative risk can divert focus, reduce efficiency, and may mean smaller events which could be carrying relatively high risk may not receive the due diligence those risks require from SAGs and Local Authorities.

5.5. Comparative Benchmarking Summary

5.5.1. In summary, the comparative benchmarking phase demonstrated that the effectiveness of safety governance systems is determined less by event type and more by the quality of implementation. The same core factors (clarity of roles, consistency of documentation, alignment of behaviours, and application of whole-event lifecycle management) drive performance across all sectors. The findings confirm that focusing on strengthening these areas, drawing on transferable good practice, rather than introducing new structures or regulatory mechanisms, will not only strengthen the SAG support to flying displays, but also be of utility to the wider event sector.

6. Comparison of KT2 with KT1 Results

6.1. Introduction

6.1.1. Using the baseline evidence from KT1, the events listed at para 5.2.1 were analysed and reviewed against key categories in The Purple Guide to allow for both a direct comparison with the guide itself and comparison against each other using The Purple Guide as the standard; this was then added to the KT1 data set.

6.1.2. This comparison determined objective adherence to The Purple Guide with the working assumption being that a more complete document set would be more effective than one that was lacking. This assumption does not consider the subjective delivery or adherence to the SAG document set for each SAG as this is unable to be determined.

6.1.3. Once completed, the documents themselves were analysed for trends, evidence of good practice, and material differences to the Flying Display SAGs which provided for additional subjective information to build a fuller picture of wider event SAG effectiveness and allow for improved comparison.

6.2. Data Comparison

6.2.1. The comparison exercise provided insight into the comprehensiveness of SAGs across a range of events, with mixed results (full table can be found at Appendix F):

Comparison Category	Overall adherence of Flying Display SAGs to the Purple Guide	Overall adherence of non-Flying Display SAGs/events/organisations
Governance Maturity	80%	71%
Inter-Agency Co-ordination	81%	67%
Event Safety Plan	92%	82%
Risk	84%	75%
Competence and Professional Capability	60%	70%
Assurance and Learning	45%	60%
Proportionality and Scalability	93%	78%
Regulatory Environment	68%	81%
Overall	75%	73%

6.2.2. The table above gives a useful quantitative comparison of the data derived from evidence collected in KT1 and 2. However, it should be noted that:

- The Flying Display SAG dataset is 75% smaller and may be biased towards FDD viewpoints due to the balance of returns in KT1, so the evidence may not be representative of the whole sector
- Two Flying Display SAGs scored greater than 90% overall vs 6 non-flying Display events
- Wembley, the University of Bolton Stadiums, and the Portsmouth EMP all scored greater than 96%. Of note, the stadiums sit under a more formal legal framework (the SGSA)

- The Flying Display event sector is comparatively weak in the Assurance and Learning elements, and the Competence and Professional Capability elements (noting the caveat regarding potential data bias)

6.2.3. In broad terms, the data shows that Flying Display SAGs are generally no less comprehensive than other event SAGs, organisations, audits, or guides. There are examples of excellence and areas that could be improved across both.

6.3. Overall Results

6.3.1. The benchmarking, supported by post-event enquiries and audits, found that no single model is complete in isolation. Transferable and repeatable good practice emerges from combining clear governance, SAG oversight, and strong operational delivery within a single safety management system. This principle is directly applicable to improving clarity of roles and responsibilities within UK civil flying displays.

6.3.2. Across all sub-themes, the benchmarking showed that[16]:

- [redacted] EMP demonstrated good practice in the areas of operational safety management, command structures, and risk integration.
- [redacted] SAG and SGSA models represented an excellent example of good practice in governance, accountability, and regulatory definition.
- [redacted] PESAG TOR and [redacted] SAGE provide strong examples of multi-agency coordination, proportionality, and oversight.
- [redacted] EMP provides robust operational planning support, although with less integration.

6.4. Common Themes

6.4.1. Several common themes emerged across the benchmarking examples:

- Clear governance and defined roles are essential to reduce uncertainty and inconsistent decision-making.
- Consistent governance arrangements improve documentation, coordination, and assurance outcomes.
- High-quality written and verbal inputs are critical; poor documentation, weak validation, and limited challenge undermine safety.
- Lifecycle safety management remains inconsistently applied, with excessive focus on planning rather than continuous management, review, and learning.
- Human factors, crowd behaviour, and event design are not consistently integrated despite their influence on risk.
- Operational resilience, particularly communication, situational awareness, and coordination during live events, often requires strengthening.

6.5. Comparison Summary

6.5.1. The benchmarking found that SAGs supporting a wide range of events experience many of the same challenges identified within flying displays. As a result, there is little evidence

[16] It is acknowledged these organisations were also the ones that most data could be found for (generally TORs and EMPs).

that Flying Display SAGs are fundamentally different from those supporting other event types, particularly as they often involve the same agencies and personnel.

7. System Level Analysis

7.1. Introduction

7.1.1. A system-level assessment of how roles, responsibilities, and safety controls operate collectively across UK civil flying display events was conducted. Drawing on documentary review, questionnaire data, and stakeholder interviews, the analysis examined how governance arrangements function in practice, with particular attention to consistency, clarity of roles, and perceived effectiveness at key interfaces between actors.

7.1.2. At a foundational level, the evidence demonstrated that the safety system is not defined by a single coherent framework, but rather by the interaction of legislation, guidance, and local practice. The primary legal accountabilities sit with the EO under Health and Safety legislation and with the FDD under the Air Navigation Order. SAGs operate outside this statutory structure and are supported by non-mandatory guidance. This structural arrangement creates an inherently distributed system in which clarity of interpretation, rather than formal prescription, appears to be the most decisive element.

7.2. Documentation

7.2.1. The documentary review confirms that there is significant variation in how the SAG system is implemented across local authorities. While most frameworks align broadly with the principles of multi-agency coordination described in the Purple Guide and other guidance, the level of detail, governance maturity, and operational integration differs substantially. Stronger examples demonstrate well-developed arrangements for emergency planning, command and control, and inter-agency working, whereas weaker examples show partial coverage, reliance on informal processes, or limited integration of aviation-specific considerations. This variation is reinforced by questionnaire findings and stakeholder interviews, which consistently indicate that perceived SAG effectiveness is closely linked to local capability, experience, and continuity rather than adherence to any consistent national model.

7.2.2. Overall, the comparative document review and benchmarking exercise allowed the team to draw the following comparisons and conclusions:

- There is no law that governs SAGs, only guidance documentation
- The only three directly applicable laws are:
  - The Health and Safety at work act, which pertains only to the EO
  - The Air Navigation Order, which pertains only to the FDD
  - The Civil Contingencies Act, which underpins multi agency collaboration
- There is a multitude of guidance documentation, but no mandated reading or official national document hierarchy
- Local authority SAG guidance is variable in quality
- TORs or even TOR templates do not exist in higher level guidance documents and only sometimes exist at the local authority level

7.2.3. All the issues above lead to a lack of standardisation which leads to personal experience filling the gaps which in turn leads to variability in the quality of SAG advice[17].

[17] It is worth noting here that whilst SAGs are wholly advisory, their advice might be used following an accident by a prosecution against a defendant who has not considered it. This reinforces the point that SAGs need well defined and arguably standardised TORs to provide consistency to EOs and FDDs and prevent SAGs from straying into areas outside their expertise.

7.3. SAG Composition and Functionality

7.3.1. This variability extends directly to SAG composition and functioning. Evidence from interviews indicates that SAG staffing and engagement are often constrained by local authority resourcing, with many participants undertaking SAG duties alongside primary roles. This leads to uneven availability, slower response times, and variability in the depth and quality of advice provided. In some cases, access to SAG support is limited, particularly for smaller or less established events, creating practical challenges for EOs. For example, during one interview, there was a disclosure regarding local authority staff operating a limited working week for normal business; however, the SAGs were organised on a Tuesday each week (SAG day) when that was the only day of the week that the SAG chair was not at work.

7.3.2. Of note, some FDDs/EOs struggled to gain SAG support for smaller flying displays. This put them in a difficult position as per the CAP 403 situation described above at para 4.5.3.

7.3.3. Despite these limitations, most stakeholders still considered SAGs to provide value as a forum for multi-agency coordination, information sharing, and emergency planning. Where SAGs were viewed positively, this was typically linked to clear chairing, proportionate engagement, continuity of personnel, and constructive working relationships between agencies, EOs, and FDDs. Conversely, where these factors were absent, SAGs were more likely to be perceived as inconsistent, overly bureaucratic, or lacking operational relevance to flying display activity.

7.4. System Mapping of Roles and Responsibilities

7.4.1. Roles and responsibilities are broadly understood in principle but inconsistently interpreted in practice, a classic Human Factors issue of work-as-imagined versus work-as-done. Quantitative analysis of stakeholder responses shows wide variation in alignment with defined safety system criteria, ranging from very high levels of alignment in some cases to minimal alignment in others. This spread indicates that while the system contains the necessary components for useful safety governance, their application is uneven and highly dependent on individual understanding and behaviour. The implication is that the system functions less as a standardised framework and more as a set of interacting practices shaped by local interpretation.

7.4.2. These results indicate that there is no consistently shared understanding across the flying display environment of how the individual elements of the overall system fit together. While some stakeholders did demonstrate a strong alignment and understanding, the wide variation in results, including amongst highly experienced individuals, indicates that roles, responsibilities and system expectations are interpreted inconsistently. The evidence suggests the system currently relies heavily on individual competence, relationships, and organisational maturity rather than consistently applied principles or structures. This appears to contribute to variable assurance, inconsistent SAG behaviours, differing levels of oversight and uneven application of proportionality between events.

7.5. Interface Analysis

7.5.1. Inconsistencies become most apparent at key interfaces, particularly between SAG advisory functions, EO accountability, and FDD technical authority. Evidence from both the questionnaires and interviews indicates that these boundaries are not always clearly understood. In some cases, SAG advice is interpreted as implicit approval or assurance, while in others, SAGs are insufficiently engaged to provide meaningful input.

7.5.2. This ambiguity is further compounded by the interface between CAP 403 guidance and the flying display application form, where the use of non-mandatory language around liaison creates uncertainty as to whether engagement with SAGs is expected practice or a formal requirement. The result is a system characterised by differing expectations, inconsistent behaviours, and variable governance outcomes.

7.5.3. The independent expert challenge and SME support provided by the SAG reinforces the importance of SAG members understanding their individual roles along with FDDs and EOs understanding where the advisory/regulatory boundaries are and what capabilities the SAG can provide. The subjective evidence shows that SAGs are perceived to be most effective in relation to ground-event safety, emergency preparedness, and multi-agency coordination. Their contribution is therefore primarily in managing the consequences of aviation incidents rather than influencing the likelihood of such events.

7.5.4. This distinction is critical, as it defines the limits of SAG responsibility and prevents inappropriate expectations that they should provide aviation assurance or replicate regulatory oversight. Where this boundary is not clearly understood, there is a risk of either overreach into areas beyond SAG competence or under-engagement with relevant ground-based risks.

7.6. Coordination and Integration

7.6.1. The coordination and integration function of SAGs emerges as their most consistent strength across all evidence sources. SAGs provide a single forum through which multiple agencies can engage with the EO, reducing fragmentation and enabling shared situational awareness.

7.6.2. This function is particularly important for large or complex events, where dependencies between transport, crowd management, emergency response, and public safety create the need for integrated planning. However, the effectiveness of this coordination varies significantly depending on the maturity of the SAG and the quality of engagement between participants.

7.7. Proportionality of Burden

7.7.1. The evidence shows that there is no consistently applied approach to scaling SAG involvement according to event size, complexity, or risk. Larger, established events tend to benefit from structured governance processes and sustained engagement, while smaller events may experience either limited access to SAG support or disproportionate administrative burden.

7.7.2. Two case examples of this are [redacted] enjoys the benefit of a full cross functional multi agency SAG run by [redacted] and supported by all the relevant agencies. [redacted] which also comes under the purview of [redacted] struggles to gain access to a SAG. [redacted] is a Tier 2 Flying Display with up to 40 aircraft, and an average crowd of 5,500. An accident at [redacted] could have a major impact, yet no SAG supports the EO.

7.7.3. This inconsistency creates both inefficiencies and potential safety gaps in emergency response, particularly where meaningful SAG engagement is absent.

7.8. Identification of System Issues

7.8.1. Across the system, a set of interrelated issues emerges. The principal system issues identified were:

- No mandated SAG national guidance
- Inconsistent use by the SAGs of what available guidance there is
- Unclear advisory boundaries between SAG advice and regulation
- Variable aviation understanding of SAG members
- Limited access to independent aviation expertise for SAGs
- Inconsistent SAG TOR use
- Reliance on individual capability within each SAG
- Fragile corporate memory within some local authorities

7.8.2. These factors do not operate in isolation but reinforce one another. For example, limited SAG aviation understanding increases reliance on individuals such as the FDD, while unclear boundaries increase the likelihood of advisory creep or disengagement. Similarly, the absence of standardised TORS reduces clarity of purpose and consistency of operation across SAGs.

7.9. Thematic Analysis

7.9.1. The thematic analysis of the combined questionnaire and interview data provide further insight into how these issues manifest in practice. Across all stakeholder groups, SAG role ambiguity is identified as the dominant theme, particularly at the interfaces between organisations. This ambiguity contributes to advisory creep, where SAGs are perceived as approval bodies, and to a reliance on informal relationships and behavioural factors rather than structured guidance or governance. Trust and continuity are shown to be critical enablers of effective systems, but they also introduce fragility, as performance becomes dependent on specific individuals rather than transferable processes.

7.10. Human Factors Mapping and HFACS analysis.

7.10.1. Human factors analysis indicates that safety challenges are predominantly systemic rather than driven by individual error. Indeed, it should be recognised that the individuals we interviewed repeatedly demonstrated and emphasised their commitment to safety and excellence but recognised where they faced challenges in delivering these.

7.10.2. Organisational ambiguity, inconsistent supervision, and misaligned mental models create latent conditions that shape behaviour. At the operational level, risks arise not from deliberate unsafe acts but from untested assumptions, incomplete preparation, and unresolved issues originating earlier in the planning process. This reinforces the conclusion that system performance is determined primarily by how roles are interpreted and how stakeholders interact, rather than by the existence of formal rules alone.

7.11. Critical Discourse Analysis

7.11.1. Critical discourse analysis further highlights that stakeholders construct differing narratives about authority, risk, and responsibility. While SAGs are formally described as advisory, language frequently reflects expectations of oversight or approval. Similarly, professional groups frame safety in different ways, with FDDs emphasising technical control, EOs focusing on delivery and accountability, and emergency services prioritising consequence management. Where these narratives compete rather than collaborate, they contribute to inconsistent expectations and reinforce the lack of a shared understanding of the system.

7.12. Analysis Summary

7.12.1. Overall, the system-level analysis demonstrates that the primary challenge is inconsistent interpretation and a lack of shared understanding. Variation in practice, ambiguity in roles, and reliance on individual capability collectively shape system performance. Where the system works well, it does so because behaviours, relationships, and expectations are aligned; where it performs poorly, it is due to misalignment at these same interfaces. The evidence therefore supports the conclusion that improving SAG clarity, consistency, and guidance is likely to deliver greater benefits to the system.

7.13. Comparative Benchmarking

7.13.1. The findings from comparative benchmarking found no material evidence that Flying Display SAGs face fundamentally different governance challenges from those encountered elsewhere within the UK events sector. Not only does this concur with the system-level analysis, but it also confirms that the opportunities for improvement within the current UK civil flying event sector lie in strengthening SAG consistency, alignment, and system coherence, rather than introducing new structures or regulatory frameworks.

7.13.2. By adopting and adapting the transferable good practices identified through benchmarking, the SAGs involved in UK Civilian Flying Display Events may be able to enhance their existing systems, achieve greater consistency, improved clarity, and more reliable safety outcomes.

8. Transferable Good Practice

8.1. Introduction

8.1.1. Identifying transferable best practice in a complicated sector such as event management is fraught with difficulty. The Cynefin framework provides a useful lens for understanding the types of challenges the events sector faces and that are addressed within this report. In the context of safety governance for flying display events, most issues sit within the complicated domain of the Cynefin model, where cause-and-effect relationships do exist but are not always immediately visible. These challenges involve “known unknowns,” requiring informed judgement, professional expertise, and careful analysis to interpret risk, define responsibilities, and apply governance effectively. Within this domain, there is no single ‘best practice’ solution that can be uniformly applied across all events. Instead, effective outcomes depend on the consistent application of good practice, supported by clear principles but allowing for proportionate, context-specific variation. This reinforces the need for guidance that enables expert-led decision-making within defined boundaries, rather than imposing rigid or overly prescriptive models that may be inappropriate across differing event scales and contexts

8.1.2. No single authority demonstrated high levels of excellence in delivery across every area of safety management. However, [redacted] (EMP), [redacted] SGSA-style governance, and the stronger SAG TOR models ([redacted] consistently represented the highest standards.

8.2. Multi-Agency Coordination

8.2.1. [redacted] demonstrated high maturity through effective multi-agency coordination and integration of public safety considerations. However, its approach is formed from the legal requirements in [redacted] law, including local authority coordination and partnership, which is different from [redacted] legal requirements. The [redacted] coordination and integration were excellent but different from the equally strong formal command-and-control and Joint Emergency Services Interoperability Principles aligned structures evident in [redacted].

8.3. Effective Safety Management

8.3.1. A consistent finding across the reviewed evidence is that effective safety management depends on clear responsibility and accountability. [redacted] and [redacted] explicitly place ultimate responsibility on the EO, supported by defined roles such as Event Manager and Safety Officer. Applying this principle to flying displays would require a clearer definition of the responsibilities of the SAG, EO, FDD, and Safety Officers.

8.4. Command and Control

8.4.1. Structured command-and-control arrangements also represent a significant area of good practice. [redacted] Operational, Tactical, and Strategic command framework, supported by an Event Control function, provides clear escalation routes and effective incident management. A similar approach would improve decision-making and emergency service integration at flying displays.

8.5. Governance

8.5.1. The strongest governance models are supported by clear TORs and defined limits of authority. [redacted], [redacted], [redacted], and [redacted] all reinforce that SAGs provide advice, scrutiny and coordination without replacing the responsibilities of organisers, regulators or statutory agencies. Similar clarity would benefit the flying display sector by reducing uncertainty and improving consistency.

8.6. Event Lifecycle

8.6.1. Good practice also includes embedding risk management, assurance, and continuous improvement throughout the event lifecycle. [redacted] and [redacted] both emphasise risk assessment, incident reporting, debriefing, and post-event review. Applying a similar lifecycle approach to flying displays would strengthen learning, accountability, and overall performance across the sector.

9. Findings

9.1. Introduction

9.1.1. The findings below draw together the combined evidence base developed across KT1 and KT2. They focus on the practical operation of SAGs and the extent to which current arrangements support clear, proportionate, and effective safety governance for flying display events.

9.2. Finding 1: Guidance For SAGs is Inconsistent and Not Mandatory

9.2.1. The review found that the guidance available to support SAGs exists across multiple national and local sources, including CAP 403, the Purple Guide, HSE guidance, local authority guidance, and locally developed TORs. These documents vary considerably in scope, detail, accessibility, and aviation-specific content. None of the principal guidance documents establish a clear hierarchy for application, and most guidance relating to SAG operation is advisory rather than mandatory[18].

9.2.2. The evidence gathered from the questionnaires and stakeholder interviews consistently identified differences in how local authorities establish, resource, and operate SAGs. Stakeholders reported significant variation in the quality of guidance, the clarity of advisory boundaries, the use of TORs, and the expectations placed upon EOs and FDDs. In many cases, local interpretation, organisational culture, and individual experience were found to compensate for gaps or ambiguities in formal guidance.

9.2.3. The key finding here is that the absence of a coherent and consistently applied national framework contributes directly to variability in SAG practice across the UK. While local flexibility allows arrangements to be tailored to circumstances, the current level of inconsistency creates differing expectations, uneven quality of advice, and uncertainty regarding roles, responsibilities, and good practice within the flying display safety system.

9.3. Finding 2: SAG Performance is Inconsistent

9.3.1. SAG performance varies considerably across the UK. Differences were observed in the quality of chairing, levels of stakeholder participation, local authority resourcing, organisational continuity, and the maturity of supporting governance processes. While some SAGs demonstrated well-established structures, regular engagement, and good multi-agency participation, others were characterised by limited engagement, inconsistent attendance, restricted accessibility, or uncertainty regarding their purpose and remit.

9.3.2. Evidence from questionnaires, interviews, and comparative analysis consistently indicated that the value of the SAG is influenced less by its existence and more by how it operates in practice. Stakeholders repeatedly identified experienced chairs, constructive challenge, continuity of personnel, strong emergency service engagement, and clear governance arrangements as characteristics of stronger-performing SAGs. Conversely, weaker examples were associated with high staff turnover, reliance on informal relationships, inconsistent interpretation of responsibilities, and reduced organisational capability.

9.3.3. The key finding is that there is no consistent applied national standard for SAGs. Current performance is largely dependent on local capability, leadership, experience, and organisational maturity rather than a shared and consistently applied operating model. This results in significant variations in the quality of advice, challenge, coordination, and support available to EOs and FDDs across the civilian flying display sector.

9.4. Finding 3: SAGs are Strongest on Multi-Agency Coordination

9.4.1. The review found that the principal function of SAGs is to provide a forum through which multiple agencies can engage collectively with EOs. Stakeholder evidence consistently demonstrated that SAGs bring together representatives from local authorities, emergency services, transport bodies, and other relevant organisations, creating a structured mechanism for information exchange and coordinated planning.

9.4.2. Subjective evidence gathered from questionnaires and interviews showed strong agreement that multi-agency coordination is the most effective aspect of SAG activity. Stakeholders described benefits including improved information sharing, enhanced situational awareness, better understanding of interdependencies, and more efficient engagement between agencies and EOs; although these benefits were not uniformly realised across all event sizes and risk levels. They were particularly evident in larger or more established events where public safety arrangements rely upon coordination between transport management, crowd safety, emergency response, communications, and wider resilience planning.

9.4.3. The key finding from this evidence is that the value of SAGs lies in their ability to facilitate multi-agency coordination and support a shared understanding of event-related risks and consequences. While stakeholders expressed differing views regarding other aspects of SAG function and effectiveness, there was broad consensus that their coordination role represents a significant and valuable contribution to the safety governance of UK civilian flying displays, when well applied.

9.5. Finding 4: Aviation-Specific Advice is Not Consistently Available

9.5.1. SAGs are advisory forums established to consider ground-based safety, emergency preparedness and multi-agency coordination. While aviation risk remains the responsibility of the FDD, aviation activity may have implications for wider event safety that require informed consideration within the advisory process.

9.5.2. Comparative benchmarking demonstrated that mature governance arrangements routinely ensured advisory forums had access to appropriate subject matter expertise relevant to the risks being considered. This enabled informed challenge, strengthens multi-agency decision making and supports clearly defined governance boundaries without extending advisory boundaries beyond their intended limit.

9.5.3. This review found that aviation-specific expertise within SAGs was inconsistent. Stakeholders identified the FDD as the primary source of aviation knowledge during the advisory process. However, because the FDD is also responsible for planning and delivering the flying display, opportunities to provide broader aviation context are limited. This contributes to variabilities in aviation understanding across SAGs and inconsistency in the consideration of aviation specific issues in the wider event safety management process.

9.6. Finding 5: Advisory Boundaries are Unclear

9.6.1. The intended distinction between advisory input, legal accountability, and decision-making authority is not consistently understood across the flying display safety system. While existing guidance generally describes SAGs as advisory bodies, the way in which this advisory role is interpreted and applied varies between organisations, local authorities,

and events. The respective responsibilities of EOs, FDDs, and SAG participants are therefore not always understood in a consistent manner.

9.6.2. Subjective evidence from questionnaires and interviews, and the subsequent analysis, identified recurring uncertainty regarding the purpose and influence of SAGs. Stakeholders described instances where SAG advice was interpreted as approval, endorsement, or assurance, while others reported situations where SAGs were only lightly engaged and therefore unable to provide meaningful challenge or support. These issues were most evident at the interfaces between EO accountability, FDD technical authority, and SAG advisory functions. Human Factors analysis highlighted associated risks including reassurance bias, authority gradients, diffusion of responsibility, and inconsistent challenge.

9.6.3. The key finding from this, therefore, is that unclear advisory boundaries are a significant source of variability within the flying display safety system. This ambiguity contributes to differing expectations of SAG purpose, inconsistent levels of challenge and engagement, and uncertainty regarding where responsibility sits when safety concerns are identified. Greater clarity regarding advisory scope, accountability, and authority would improve consistency, influencing safety, without altering existing legal responsibilities.

9.7. Finding 6: Flying Display Application / CAP 403 Creates a Grey Area

9.7.1. The Flying Display application process requires the applicant to declare compliance with CAP 403 as part of the approval process. CAP 403 also contains guidance regarding liaison with local authorities, emergency services, and SAGs. However, this engagement is generally described using advisory language and is often framed in terms of what organisers "should" do or what may be appropriate where SAG arrangements exist.

9.7.2. The document review, questionnaires, interviews, and system-level analysis identified differing interpretations of what constitutes appropriate SAG engagement. Stakeholders described uncertainty regarding whether SAG involvement represents a regulatory expectation, recommended good practice, or a locally determined arrangement. This uncertainty was particularly evident where access to SAGs was limited, or where local authority engagement varied significantly. Comparative analysis of more mature governance arrangements found that clearer articulation of responsibilities, engagement expectations, and governance interfaces reduced ambiguity and improved consistency of application.

This is a key finding regarding the flying display application process and the supporting CAP 403 guidance, which has created uncertainty regarding the role and expected involvement of SAGs. In order to highlight and protect the advisory nature of SAGs and the statutory responsibilities of EOs and FDDs, greater clarity regarding engagement expectations would improve consistency of interpretation and application across the flying display sector.

9.8. Finding 7: Governance is Person-Dependent

9.8.1. Repeatedly SAGs appear to be strongly influenced by the individuals involved in their operation. The Manchester Arena (Kerslake) Inquiry emphasised maintaining mature multi-agency arrangements and ensuring organisations do not rely solely on individual knowledge or ad hoc relationships. The inquiry's recommendations stressed the importance of enduring governance arrangements, tested plans, and effective organisational memory. Likewise, while the Macabi Inquiry did not specifically identify SAG attendance continuity or membership turnover, it did reinforce the importance of

robust governance processes, clear decision-making, review mechanisms, and organisational learning rather than dependence on individual judgement.

9.8.2. Stakeholder evidence demonstrated that factors such as the experience of the chair, continuity of attendance, institutional knowledge, and the quality of relationships between participants frequently shape how well a SAG functions. Changes in personnel, staffing pressures, and inconsistent handovers were repeatedly identified as factors that can affect continuity and the quality of engagement. Higher-performing SAGs were typically associated with experienced chairs, stable membership, constructive challenge, effective emergency service participation, and established working relationships. Conversely, lower-performing examples were more likely to be affected by staff turnover, limited organisational memory, inconsistent participation, and differing interpretations of roles and responsibilities. Stakeholders frequently reported that successful outcomes often relied upon the knowledge and commitment of particular individuals rather than on consistently applied processes.

9.8.3. It is a key finding that current governance arrangements are vulnerable to variability in individual capability and organisational continuity. While experienced personnel can significantly enhance SAG effectiveness, excessive reliance on individuals rather than resilient governance processes contributes to inconsistent advisory quality, challenge, oversight, and proportionality. Strengthening organisational resilience and standardising core governance arrangements would help reduce this dependency while preserving local flexibility.

9.9. Finding 8: Improved SAG Guidance is Required

9.9.1. The guidance relevant to SAGs exists across a number of national and local documents, including CAP 403, the Purple Guide, HSE guidance, local authority guidance, and locally developed TORs. These documents address different aspects of governance, safety management, and stakeholder engagement, but vary in content, level of detail, and application. The review also found that guidance relating to SAG roles, advisory boundaries, aviation awareness, and engagement expectations is not applied consistently across the sector.

9.9.2. Subjective evidence from this review consistently highlights a need for greater clarity and consistency. Stakeholders from all groups identified uncertainty regarding roles, responsibilities, advisory boundaries, proportionality, aviation-related knowledge, and the relationship between aviation and wider event safety systems. Respondents generally supported clearer national guidance, more consistent TORs, improved understanding of aviation considerations, and better articulation of how SAGs should operate within the wider safety framework.

9.9.3. The key conclusion from this evidence is that the current guidance framework does not provide a sufficiently consistent basis for SAG operation across the civilian flying display sector. While local flexibility remains important, clearer and more coherent national guidance would help reduce variability, improve governance maturity, support proportionate engagement, and promote a more consistent understanding of roles, responsibilities, and advisory practice across stakeholders.

9.10. Finding 9: Responsibility and Accountability

9.10.1. Responsibility and accountability within the UK civilian flying display system are defined through existing legal and regulatory frameworks. EOs are responsible for the management of public and ground safety, while FDDs are responsible for the safe

conduct of flying display activity. SAGs operate as multi-agency advisory forums and do not possess statutory decision-making, approval, licensing, or regulatory authority.

9.10.2. However, evidence identified recurring differences in how these responsibilities are interpreted in practice. While most stakeholders recognised that SAGs are advisory bodies, there was variation in expectations regarding their role, influence, and contribution. Stakeholders described instances where SAG advice was perceived as approval, assurance, endorsement, or evidence of compliance, while others viewed SAGs solely as a mechanism for coordination and information sharing. This variation was most evident at the interfaces between EO accountability, FDD authority, and SAG advisory activity.

9.10.3. A key finding in this review is then that, although responsibility and accountability are formally established, the practical boundaries between accountability, advisory input, challenge, and assurance are not consistently understood across the sector. This contributes to differing expectations of SAG involvement and can create uncertainty regarding ownership of safety decisions, particularly where governance arrangements, guidance, or local practices are unclear.

9.11. Finding 10: Event Lifecycle

9.11.1. Safety Management Systems supporting the UK event sector, including civilian flying display events, are generally concentrated on the planning phase. Most events examined had established arrangements for event planning, risk assessment, documentation, and stakeholder engagement before delivery. However, there was greater variation in the way operational assurance, post-event review, lessons management, and continuous improvement activities were conducted and documented.

9.11.2. Stakeholders frequently reported that post-event learning, assurance activities, and organisational learning processes varied considerably between events and organisations. Benchmarking evidence from this review demonstrated that the most mature systems applied safety management throughout the entire event lifecycle. These systems incorporated planning, exercising, operational monitoring, structured debriefing, lessons identification, and implementation of improvements before the next event cycle.

9.11.3. Given this, a key finding is that the application of safety management across the full event lifecycle is inconsistent within the flying display sector. Although planning activity is generally well established, the systematic capture, implementation, and review of lessons identified is less consistent. A more structured whole-lifecycle approach would strengthen organisational learning, improve governance maturity, and support greater consistency in safety management and advisory activity across successive events.

9.12. Summary

9.12.1. It should be noted that the evidence demonstrated that many of the characteristics associated with safety governance already exist within both flying display and non-flying display event sectors. Comparative benchmarking identified examples of mature governance arrangements, effective multi-agency coordination, clear accountability structures, proportionate oversight, and strong lifecycle safety management operating

within the current governance framework. Examples include [redacted] integration of governance, command and control, and operational safety management, [redacted] proportionate and structured multi-agency processes, and [redacted] highly integrated multi-agency coordination arrangements.

9.12.2. However, the findings demonstrated that the primary challenges within SAGs relate to inconsistent application, weak process discipline, and insufficient clarity across roles, and governance boundaries. While the system is structurally sound, with many examples of good practice available, its overall consistency and effectiveness is undermined by variability in implementation, limited assurance of evidence quality, and inconsistent application of proportional, lifecycle-based governance.

10. Recommendations

10.1. Introduction

10.1.1. The recommendations below are derived from the body of evidence gathered during this review, including documentary evidence, questionnaires, structured interviews, and subsequent discussions with expert stakeholders.

10.1.2. The evidence demonstrates that the quality of SAG support to UK Civilian Flying Displays is not reduced due to a lack of regulation, nor due to the existence of SAGs, but could be reduced due to inconsistent guidance, understanding of roles, uneven behaviours, and distorted expectations at the interfaces between aviation and event safety.

10.1.3. This section sets out a consolidated set of recommendations designed to improve the effectiveness, consistency, and integrity of safety governance for UK civil flying display events. These recommendations are derived directly from the combined evidence base developed through KT1 and KT2 comparative benchmarking, including supporting insights from audit and inquiry findings. They reflect recurring systemic issues rather than isolated failures and are therefore focused on strengthening the application and alignment of the existing system, rather than introducing new structures or regulatory burdens.

10.1.4. The evidence repeatedly highlights that the current system is structurally sound but inconsistently implemented. As such, these recommendations focus on improving clarity, strengthening process discipline, enhancing information integrity, and reinforcing behavioural and governance practices that underpin effective safety outcomes. They are designed to be proportionate, practical, and scalable, and recognise the wide range of event types and organisational contexts in which SAGs operate. Consistent with the findings of both KT1 and KT2, these recommendations are not intended to create a rigid or prescriptive model. Instead, they seek to establish a clearer national baseline founded upon transferable good practice, while allowing proportionate application according to local circumstances, event complexity, and risk profile.

10.2. Implementation Considerations

10.2.1. Implementation should be staged and guidance led. Attention should be given to ensuring that any new expectations do not inadvertently threaten smaller events or create disproportionate workload for local authorities.

10.2.2. The recommendations below therefore focus on **clarity, proportionality, and disciplined advisory practice**, while preserving the accountability structure established by the HSE (EO) and the Air Navigation Order (FDD).

10.3. Recommendation 1: Enhance SAG National Guidance

10.3.1. The review found that a range of guidance documents currently influence the planning and governance of UK civilian flying displays, including CAP 403, the Purple Guide, HSE guidance, local authority guidance, and locally developed SAG TORs. While these documents address many of the same stakeholders and activities, they do not provide a single, consistently applied explanation of how responsibilities and authority interact across the flying display system. Roles are generally defined, but their practical application varies between events and local authorities.

10.3.2. Subjective evidence and subsequent analysis all identified recurring differences in how stakeholders understand and apply roles within the system. EOs, FDDs, SAG Chairs, emergency services personnel, and local authority representatives frequently described

the same governance arrangements in different ways. Stakeholders generally understood their own responsibilities but were less consistent in their understanding of the responsibilities, limitations, and expectations of others. Evidence also showed differing interpretations of advisory responsibility, accountability, challenge, assurance, and the role of SAGs in relation to aviation safety.

10.3.3. Given this, national guidance should more clearly explain the respective roles, responsibilities, accountabilities, and limitations of EOs, FDDs, SAGs, local authorities, emergency services, and regulators. The objective should be to improve consistency of understanding and application across the system while preserving existing statutory and regulatory responsibilities. This recommendation is derived directly from Finding 1 (para 9.2), which identified inconsistent and non-mandatory guidance, and Finding 4 (para 9.5), which identified unclear advisory boundaries. It is also supported by Finding 2 (para 9.3), which found that SAG effectiveness varies considerably depending on local interpretation and organisational maturity.

Practical implementation of this recommendation by the CAA could include:

10.3.4. Developing or contributing to a concise, aviation-specific national framework defining roles and responsibilities, supported by a visual diagram illustrating how the principal organisations and individuals interact before, during, and after a flying display.

10.3.5. Revising relevant CAP 403 guidance material to include an explanatory section describing the distinction between aviation safety management, event safety management, regulatory oversight, and advisory activity, providing a common reference point for local authorities, SAGs, EOs, and FDDs.

10.4. Recommendation 2: Introduce a Consistent Induction for Advisory Participants

10.4.1. SAG members come from a wide range of professional backgrounds and levels of experience. While many participants possess significant expertise within their own disciplines, there is no consistent requirement for induction or familiarisation with the flying display environment. Evidence also showed considerable variation in participants' understanding of aviation terminology, regulatory structures, advisory responsibilities, and the interaction between aviation and wider event safety systems.

10.4.2. Subjective questionnaire and interview data identified a recurring pattern whereby participants often demonstrated confidence in their own roles but differing levels of understanding of aviation-specific activity and governance boundaries. FDDs and EOs frequently reported frustration with questions or challenges that were technically inappropriate or directed towards the wrong part of the safety system. Emergency services personnel and other SAG members also highlighted differing assumptions regarding responsibilities, authority, and decision-making. Human Factors analysis identified role ambiguity, authority gradients, and reassurance bias as recurring influences on advisory effectiveness, while thematic analysis showed that understanding of SAG purpose and aviation context varied significantly between individuals and locations.

10.4.3. A consistent induction package could be developed for individuals participating in aviation-related advisory forums. The induction should establish a common baseline understanding of the regulatory framework, the purpose and boundaries of SAGs, the distinction between advisory and decision-making roles, aviation terminology and concepts, and relevant human factors considerations. The objective is not to create aviation experts, but to ensure that participants understand where they can contribute most effectively and how their role interacts with the wider safety system. Relevant

aviation education could also be considered as a thru-life support mechanism, beyond an induction, supporting all points of the event life cycle. This recommendation is primarily derived from Finding 1 (para 9.2), Finding 2 (para 9.3), and Finding 4 (para 9.5). Together, these findings indicate that inconsistent understanding contributes directly to variability in challenge, advice, and decision support across the system

Practical implementation from this recommendation for the CAA could include:

10.4.4. Developing a short online induction module covering CAP 403, relevant sections of the Purple Guide, advisory boundaries, aviation terminology, and common Human Factors issues. Completion could be recommended before an individual participates in a flying display SAG.

10.4.5. Provision of a standard aviation familiarisation briefing template for use by FDDs or EOs to SAG members at the beginning of each season. This could explain basic aviation concepts, display operations, emergency considerations, and the areas where SAG members can provide the greatest value through challenge and advice.

10.5. Recommendation 3: SAG Advisory Engagement Should be Appropriately Scaled

10.5.1. The review found considerable variation in SAG engagement across flying display events. Some larger or more complex events benefited from multiple meetings, exercises, and extensive multi-agency involvement, while smaller events either received limited engagement or were subject to governance arrangements that stakeholders considered disproportionate to the risks involved. Evidence also showed that event scale, complexity, aviation activity, and public safety considerations vary significantly across the flying display sector.

10.5.2. The subjective evidence consistently highlighted the importance of proportionality. EOs, FDDs, and SAG representatives reported that large, mature events can support more extensive advisory arrangements due to their complexity and available resources. Conversely, smaller and volunteer-led events often struggle with the administrative burden associated with more extensive governance models. Stakeholders also reported examples of governance overreach, inconsistency of engagement, and differing expectations regarding the level of SAG involvement required. Comparative analysis of high and low-maturity environments demonstrated that effective governance is not determined by the volume of engagement, but by the appropriateness of engagement to the risks and complexity of the event.

10.5.3. SAG engagement therefore should be scaled using the complexity-based principles reflected within CAP 403 and wider event safety guidance. The level of engagement should be proportionate to an event-appropriate combination of size, complexity, aviation activity, site characteristics, crowd profile, and overall associated risk. Expectations regarding the extent of SAG involvement should be established early in the planning process and clearly communicated to all stakeholders. This recommendation is derived from Finding 2 (para 9.3), Finding 3 (para 9.4) and Finding 6 (para 9.7). Together, these findings demonstrate that inconsistent and sometimes disproportionate engagement contributes to variable governance outcomes across the sector.

Practical implementations from this recommendation for the CAA could include:

10.5.4. Developing supplementary guidance illustrating how different levels of advisory engagement may be applied to Tier 1, Tier 2, and Tier 3 flying displays, including

examples of proportionate meeting schedules, exercises, and documentation requirements

10.5.5. Working with the Purple Guide steering group and relevant stakeholder organisations to include examples of proportionate SAG engagement for different types of flying display events, helping local authorities and organisers align governance arrangements with event complexity rather than applying a single model to all events.

10.6. Recommendation 4: Use Standardised SAG TORs to Enhance Consistency

10.6.1. There was considerable variation in the existence, quality, accessibility, and application of SAG TORs. National guidance documents such as the Purple Guide and HSE guidance do not provide a standard SAG TOR template, resulting in local authorities developing their own arrangements. Some SAGs operated under clear and well-understood TORs, while others had limited, inaccessible, or poorly understood governance documentation.

10.6.2. Subjective evidence (questionnaires and interviews) demonstrated that well-developed TORs contributed to greater perceived clarity regarding purpose, membership, responsibilities, escalation arrangements, and governance boundaries. However, stakeholders also reported examples where TORs were interpreted as conferring authority beyond an advisory function or where participants were unfamiliar with their content. Thematic analysis identified role ambiguity and inconsistent advisory practice as recurring themes, while Human Factors analysis highlighted the risks of unclear boundaries, authority gradients, reassurance bias, and inconsistent challenge. Stakeholders from governance, emergency planning, and aviation backgrounds consistently emphasised the importance of clearly defining what a SAG can and cannot do.

10.6.3. A standardised SAG TORs framework should be developed to provide a consistent baseline for safety and governance arrangements across the civilian flying display sector. These TORs should clearly define purpose, scope, membership, advisory status, governance boundaries, and escalation arrangements of SAGs. They should also explicitly distinguish advisory activity from approval, assurance, sign-off, or regulatory decision-making functions. This recommendation is derived from Finding 1 (para 9.2), Finding 5 (para 9.6), and Finding 7 (para 9.8), which collectively demonstrate that inconsistency in governance arrangements contributes directly to differing interpretations of purpose, authority, and advisory practice.

A practical implementation from this recommendation for the CAA could be:

10.6.4. Working with local authorities and stakeholder organisations, the CAA could develop a model SAG TOR template or wording relevant to safety and governance for UK civilian flying display events, which could then be adopted or adapted locally. It could include a simple statement such as: *"This forum provides coordinated multi-agency advice to the Event Organiser and does not approve, assure, licence, authorise, or regulate the event or flying display activity."* This would provide a clear and consistent reference point for all participants.

10.7. Recommendation 5: Define SAG Good Practice Through Process Rather Than Outcomes

10.7.1. There was considerable variation in how stakeholders assessed SAGs. Some stakeholders judged SAGs by the absence of incidents or the smooth delivery of events, while others focused on the quality of challenge, engagement, planning, and learning. Incident-free events can create false reassurance and may mask weaknesses in governance, challenge, or preparedness. Evidence showed that SAGs do not control

many of the factors that ultimately determine event outcomes, as responsibility for event delivery and aviation operations remains with EOs, FDDs, regulators, and other duty holders.

10.7.2. Analysis of subjective stakeholder evidence showed that SAGs were viewed most positively when their processes included constructive challenge, clear role boundaries, pro-active communication, shared situational awareness, structured learning processes, and robust information management. Emergency services and multi-agency stakeholders frequently described the importance of learning from exercises, near misses, emerging risks, and operational observations rather than relying solely on outcome measures. Audit and inquiry evidence also highlighted the importance of maintaining accurate records, preserving information integrity, and handling personal data appropriately throughout the event lifecycle.

10.7.3. SAGs should be judged primarily by the quality of their processes rather than by whether incidents occur. Assessment should focus on the clarity of discussion, the appropriateness of challenge, adherence to role boundaries, transparency of unresolved issues, the capture and implementation of lessons identified, and the integrity of information management throughout the event lifecycle. This recommendation is derived from Finding 2 (para 9.3), Finding 3 (para 9.4), and Finding 7 (para 9.8). These findings demonstrate that effective governance is more closely associated with the quality of processes and interactions than with event outcomes alone.

Practical implementations from this recommendation could capitalise on familiar aviation debriefing practices. The CAA could:

10.7.4. Develop a simple post-event review framework that evaluates challenge, coordination, decision-making, and learning activities rather than focusing solely on incident statistics.

10.7.5. Promote a standard approach to recording, retaining, and reviewing SAG activities to support consistent learning, information integrity, and compliance with data protection requirements.

10.8. Recommendation 6: Revise the Flying Display Application Form

10.8.1. Evidence identified differing interpretations of what constitutes adequate engagement under CAP 403, particularly where SAGs are unavailable, difficult to access, or operate differently across local authority areas.

10.8.2. Stakeholders repeatedly highlighted uncertainty regarding the relationship between the Flying Display application process, CAP 403 expectations, and wider event safety governance. The document review found that the Purple Guide, particularly Chapter 43, contains relevant event safety guidance but is not consistently referenced or applied within the flying display application process.

10.8.3. The CAA should review the Flying Display application process to make relevant governance and engagement expectations clearer at the earliest stage of event planning. This should reinforce awareness of wider event safety responsibilities and encourage timely engagement with appropriate stakeholders. This recommendation is derived from Finding 1 (para 9.2), Finding 5 (para 9.6), and Finding 6 (para 9.7).

10.8.4. The Flying Display application form could be expanded to include a dedicated section recording engagement with relevant local authorities, emergency services, and SAGs where they exist. The application guidance could also provide a direct reference to

Chapter 43 of the Purple Guide, highlighting its relevance to flying display event planning and encouraging its consideration alongside CAP 403 requirements.

10.9. Summary of Recommendations

10.9.1. In summary, the recommendations focus on national purpose, expanding and strengthening the language in the Flying Display application form, proportionate SAG engagement, TOR templates, relevant aviation education, chair behaviours, accessibility, lessons management, and protection of smaller events.

10.9.2. They seek to **align behaviours, expectations, and understanding** across the system in relation to flying displays, while preserving the legal framework that already exists.

10.9.3. These consolidated recommendations reflect a clear and consistent message from the evidence: improvement in safety governance does not require additional authority, but rather greater clarity, stronger processes, improved information integrity, and more effective behaviours within the existing framework.

10.9.4. The role of the CAA is central to enabling this improvement. Through targeted updates to guidance, proportionate oversight, appropriately available expertise, and sector leadership, the CAA can drive greater consistency, alignment, and effectiveness across the system, while preserving the advisory nature of SAGs and maintaining clear accountability for safety outcomes.

10.9.5. It should be noted that not all stakeholders agreed with every aspect of the review. Stakeholder points were noted and where disagreements existed, they were aligned as described in appendix G.

10.9.6. Taken together, these recommendations provide a coherent and proportionate pathway to strengthening the safety governance of UK civil flying display events in line with the evidence from KT1, KT2, and the broader analysis.

11. Conclusion

11.1. Introduction

11.1.1. The evidence analysed throughout this review suggests that SAGs are valuable but inconsistent. Their strongest contribution is multi-agency coordination and consequence management; their weakest area is consistency.

11.2. Areas of Excellence

11.2.1. The review identified several areas where SAGs consistently demonstrated good practice. Their greatest strength was providing an established forum for effective multi-agency coordination, enabling the early identification and management of cross-cutting risks and supporting collaborative decision-making between stakeholders. Mature SAGs demonstrated proportionate, risk-based engagement, constructive challenge, clear communication and a commitment to continuous improvement through post-event learning and the sharing of good practice.

11.3. Areas for Improvement

11.3.1. The central system gap is clarity: clarity of role, clarity of authority, clarity of aviation expectations and clarity of what constitutes sufficient engagement. Addressing that gap through clear guidance, better templates and access to aviation expertise, would improve safety governance without undermining the advisory nature that makes SAGs useful.

11.4. Recommendations

11.4.1. The recommendations emerging from this review collectively describe a model of good practice founded on clarity, proportionality, and disciplined and coherent advice. The evidence indicates that effectual SAGs are those in which: roles, responsibilities, and authority boundaries are consistently understood; advisory forums operate within clearly defined limits; engagement is proportionate to complexity; and participants possess sufficient governance understanding and aviation awareness to contribute constructively.

11.4.2. Good practice also depends upon accessible and consistent national guidance, strengthening the language and expectations within the Flying Display application process to reduce ambiguity, effective SAG chairing behaviours, structured learning and continuous improvement, and the ability to share lessons and good practice nationally. Taken together, these measures can strengthen consistency, understanding and confidence while preserving the existing framework.

11.5. Summary

11.5.1. In sum, the evidence indicates that effective SAGs are those in which:

- Guidance documentation is clear and unambiguous
- Roles, responsibilities, and authority boundaries are clearly defined and understood
- Advisory forums operate within clearly defined limits
- Engagement is proportionate to risk and complexity
- TORs are present, clear, consistent, understood and followed
- Participants possess sufficient governance understanding and aviation awareness to contribute constructively

Appendix A – Documents and Benchmarking Source Material

The following documents and materials were used to assist in data gathering and benchmarking.

Document / Material	Description	Link (if applicable)
Air Navigation order Article 86	UK Law	https://www.legislation.gov.uk/uksi/2016/765/article/86
HSE Event Safety	UK Law	https://www.hse.gov.uk/event-safety/
CAP 403	Guidance Material	https://www.caa.co.uk/data-and-publications/cap-403/
CAP 1694	Guidance Material	https://www.caa.co.uk/data-and-publications/publications/documents/content/cap1694/
LAEOG	Guidance Material	https://www.laeog.co.uk
The Purple Guide to Health, Safety and Welfare at Outdoor Events	Guidance Material	https://www.thepurpleguide.co.uk/index.php
UK Resilience Academy	Guidance Material	https://ukresilienceacademy.org
The Green Guide (Guide to safety at sports grounds)	Guidance Document	https://sgsa.org.uk/green-guide/
Protect UK	Guidance Document	https://www.protectuk.police.uk
[redacted]	Guidance Document	https://www.wokingham.gov.uk/Safety Advisory Group guidance.pdf
	Guidance Document	https://www.telford.gov.uk/esag
	Guidance Document	https://beta.southglos.gov.uk/static/Event-safety-guide.pdf
	Terms of Reference	https://www.scambs.gov.uk/event-safety-advisory-group-sag
	Checklist	https://www.scambs.gov.uk/media/event-checklist-2023.pdf
	Guidance Document	https://www.rbwm.gov.uk/business-and-economy/licensing-and-regulation/safety-advisory-group
SAGs under the spotlight / Why the industry is calling for change	Article	https://www.eventindustrynews.com/news/safety-advisory-groups-under-the-spotlight
[redacted]	Guidance Document	South Gloucester Event Safety Guide
	Terms of Reference	
	Guidance Document	https://www.torbay.gov.uk/media/10539/guide-for-organisers.docx
	Guidance Document	https://www.publicprotectionpartnership.org.uk/safety-advisory-group-sag
	Guidance Document	https://www.buckinghamshire.gov.uk/organising-an-event/
	Guidance Document	https://www.buckinghamshire.gov.uk/event-safety-guide-for-event-organisers/
	Guidance Document	https://www.redcar-cleveland.gov.uk/about-the-council/events-planning-and-guidance-documents

Document / Material	Description	Link (if applicable)
[redacted]	Guidance Document	https://www.hartlepool.gov.uk/emergencies-community-safety/independent-safety-advisory-group-isag
	Guidance Document	Herefordshire SAG
	Guidance Document	https://www.adur-worthing.gov.uk/media/Media,153727,smxx.pdf

Appendix B – Summary of Questionnaire Results

A questionnaire was sent to the EOs, FDDs, and SAG members.

The questionnaire gathered 35 responses from stakeholders involved in UK civil flying displays, including Flying Display Directors (FDDs), Event Organisers (EOs), Safety Advisory Group (SAG) members, military representatives and independent chairs. Respondents represented a highly experienced sample, with over half reporting more than ten years' involvement in flying displays and many having supported dozens, and in some cases hundreds, of events.

Additionally, 44.44% identified as core SAG members and a further 33.33% reported regularly interfacing with SAGs despite not being formal members, indicating that responses were largely informed by individuals with direct involvement in safety governance arrangements.

Participants also brought broad experience across aviation and event safety roles, including display pilots, Flying Control Committee members, emergency services personnel and event safety professionals.

Overall, respondents demonstrated high levels of confidence in their own roles and responsibilities and generally viewed existing flying display safety arrangements positively. However, whilst the findings suggest many established arrangements are functioning effectively, questionnaire responses also identified recurring variation in role interpretation, governance arrangements and operational implementation. Despite high reported confidence levels, some respondents also identified weaker formal structures, including the absence of written role descriptions and uncertainty surrounding governance documentation. Areas including advisory boundaries, escalation pathways, aviation-specific knowledge and operational interfaces produced more mixed findings, suggesting that consistency of application may vary across events and local arrangements.

Governance and role clarity

Questionnaire responses suggest governance arrangements are generally functioning effectively, although consistency remains a recurring theme. Most respondents reported that their SAG operated under formal Terms of Reference (TORs), with these generally viewed as sufficient and adhered to where they existed. However, confidence reduced when respondents considered escalation pathways and decision-making arrangements, which appeared less consistently defined than broader purpose and membership arrangements.

85.71% of respondents considered the size of their SAG to be proportionate to the scale of the event, suggesting that concerns raised elsewhere in the questionnaire were generally related to consistency and implementation rather than the size of governance structures themselves.

Whilst respondents generally reported a strong understanding of their responsibilities, 22.22% indicated they did not have a written role description for their duties, suggesting that formal definition of responsibilities may not be universal across all roles and organisations.

Whilst most respondents reported operating under formal TORs, only 17% indicated they were able to readily provide a copy, whilst 33% could not and 50% were unsure. This may suggest variability in the visibility, ownership or accessibility of governance documentation.

Role clarity between EOs, FDDs and SAGs produced more mixed findings. The EO/FDD relationship was viewed as comparatively well understood; however, interfaces involving SAGs were less clearly defined. Responses also highlighted uncertainty around accountability

boundaries, with 23.00% of respondents indicating that the distinction between advisory responsibility and legal accountability was "not very clearly understood."

A further finding of note was variation in how SAGs are perceived to operate in practice. Whilst 42.86% described their SAG as a clearly advisory forum and 35.71% as a collaborative but non-decision-making body, 17.86% considered their SAG to operate as a body that effectively approves events.

Open-ended responses reinforced these findings. Several respondents highlighted uncertainty regarding whether SAGs should act solely as advisory bodies or whether, in practice, they were operating beyond that remit. Some felt EOs could become too embedded within SAG processes, blurring the distinction between event ownership and independent scrutiny. Others noted examples where SAG members themselves appeared unclear regarding advisory boundaries.

Variation between individual SAGs emerged as a strong recurring theme throughout the questionnaire. While some were described as highly professional, engaged and proactive, others were characterised as inconsistent, difficult to engage with or having limited involvement in aviation-related matters. Respondents repeatedly noted that the effectiveness of arrangements often appeared dependent upon local implementation and individual engagement.

Safety Management and Documentation

Responses indicate generally positive safety management practices. Event Management Plans (EMPs), emergency response plans, crowd management plans and medical plans were commonly reviewed through SAG structures and documentation quality was typically regarded as high. Respondents also generally felt that documents were circulated with sufficient notice to enable meaningful review.

However, one area that stood apart from wider documentation practices related to aircraft display risk assessments. Only 37.5% of respondents reported aircraft display risk assessments being reviewed by the SAG, whilst 33.33% reported these were not reviewed and 29.17% were unsure. This contrasts with other documentation categories that attracted considerably higher levels of review.

Similarly, standardised templates and checklists appeared either uncommon or inconsistently applied across arrangements, with respondents divided between those who used them and those who did not or were unsure whether such processes existed.

Operational Interfaces and Recurring Safety Themes

Although most respondents reported no significant gaps, overlaps or pinch points in responsibility arrangements, the findings suggest some operational friction remains. Whilst 39.29% of respondents reported no gaps in responsibility and 44.44% reported no pinch points, a sizeable proportion identified either significant or minor issues across these areas. Minor or significant gaps were identified by 35.71% of respondents, whilst 29.63% identified overlaps and 22.22% identified operational pinch points.

Qualitative responses suggested these issues appeared to arise more from local implementation, relationships and differing levels of engagement than from formal structural deficiencies. Several respondents described variation in the quality of SAG participation and differing expectations regarding responsibilities and involvement. Others highlighted overlap between emergency functions or deliberate overlap between safety roles intended to improve resilience.

Secondary and tertiary spectators emerged as one of the strongest recurring themes within the qualitative responses. Management approaches varied considerably and included security patrols, signage, policing, road closures, monitoring through air traffic control and local byelaws. Whilst some respondents described mature and effective approaches, others raised concerns regarding off-site spectators and associated risks remaining insufficiently addressed, particularly at larger or more complex events. Several comments suggested this issue may not yet be addressed consistently across all arrangements.

Emergency exercising arrangements also varied considerably. 42.86% of respondents reported tabletop exercises, and 35.71% reported live exercising activity, however 14.29% reported that emergency plans were only verbally reviewed and 7.14% reported no testing activity.

Some respondents also highlighted concerns that exercising activity occasionally focused heavily on emergency service responses without adequately testing wider organisational structures and command arrangements. Time and resource pressures were also identified as influencing exercise design.

Aviation Knowledge and Integration

The integration of aviation and non-aviation safety systems was generally viewed positively; however, respondents were more cautious when considering aviation-specific understanding within SAGs. Only 25% of respondents felt SAG members demonstrated understanding of aviation-specific risk "to a great extent", while 50% selected "to some extent", 15% "to a limited extent" and 10% "no extent".

Open-ended responses highlighted differing views on whether additional aviation expertise would be beneficial. Some respondents argued that SAG members do not necessarily require deep aviation knowledge, provided suitable subject matter expertise exists through FDDs and specialist representatives. Others felt that limited aviation understanding could create challenges when considering dynamic operational risks, weather, multi-aircraft operations and wider consequences arising from aviation incidents. Several respondents also suggested an independent aviation subject matter expert could strengthen assurance and reduce reliance on the FDD as the sole source of aviation expertise.

Culture, Challenge and Overall Effectiveness

The questionnaire responses indicate a generally positive safety culture. Respondents largely felt able to challenge EOs openly and most believed SAGs operated independently from commercial or political pressures. Communication between SAG members and EOs was also viewed positively, with 50% of respondents reporting that recommendations were fully implemented and a further 35% indicating they were mostly implemented. This suggests that, where recommendations are made, they are generally acted upon and incorporated into event planning processes.

Findings also suggested generally positive approaches towards organisational learning. 58.33% of respondents reported that post-event debriefs involving key stakeholders were held consistently, whilst 20.83% reported more limited participation and 16.67% indicated these occurred only occasionally. Similarly, 45.83% stated lessons identified were largely implemented and 29.17% to some extent, suggesting that learning and continuous improvement processes are established within many arrangements, although not consistently across all events.

However, governance arrangements surrounding escalation appeared less certain. Only 45% of respondents indicated there was a clear escalation pathway where recommendations were not followed, whilst 25% reported no clear pathway and 30% were unsure whether one existed.

Examples of effective practice repeatedly referenced strong relationships, early engagement, open communication, multi-agency collaboration and the incorporation of lessons identified from previous events. Respondents highlighted examples where challenge processes had led to event redesign, amended emergency plans, revised layouts, enhanced traffic management arrangements and, in some cases, cancellation of events where risks could not be adequately mitigated.

However, the questionnaire responses also identified examples where respondents felt safety concerns had not been adequately addressed. Concerns included insufficient command structures, limited understanding of emergency management arrangements, difficulties controlling off-site spectators and uncertainty regarding responsibility for individuals outside formal viewing areas.

Overall observations

Across the responses, a recurring message was not that respondents viewed the current system as fundamentally ineffective, but that effectiveness appeared influenced by local implementation, individual experience and the quality of relationships between stakeholders. Many respondents described examples of highly effective and mature safety governance arrangements; however, others highlighted variation in engagement, interpretation and consistency between SAGs.

While most respondents reported no significant gaps or pinch points in operational responsibilities, the questionnaire also identified measurable levels of operational friction, including gaps, overlaps and interface issues. Combined with qualitative responses, this suggests that differences in implementation and local arrangements may influence how responsibilities and governance structures operate in practice.

The findings also suggest some appetite for greater consistency at a national level. 65% of respondents indicated that a standardised national framework defining SAG roles and responsibilities would improve safety governance to some extent, with a further 15% indicating improvement to a great extent.

Views were more mixed regarding the extent to which any framework should be formally underpinned through regulation, suggesting support for greater consistency but less consensus regarding how prescriptive future arrangements should become.

Overall, the questionnaire responses suggest that flying display safety governance benefits significantly from experienced personnel, collaborative working and established local relationships, whilst also identifying opportunities to improve consistency around role boundaries, accountability, escalation arrangements, operational interfaces and supporting governance frameworks.

Appendix C – List of One-to-One Interviews

The following interview framework was used when conducting one-to-one interviews with FDDs, EOs, or SAG members, noting Farnborough International FDD and Operations Manager were interviewed together.

People holding the following roles were interviewed:

Role	Location
SAG Chair	[redacted]
SAG Chair	[redacted]
RAFLO / NILO	
Event Organiser	[redacted]
Flying Display Director	[redacted]
Flying Display Director	[redacted]
SAG Chair	[redacted]
Military RAF Liaison Officer	[redacted]
Flying Display Director	[redacted]
Flying Display Director and Operations Manager	[redacted]
Event Organiser	[redacted]
Flying Display Director	Various UK Flying Displays
Flying Display Director	Various UK Flying Displays
Flying Display Director	[redacted]
Flying Display Director	[redacted]

Appendix D – Comparative Benchmarking Analysis (Flying Display SAGs)

The comparative Benchmarking Analysis of SAG Guidance and SGSA guidance to the Purple Guide is shown below:

Section	Description	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Governance Maturity	Emphasises clear command structures	Partially Aligns	Partially Aligns	Aligns	Aligns	Aligns	Aligns	Aligns
	Event Organiser Role defined	Partially Aligns	Aligns	Aligns	Aligns	Aligns	Aligns	Aligns
	Safety Officer Roel Defined	Aligns	Aligns	Aligns	Aligns	Aligns	Aligns	Aligns
	TORs present for all roles	Partially Aligns	Aligns	Aligns	Aligns	Aligns	Aligns	Aligns
	Conflict of interest managed	Partially Aligns	Partially Aligns	Partially Aligns	Partially Aligns	Partially Aligns	Does not Align	Partially Aligns
	Chair competence	Aligns	Aligns	Aligns	Aligns	Aligns	Partially Aligns	Aligns
	Escalation routes defined	Partially Aligns	Aligns	Aligns	Aligns	Aligns	Partially Aligns	Aligns
	Decision making authority clear	Partially Aligns	Aligns	Aligns	Aligns	Aligns	Partially Aligns	Aligns
Inter-Agency Coordination	Encourages a control room / event control structure	Partially Aligns	Partially Aligns	Aligns	Partially Aligns	Partially Aligns	Partially Aligns	Aligns
	Evidence of effective interagency co-ordination	Partially Aligns	Aligns	Aligns	Aligns	Aligns	Aligns	Aligns
	TTX undertaken prior to the event?	Partially Aligns	Aligns	Aligns	Aligns	Aligns	Aligns	Aligns
	Promotes a multi-agency approach	Partially Aligns	Aligns	Aligns	Aligns	Aligns	Aligns	Aligns
	Encourages the use of SAGs to coordinate agencies	Aligns	Aligns	Aligns	Aligns	Aligns	Aligns	Aligns
	Information sharing protocols	Partially Aligns	Aligns	Aligns	Aligns	Aligns	Aligns	Aligns

Section	Description	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Real-time communications systems	Partially Aligns	Partially Aligns	Partially Aligns	Partially Aligns	Partially Aligns	Partially Aligns	Aligns
	Common operating picture	Partially Aligns	Partially Aligns	Partially Aligns	Partially Aligns	Partially Aligns	Partially Aligns	Aligns
Event Safety Plan	Recommends production of a comprehensive Event Safety Plan	Partially Aligns	Aligns	Aligns	Aligns	Aligns	Aligns	Aligns
	Emergency planning undertaken	Partially Aligns	Aligns	Aligns	Aligns	Aligns	Aligns	Aligns
	Site plans available and up to date	Aligns	Aligns	Aligns	Aligns	Aligns	Aligns	Aligns
	Crowd management plans present	Partially Aligns	Aligns	Aligns	Aligns	Aligns	Aligns	Aligns
	Medical provision present	Partially Aligns	Does not Align	Aligns	Aligns	Partially Aligns	Partially Aligns	Aligns
	Traffic management plans present	Aligns	Aligns	Aligns	Aligns	Aligns	Aligns	Aligns
	Evacuation plans produced	Partially Aligns	Aligns	Aligns	Aligns	Aligns	Aligns	Aligns
	Casualty handling plans present	Partially Aligns	Aligns	Aligns	Aligns	Aligns	Aligns	Aligns
Risk	Risk profile considered	Partially Aligns	Aligns	Aligns	Aligns	Aligns	Aligns	Aligns
	Risk escalation thresholds	Aligns	Aligns	Aligns	Aligns	Aligns	Partially Aligns	Aligns
	Review Frequency	Partially Aligns	Aligns	Partially Aligns	Aligns	Partially Aligns	Partially Aligns	Aligns
	Dynamic risk assessment	Aligns	Partially Aligns	Aligns	Partially Aligns	Partially Aligns	Partially Aligns	Aligns
	Risk assessments conducted and present	Partially Aligns	Aligns	Aligns	Aligns	Aligns	Aligns	Aligns
	Dedicated Safety Professionals	Partially Aligns	Partially Aligns	Aligns	Partially Aligns	Partially Aligns	Partially Aligns	Aligns

Section	Description	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Competence and Professional Capability	Leadership Competence	Aligns	Aligns	Partially Aligns	Aligns	Aligns	Partially Aligns	Aligns
	Required Qualifications	Partially Aligns	Does not Align	Aligns	Does not Align	Does not Align	Partially Aligns	Aligns
	Experience Expectations	Partially Aligns	Partially Aligns	Does not Align	Partially Aligns	Partially Aligns	Partially Aligns	Aligns
Assurance and Learning	Debriefs/Lessons Learned	Aligns	Partially Aligns	Partially Aligns	Partially Aligns	Does not Align	Partially Aligns	Partially Aligns
	Audits	Partially Aligns	Does not Align	Does not Align	Does not Align	Does not Align	Does not Align	Partially Aligns
	Governance proportional to event complexity	Aligns	Aligns	Aligns	Aligns	Aligns	Aligns	Aligns
	Thresholds for advanced oversight	Partially Aligns	Aligns	Aligns	Aligns	Aligns	Aligns	Aligns
Regulatory Environment	Resource scalability	Partially Aligns	Aligns	Aligns	Aligns	Aligns	Partially Aligns	Aligns
	Advisory v Mandatory system	Aligns	Aligns	Partially Aligns	Aligns	Aligns	Aligns	Partially Aligns
	Primary Regulator	Partially Aligns	Partially Aligns	Aligns	Aligns	Aligns	Aligns	Partially Aligns
% of full alignment with the Purple Guide		66%	77%	75%	78%	75%	70%	86%

Appendix E – Stakeholder Interview Comparative Analysis

Table 1: Coding

Code	Meaning	Use when
++	Strongly evidenced / strongly present	The interview clearly and repeatedly supports the criterion or gives strong concrete examples.
+	Present / generally supported	The criterion is present, but with less intensity, fewer examples, or more limited confidence.
~	Mixed / unclear / variable	The evidence is mixed, context-dependent, uncertain, or different across events.
-	Weak / limited	The criterion appears only weakly, partially, or in a limited/fragile way.
--	Strongly absent / strongly criticised	The interview explicitly says the criterion is absent, poor, ineffective, or strongly problematic.
NA	Not discussed / not applicable	The interview does not cover the criterion, or it is not relevant to that participant's role/context.

Table 2: Analysis by category

Role	SAG Engagement	SAG Maturity / Quality	SAG Variability	TOR Clarity	SAG Communication	SAG Engagement Cadence	SAG Learning / Debriefing	SAG Escalation Pathway	SAG Independence	SAG Challenge Function	SAG Aviation Understanding	Role Clarity	Advisory Boundary Clarity	SAG Overreach / Assurance Creep	National Standardisation Support	Regulation Support	Proportionality / Tiering	Independent Aviation Assurance	EMP / Documentation Quality	Emergency Exercising	Secondary Spectator Risk	Aviation–Ground Integration	HF Themes	Overall Position
FDD (Non-SAG)	-	-	+	NA	-	-	NA	NA	--	-	~	++	+	--	-	-	+	-	~	~	~	+	~	Professional aviation SMS model
Military SAG Member	+	~	+	NA	~	~	-	-	-	++	~	++	-	++	++	+	++	++	-	~	++	-	~	Independent assurance advocate
FDD	+	+	~	~	+	~	+	-	++	~	-	++	+	+	-	-	+	-	++	++	++	~	~	Command-centric governance

Role	SAG Engagement	SAG Maturity / Quality	SAG Variability	TOR Clarity	SAG Communication	SAG Engagement Cadence	SAG Learning / Debriefing	SAG Escalation Pathway	SAG Independence	SAG Challenge Function	SAG Aviation Understanding	Role Clarity	Advisory Boundary Clarity	SAG Overreach / Assurance Creep	National Standardisation Support	Regulation Support	Proportionality / Tiering	Independent Aviation Assurance	EMP / Documentation Quality	Emergency Exercising	Secondary Spectator Risk	Aviation–Ground Integration	HF Themes	Overall Position
FDD	+	++	~	++	++	+	++	+	++	~	+	++	++	-	+	-	++	-	~	~	++	+	~	Consequence-management focus
SAG Chair	+	++	+	~	++	+	++	+	++	++	-	+	++	~	+	-	++	++	~	~	+	+	~	Advisory model defender
FDD (Non-SAG)	-	~	+	NA	~	+	NA	NA	-	+	+	++	+	-	+	-	++	-	~	+	++	+	~	Pragmatic scalable model
Independent SAG Chair	+	-	~	++	++	+	~	--	~	~	-	+	++	--	++	++	+	+	-	-	+	-	~	Regulation-seeking chair
FDD (Non-SAG)	-	~	+	NA	+	+	NA	NA	+	-	+	++	~	~	+	-	++	-	++	+	++	++	~	Governance literacy focus
Independent SAG Chair	+	++	~	++	++	+	++	+	++	++	++	++	++	-	++	++	+	+	++	~	~	++	~	Experienced advisory chair
EO	-	++	~	++	++	~	+	+	++	++	+	++	++	-	++	++	++	+	++	~	++	+	+	Professionalised governance
SAG Chair	+	~	++	--	++	~	++	+	++	++	~	++	++	-	+	-	++	-	~	++	~	~	~	Natural experiment
FDD	+	~	++	+	~	+	+	+	~	++	+	++	+	+	++	+	++	-	~	+	+	~	~	Tiered proportional approach
FDD (Non-SAG)	-	~	++	NA	++	+	~	+	~	+	++	++	+	-	-	-	+	-	++	++	~	++	~	Institutional maturity focus
Military SAG Member	+	++	~	+	+	~	++	++	~	++	-	+	++	-	++	++	++	-	~	~	~	++	~	Military-resilience worldview
FDD (Non-SAG)	-	~	++	NA	-	~	NA	-	-	-	-	++	~	+	++	-	+	-	~	~	~	+	~	System coherence deficit
Governance / Legal	~	~	++	NA	~	NA	NA	NA	++	~	--	++	~	++	+	-	++	-	NA	NA	~	NA	~	Legal realist / system guardian
EIF / FDD	~	~	++	+	~	~	NA	NA	~	+	-	++	~	++	++	-	++	+	~	NA	~	-	~	Best-practice guidance advocate
Consultant / Aviation	~	~	++	-	~	~	~	-	~	++	~	++	-	~	+	-	++	++	~	~	++	-	~	Multi-agency value despite flaws

Role	FDD	FDD	[redacted]	Airfield Owner / FDD
SAG Engagement	+	+	+	+
SAG Maturity / Quality	++	~	~	~
SAG Variability	++	++	++	+
TOR Clarity	+	+	!	!
SAG Communication	~	~	~	~
SAG Engagement Cadence	+	~	~	~
SAG Learning / Debriefing	~	NA	~	~
SAG Escalation Pathway	~	~	~	~
SAG Independence	!	~	~	~
SAG Challenge Function	+	++	++	++
SAG Aviation Understanding	~	~	~	~
Role Clarity	++	++	++	++
Advisory Boundary Clarity	~	~	~	~
SAG Overreach / Assurance Creep	~	++	++	++
National Standardisation Support	++	++	++	+
Regulation Support	+	~	~	~
Proportionality / Tiering	++	++	++	++
Independent Aviation Assurance	++	++	+	++
EMP / Documentation Quality	~	~	~	~
Emergency Exercising	~	~	~	~
Secondary Spectator Risk	~	~	+	+
Aviation–Ground Integration	~	~	~	~
HF Themes	~	~	+	~
Overall Position	Maturity-driven effectiveness	Guidance not legislation	Individuals compensating for weak system	CAA support advocate

Appendix F – Comparative Benchmarking Analysis (Full)

The comparative Benchmarking Analysis of all analysed SAG guidance (both Flying Display related and otherwise) is shown below against set criteria from The Purple Guide:

High (H)	Fully complies with and demonstrates evidence within that category
Medium (M)	Partially complies with and some evidence is present within that category
Low (L)	Does not comply / there is no or minimal evidence to demonstrate compliance within that category
No Evidence (N)	No evidence was found in this category

Themes	Governance Maturity								Inter-Agency Coordination								Event Safety Plan								Risk					Competence & Professional Capability				Assurance and Learning		Proportionality and Scalability			Regulatory Environment	
Sub themes	Emphasises clear command structures	Event Organiser Role defined	Safety Officer Roel Defined	TORs present for all roles	Conflict of interest managed	Chair competence	Escalation routes defined	Decision making authority clear	Encourages control room / event control	Evidence of interagency co-ordination	TTX undertaken prior to the event?	Promotes a multi-agency approach	Use of SAGs to coordinate agencies	Information sharing protocols	Real-time communications systems	Common operating picture	Production of Event Safety Plan	Emergency planning undertaken	Site plans available and up to date	Crowd management plans present	Medical provision present	Traffic management plans present	Evacuation plans produced	Casualty handling plans present	Risk profile considered	Risk escalation thresholds	Review Frequency	Dynamic risk assessment	Risk assessments conducted and present	Dedicated Safety Professionals	Leadership Competence	Required Qualifications	Experience Expectations	Debriefs/Lessons Learned	Audits	Governance proportional to event complexity	Thresholds for advanced oversight	Resource scalability	Advisory v Mandatory system	Primary Regulator
[redacted]	M	M	H	M	M	H	M	M	M	M	M	M	H	M	M	M	M	M	H	M	M	H	M	M	M	M	M	M	M	H	M	M	H	M	M	H	M	H	M
[redacted]	M	H	H	H	M	H	H	H	M	H	H	H	H	H	M	M	H	H	H	H	L	H	H	H	H	H	H	M	H	M	H	L	M	M	L	H	H	H	H	M
[redacted]	H	H	H	H	M	H	H	H	H	H	H	H	H	H	M	M	H	H	H	H	H	H	H	H	H	H	M	H	H	M	M	M	L	M	L	H	H	H	M	M
[redacted]	M	H	H	H	M	H	H	H	M	H	H	H	H	H	M	M	H	H	H	H	H	H	H	H	H	H	H	M	H	M	H	L	M	M	L	H	H	H	H	M
[redacted]	M	H	H	H	M	H	H	H	M	H	H	H	H	H	M	M	H	H	H	H	M	H	H	H	H	H	M	M	H	M	H	L	M	L	L	H	H	H	H	M
[redacted]	M	M	M	H	L	M	M	M	M	H	H	H	H	H	M	M	H	H	H	H	M	H	H	H	H	M	M	M	H	M	M	M	M	M	M	H	H	M	H	M
[redacted]	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	M	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H
[redacted]	H	H	H	M	M	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	M	M	M	H	H	H	M	M
[redacted]	H	H	H	H	M	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	M	H	H	M	M	M	H	H	H	M	M
[redacted]	H	H	M	H	H	H	H	H	M	H	L	H	H	H	M	M	H	H	H	H	H	H	H	H	H	H	H	M	H	M	H	L	H	M	M	H	H	H	H	M
[redacted]	L	H	M	L	L	L	L	M	L	M	M	M	M	M	L	L	H	H	H	M	M	M	M	M	H	L	L	L	H	L	M	L	L	L	L	M	L	L	H	M
[redacted]	M	M	L	L	L	M	L	L	M	M	L	H	H	L	M	L	M	M	M	M	M	M	M	M	L	L	L	L	L	L	M	L	M	L	L	L	M	L	L	L

Sub themes	Emphasises clear command structures	Event Organiser Role defined	Safety Officer Roel Defined	TORs present for all roles	Conflict of interest managed	Chair competence	Escalation routes defined	Decision making authority clear	Encourages control room / event control	Evidence of interagency co-ordination	TTX undertaken prior to the event?	Promotes a multi-agency approach	Use of SAGs to coordinate agencies	Information sharing protocols	Real-time communications systems	Common operating picture	Production of Event Safety Plan	Emergency planning undertaken	Site plans available and up to date	Crowd management plans present	Medical provision present	Traffic management plans present	Evacuation plans produced	Casualty handling plans present	Risk profile considered	Risk escalation thresholds	Review Frequency	Dynamic risk assessment	Risk assessments conducted and present	Dedicated Safety Professionals	Leadership Competence	Required Qualifications	Experience Expectations	Debriefs/Lessons Learned	Audits	Governance proportional to event complexity	Thresholds for advanced oversight	Resource scalability	Advisory v Mandatory system	Primary Regulator
	H	M	M	M	H	M	M	H	H	M	H	H	H	L	M	M	H	H	H	M	M	M	M	H	M	M	M	H	M	M	H/M	H	H	H	M	L	L	H	M	M
	M	M	M	M	L	M	M	M	N	M	N	H	H	L	N	L	M	M	M	M	M	M	N	N	M	L	L	L	M	M	M	N	M	L	H	M	L	L	H	M
	L	L	L	M	L	L	L	L	L	L	L	M	M	L	N	N	L	L	L	L	L	L	N	N	L	L	L	L	L	L	L	L	L	L	M	L	L	L	M	L
	H	H	M	H	H	H/M	H	H	M	H	N	H	H	M	M	M	H	H	H	H	H	H	H	H	H	H/M	M	M	H	H	M	N	N	H/M	M	H	M	M	H	H
	H	H	H	H	H	H	H	H	M	H	N	H	H	H	M	M	H	H	H	H	H	H	H	H	H	H/M	H	H	H	H	M	M	H	M	M	H	M	H	H	H
	M	H	M	N	N	N	M	M	H	M	N	H	M	H	H	H/M	H	H	H	H	H	H	H	H	H	M	M	H	H	H	H/M	H	H	L	M	H	M	H	M	H
	H	H	H	M	N	M	M	H	H	H	M	H	H	M	H	M	H	H	H	H	H	H	H	M	H	M	M	H	H	H	M	M	H	M	N	H	M	M	H	N
	H	H	M	H	L	H	M	M	L	H	N	H	H	M	M	L	H	M	H	M	H	H	M	M	H	M	M	M	H	H	H	M	M	M	L	H	M	H	H	H
	H	H	M	H	M	H	M	H	N	H	N	H	H	M	N	N	H	M	H	M	H	H	M	M	H	H	M	N	H	H	H	H	H	H	L	H	H	M	H	H
	H	H	H	M	N	M	M	H	L	M	N	M	M	H	H	M	H	H	H	H	H	H	H	H	H	M	M	H	H	M	M	M	M	M	L	H	M	H	H	H
	M	H	L	M	N	N	M	H	M	H	N	H	H	M	N	N	H	H	H	H	H	H	M	M	H	M	M	M	H	H	M	N	M	M	N	H	M	H	H	M
	H	M	M	H	H	H	H	H	N	H	M	H	H	M	N	N	M	M	N	M	M	N	M	N	H	M	H	M	M	H	H	M	H	H	H	H	M	H	H	H
	M	M	M	L	N	L	M	H	H	H	N	H	H	M	H	M	H	H	M	M	H	H	H	M	H	M	M	M	H	M	M	N	M	M	N	H	H	M	H	M
	H	H	H	L	N	M	H	H	H	H	M	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	M	H	H	H	H	H	H	H	H	H
	M	H	M	N	N	L	H	H	M	M	N	M	N	M	H	M	H	H	H	M	H	M	H	H	H	H	M	M	H	M	M	M	M	M	N	M	L	M	M	H
	H	H	H	H	M	H	M	H	M	H	M	H	H	H	N	M	H	H	M	H	H	M	H	H	H	M	H	M	H	H	H	H	H	H	H	H	H	H	H	H
	H	H	H	H	M	H	H	H	H	H	M	H	H	H	M	M	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H
	H	H	M	H	H	H	H	H	M	H	N	H	H	H	N	N	H	M	M	M	H	H	M	M	H	H	H	M	H	H	H	H	H	H	M	H	H	H	H	H
	H	H	H	M	N	M	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H
	H	H	H	H	M	H	M	H	H	H	M	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	M	H	H	H	M	H	H	M	H	H	H	H	M

[redacted]		Sub themes
H	H	Emphasises clear command structures
H	H	Event Organiser Role defined
H	H	Safety Officer Roel Defined
H	M	TORs present for all roles
M	H	Conflict of interest managed
H	H	Chair competence
H	H	Escalation routes defined
H	H	Decision making authority clear
H	H	Encourages control room / event control
H	H	Evidence of interagency co-ordination
H	M	TTX undertaken prior to the event?
H	H	Promotes a multi-agency approach
H	H	Use of SAGs to coordinate agencies
H	H	Information sharing protocols
H	H	Real-time communications systems
H	H	Common operating picture
H	H	Production of Event Safety Plan
H	H	Emergency planning undertaken
H	H	Site plans available and up to date
H	H	Crowd management plans present
H	H	Medical provision present
H	M	Traffic management plans present
H	H	Evacuation plans produced
H	H	Casualty handling plans present
H	H	Risk profile considered
H	H	Risk escalation thresholds
H	H	Review Frequency
H	H	Dynamic risk assessment
H	H	Risk assessments conducted and present
H	H	Dedicated Safety Professionals
H	H	Leadership Competence
H	H	Required Qualifications
H	H	Experience Expectations
H	H	Debriefs/Lessons Learned
H	H	Audits
H	H	Governance proportional to event complexity
H	H	Thresholds for advanced oversight
H	H	Resource scalability
H	H	Advisory v Mandatory system
H	H	Primary Regulator

Appendix G – Addressing Stakeholder Disagreement

Throughout the course of this review, a small number of areas of stakeholder disagreement have emerged, most notably between FDDs, EOs, and those with legal or governance expertise. These disagreements do not reflect conflicting evidence about *what problems exist* but rather identify *how those problems should be resolved*.

Some FDDs expressed a desire for stronger advisory forums, clearer escalation mechanisms, or greater authority to resolve persistent safety concerns. Similarly, some EOs sought reassurance, consistency, or forms of external validation comparable to those used in non-aviation event sectors. These perspectives reflect genuine operational frustration and are supported by evidence showing variability in SAG practice and uneven quality of engagement, and are, notably, evident across all sectors, not just within flying displays.

However, the recommendations in this report do not adopt every stakeholder proposal wholesale. Where specific requests would introduce implied authority, shared accountability, pseudo or actual assurance, or escalation functions, they have been deliberately declined. This decision is informed by equally strong evidence from SAG Chairs, emergency services practitioners, and legal specialists demonstrating that such functions would be incompatible with the advisory nature of SAGs, inconsistent with CAP 403 and Article 86 intent, and likely to increase legal and safety risk through actual or pseudo-assurance and blurred accountability.

Importantly, declining these requests does not disregard stakeholder evidence collected so far. Instead, it reflects a necessary balancing of professional perspectives, with weight given to systemic risk, legal coherence, and human factors analysis. In several cases, the recommendations address the *underlying concern* raised by stakeholders, such as confidence, clarity, or proportionate challenge, through alternative means that do not require expanding authority or regulation.

Stakeholder disagreement has therefore been treated not as an obstacle, but as an important analytic signal. The final recommendations intentionally resolve these tensions in favour of clarity, constraint, and accountability preservation, rather than increased governance power. This approach is consistent with the evidence, the regulatory framework, and the long-term safety interests of UK civilian flying displays