

**Safety Management System Manual**

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# Acronyms & Definitions

## Acronyms

Acronyms and definitions used within this standard:

ALARP: As Low As Reasonably Practicable.

ASR: Air Safety Report.

SAG: Safety Action Group.

ERP: Emergency Response Plan (or Planning).

GOR: Ground Occurrence Report.

ICAO: International Civil Aviation Organisation.

JV: Joint Venture

IR: Incident Report

MOC: Management Of Change

MR: Management Review

QA: Quality Assurance

QC: Quality Control

QMS: Quality Management System

SAG: Safety Action Group.

SAT: Safety Action Team

SC: Safety Case

SI: Safety Investigation.

SMS: Safety Management System.

SMT: Safety Management Team.

SPR: Safety Performance Review.

SRB Safety Review Board

## Definitions

**Accident Aircraft:**

An occurrence during the operation of an aircraft which entails: (a) a fatality or serious injury, (b) substantial damage to the aircraft involving structural failure or requiring major repair, (c) or the aircraft is missing or completely inaccessible.

**Accident:**

An unintended event or sequence of events, giving rise to death, ill-health, injury, environmental or material damage or other loss.

**Active Error:**

Usually associated with human error by a frontline employee.

The consequences of this type of error are usually immediately apparent.

**As Low As Reasonably Practicable:**

A management strategy where the effects of an identified safety risk are mitigated to a tolerable level.

**Audit:**

A systematic and independent examination to determine whether activities and their output comply with company policies, standards, processes and procedures including any applicable national regulatory requirements.

**Base:**

A place where any flight operations, maintenance, support activity or administration activity takes place.

**Consequence:**

The final result of the release of a hazard that was not controlled.

**Continuous Improvement:**

A management strategy based on measurement and analysis of relevant data that leads to positive change.

**Control:**

Procedures or measures put in place to prevent an identified threat becoming a hazard.

**Emergency Response Management Team:**

A management team at the high level authorized to respond to or implement the emergency response plan.

**Hazard:**

Any condition that has the potential to cause an accident or harm.

**Incident:**

An occurrence, other than an accident, that affects or could affect the safety of the operation.

**Just Culture:**

“... An atmosphere of trust in which people are encouraged, even rewarded, for providing essential safety-related information, but in which they are also clear about where the line must be drawn between acceptable and unacceptable behavior.”

**Latent Condition:**

A systemic flaw usually associated with management decisions or actions. The consequences may not be identified for long periods of time. (Note: A latent condition will never be the sole cause an accident)

**Management Review:**

A structured meeting that takes place at regular intervals to discuss the functioning of a system and/or process to analyze its effectiveness, ability to identify areas for continued improvement and value to the business. To take action to correct or modify the system and/or process when necessary.

**Management Of Change:**

The Strategy and plan to facilitate change.

**Operational Control:**

A direct influence, input and management of day to day operations with the authority and ability to stop/cease maintenance operations and/or flight operations. I.e. bring to a stop a maintenance activity and/or grounding of aircraft operations.

**Quality Assurance:**

The independent management control process for evaluating the performance of a product or service which promotes continuous improvement of such products or services.

**Quality Control:**

An ongoing analysis of operations, to verify a product or service meet specified standards.

**Compliance Monitoring System:**

The managerial controls and oversight which assures a particular system, process or product operates to a defined standard and remains safe and airworthy

**Quality:**

The measure or degree of performance of a service or product to a defined standard.

**Quality of Service:**

A system designed to provide customers with the highest quality of service while ensuring compliance with all corporate and governmental standards, codes, and regulations that is communicated throughout the Organisation and promotes continuous improvement.

**Risk Assessment:**

Evaluation of the severity and probability of a hazard.

**Risk Control:**

The mitigation measures which may (a) act to prevent the hazardous event from occurring or

(b) to provide a suitable means of recovery from the hazardous event

**Risk Management: XX mitigation**

Consists of hazard identification, risk assessment, and the allocation of resources to address the risk (if required).

**Risk Matrix:**

A cross reference chart used as a decision aide based on set criteria to enable classification of a hazard.

**Safety:**

The state in which the possibility of harm or damage to persons or of property is reduced to, maintained at or below an acceptable level through a continuing process of hazard identification and safety risk management.

**Safety Action Team:**

Frontline leaders who identify hazards and implement corrective action.

**Safety Investigation:**

A structured and independent review of an incident.

**Safety Action Group:**

The mean’s in which risks are collectively assessed, classified and accepted within a specific function.

The Safety Action Groups (SAG) objectives are to seek methods to improve the company’s safety program to encourage safe practices, facilitate targeted risk based decision making and provide accident prevention and safety recommendations to the Accountable Manager. SAG can also be established as an ad-hoc group by the Accountable Manager or the Safety Manager for a certain safety case. SAG teams will identify Hazards, conduct Risk Assessments and MOC`s as required. All decisions and actions taken by SAG shall be followed up the company’s global archive or another acceptable system.

**Safety Case:**

A complete body of evidence and argument that demonstrates that an operation, system or activity is acceptably safe. A safety case is made up of a number of risk assessments.

**Safety Case Report:**

The documented body of evidence that identifies the hazards and controls necessary to ensure the equipment and processes utilized in a particular environment meet the principles of ALARP. A safety case report should consider (but not limited to): (a) personnel, (b) environment, (c) equipment, (d) facilities, and (e) processes.

**Safety Management Team ,**

Organization senior management structure consisting of Safety Manager, Chief Pilot, Operation Manager and AMO. The Safety Management team will be responsible for the development, administration and maintenance of an effective Safety Management System, which focuses more on the safety aspects of the operation

**Safety Review Board:**

The Safety Review Board (SRB) is a high level committee which considers strategic safety functions. The Accountable Manager will normally chair the meeting with nominated personnel and Safety & Compliance in attendance. The Safety Review Board meetings should be conducted as quarterly meetings focusing on resource allocation, safety performance and strategic direction to Safety Action Groups (SAG). The SRB will look to the SAG to highlight high level risks and provide input to high level strategy.

**Safety Management System:**

“A systematic approach to managing safety, including the necessary organisational structures, accountabilities, policies, and procedures.”

**Safety Performance Indicator**

A data-based safety parameter used for the monitoring and assessing of safety performance.

**Safety Performance Review:**

A planned periodic management review of safety performance and risk management capability. Reviews are conducted throughout the company at various levels.

**Threat:**

Something with the potential to release a hazard.

# Introduction

This manual sets out the policy, responsibilities, structure and processes that are used to manage the safety risks associated with Brook Aviation as part of the organisation wide Safety Management System (SMS).

The SMS is based upon a systematic and proactive approach to hazard identification and risk management which is intended to improve the organisation’s overall safety performance. It aims to go beyond compliance with prescriptive regulatory requirements and to adopt a business-like approach to safety management focusing more on effective performance within each of the constituent components.

This manual defines the, procedures, processes and policies required to maintain the SMS. Including general descriptions of the organisational and management structures, management responsibilities, Risk and Change Management and Performance Review Processes.

**Contents Description**

scope of the safety management system;

safety policy and objectives;

safety accountability of the accountable manager;

safety responsibilities of key safety personnel;

documentation control procedures;

hazard identification and risk management schemes;

safety action planning;

safety performance monitoring;

incident investigation and reporting;

emergency response planning;

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

Safety promotion.

## Objectives

* + 1. The objective of the Safety Management System is to have a systematic approach to managing safety, to monitor and regularly assess safety performance, including the necessary structures, accountabilities, policies and procedures. SMS is not a single entity but a group of defined organisational processes to be utilized when a hazard is identified and risk assessment is required to mitigate and control risk.
    2. The Hazard identification and risk assessment system should communicate the ability to demonstrate that safe operations can be achieved and that identified levels of risk are controlled and held at an appropriate level of the organisation. A risk assessment is a document produced that identifies the hazards and describes how risks are mitigated and controlled.
    3. The Hazard identification and Risk assessment system is a live system, which is updated to reflect the current status following any significant changes.
    4. The Safety Management Systems objectives cover a demonstration of the following:
       1. The provisions of the Company’s corporate Safety Management System are being applied to the particular operation to ensure that it is fit for purpose and safe for continued operation.
       2. All potential hazards and issues which could present a major risk to safety of the operation have been identified and fully assessed, and that adequate management controls are in place to ensure that the risk is as Low as Reasonable Practicable (ALARP).
       3. The customer contract and the relevant safety regulators safety requirements are complied with.
       4. Appropriate procedures and controls are in place to ensure that all safety significant interfaces between the company and the client are maintained and cross boundary risks are identified and managed.
       5. All significant safety deficiencies have been identified, and targeted remedial action programme is in place to improve effectiveness.
       6. A programme of proactive work is in hand to achieve continuous safety improvement.
       7. A relevant set of safety targets and performance indicators is in use to enable safety performance to be closely monitored.
    5. There are adequate arrangements for incident investigation and follow-up, audits and management reviews to assure the effectiveness of the Safety Management System.

## Scope

* + 1. The SMS is the explicit element of the corporate responsibility which sets out the company safety policy and defines how it intends to manage safety as part of its overall business.
    2. This manual demonstrates compliance with the Brook SMS Standard and serves as the combined Safety and Compliance Management documentation to meet the requirements of all aviation regulatory requirements applicable to our business.
    3. The applicable requirements apply to all aspects of Brook business; these responsibilities may be shared between parties through a contract, although accountability remains within the Brook management organisation.

## Applicability

* + 1. This manual applies to all Brook work areas, all Brook staff and any staff working on a Brook site.

# Safety and Compliance Governance

The diagram below represents the basic Safety Management process adopted by Brook.

The Brook Safety Management System is comprised of four fundamental pillars. These are Compliance Monitoring, Safety Management, HSE and Flight Safety. The activities underneath these pillars, and the interactions between them, ensure that the Brook safety standards are maintained.

The objective of the Safety organisation is to promote safety, continuous improvement and to ensure the proactive management of risk to an acceptable level whilst maintaining compliance with industry standards and regulatory requirements.

Brook’s Safety Management structure:



## Safety Manager

* + 1. The Safety Manager will ensure Brook practices are aligned with National Aviation Authority requirements and customer contractual obligations.
    2. This position is accountable for identifying the employees safety training needs while ensuring the right standards and capability within the company are met and sustained.

## Safety Management

* + 1. The primary point of contact for the role will be the Safety Manager as the nominated person. Activities will include:
       1. Monitoring the effectiveness of the SMS
       2. Initiating corrective actions when necessary
       3. Providing safety reports on SMS performance
       4. Providing safety related advice
       5. Ensuring safety related documentation and records are available and up to date
       6. Facilitating and managing monthly Safety Committee meetings

## Safety Management Team

* + 1. As a minimum, The following participants will be members of the Safety Management Team:
       1. Safety Manager
       2. Chief pilot
       3. Ops Manager
       4. CAO
    2. The safety manager can add members to the committee if needed.
    3. The Safety Management Team meetings should be conducted as Monthly meetings focusing on resource allocation, safety performance and strategic direction to Safety Action Group (SAG).
    4. The Safety Management team will be responsible for the development, administration and maintenance of an effective Safety Management System, which focuses more on the safety aspects of the operation. This will assume responsibility for the coordination and control of the following elements:
       1. Risk Management
       2. Safety Promotion
       3. Management of Change
       4. Emergency Response Planning
       5. Continual Improvement

# Safety Management Policy

Brook Aviation Ltd. is committed to providing our clients with safe and reliable helicopter operation services to the highest degree. We recognize that helicopter operations pose unique risks and challenges. To mitigate these risks and ensure the safety of our employees, clients, and the public, we have developed this Safety Policy that manages all safety risks to As Low As Reasonably Possible (ALARP) levels.

Our senior management is committed to providing leadership, resources, and support to implement and maintain effective safety management practices. Safety is a core value at Brook Aviation Ltd., and we will strive to continuously improve our safety performance through active participation and engagement at all levels of the organization.

Our Safety Policy is based on the following principles:

1. Compliance: We will comply with all applicable laws, regulations, and industry standards to ensure safe operations.
2. Risk Management: We will identify, assess, and mitigate the risks associated with our operations to minimize the likelihood of accidents and incidents.
3. Safety Culture: We will foster a positive safety culture by promoting open communication, reporting of safety concerns, and learning from incidents and accidents.
4. Training and Competence: We will provide our employees with the necessary training and resources to perform their duties safely and effectively.
5. Continuous Improvement: We will monitor and evaluate our safety performance to identify opportunities for improvement and implement corrective actions to prevent recurrence.

To achieve these principles, we will implement the following safety management systems:

1. Safety Reporting System: We will establish a safety reporting system to encourage reporting safety concerns and incidents without fear of retribution. All reports will be investigated and corrective actions implemented as necessary.
2. Safety Risk Management System: We will implement a safety risk management system to identify, assess, and mitigate the risks associated with our operations.
3. Safety Assurance System: We will implement a safety assurance system to monitor and evaluate our safety performance, and implement corrective actions to prevent recurrence.
4. Safety Promotion System: We will promote safety through training, communication, and engagement with all employees.
5. We will regularly review and update our Safety Policy and safety management systems to ensure their effectiveness and continuous improvement. This Safety Policy will be communicated to all employees, contractors, and stakeholders, and will be available to the public upon request.
6. We believe that safety is everyone's responsibility, and we expect all employees and contractors to actively participate in our safety management systems and support our Safety Policy.

# Safety Committees

## Safety Action Group

* + 1. The Safety Action Group (SAG) objectives are to seek methods to improve the company’s safety program to encourage safe practices, facilitate targeted risk based decision making and provide accident prevention and safety recommendations to the Accountable Manager & Safety Management Team. SAG can be established as an ad-hoc group by the Accountable Manager or the Safety Manager for a certain safety case. SAG teams will identify Hazards; conduct Risk Assessments and Management of Change (MOC) as required. All decisions and actions taken by SAG shall be followed up in an acceptable system.
    2. SAG reports to the Safety Manager. Within the defined scope of interest SAG will:
       1. Monitor operational safety;
       2. Resolve identified risks;
       3. assess the impact on safety of operational changes; and
       4. Ensure that safety actions are implemented within agreed timescales.
       5. Review the effectiveness of previous safety recommendations and promotion.
       6. Propose safety recommendations.

## Safety Performance Review Process

* + 1. An overall review will perform quarterly by the Safety Review Board. This review will focus on the Company’s Safety Policy and Safety Management System. The purpose is to establish and review the effectiveness of Safety Performance Indicators, review safety policies, consider and endorse (as appropriate) major initiatives and review Safety & Compliance performance.

# Introduction to Continuous Improvement

The aim of the Brook Safety Management System is to promote a process approach to continuous improvement across all aspects of the Organisation to enhance both internal and external customer satisfaction and ensure the promotion of safety both internally and outwardly toward our clients and business partners. The ultimate goal is to ensure the proactive management of risk to an acceptable level, as low as reasonably practical (ALARP).

Continuous improvement of the SMS is measured through the monitoring of the organisation’s safety performance indicators and is related to the maturity and effectiveness of the SMS. Safety assurance processes support improvements to the SMS through continual verification and follow-up actions. These objectives are achieved through the application of internal evaluations and independent audits of the SMS.

Employees are encouraged to challenge and intervene where aspects of safety are compromised and similarly where areas of compliance are breached through a variety of formal safety reporting mechanisms whilst also having the freedom and means available to proactively highlight opportunities for improvement.

For the organisation to function effectively each process must be identified, documented, managed and communicated to all staff in order to ensure effective interaction between all internal departments, business units and clients alike. i.e. all parts of the business.

Each element of the company standards are addressed within the Compliance Monitoring Function, however due to the nature and complexity of the company regulatory approved disciplines these elements are spread out over a number of Company Manuals.

## Introduction to Continuous Improvement

* + 1. The diagram below is a simplified guide to how the company implements the continual improvement process across the business.
    2. The above is a representative PDCA (Plan Do Check Act) cycle within our business. This promotes the opportunity to continually improve our business by monitoring our success against our planned goals and objectives further to the initial risk assessment.

# Safety Management System Structure

The Brook Safety Management System designed to achieve safe, compliant operations at all levels.

The Accountable manager is responsible for the effective management of the risks associated with the activities carried out at their operations. The Accountable Manager will be supported by the Safety Management Team, who will include any regulatory authority nominated persons appointed in compliance with the regulatory environment.

The management of associated safety and regulatory compliance is cascaded down to operational level where all Staff lend their operational experience particular to their technical discipline toward the conduct and maintenance of the associated safety and compliance risks.

## Responsibility

* + 1. An effective SMS requires team activity, involving people with different backgrounds from across the organisation. Clear allocation of safety responsibility and accountability is essential.
    2. It is important to understand that responsibility is different from accountability.
    3. An individual is ‘**Responsible**’ when they are capable of being trusted with and assigned important duties, independent decision-making, and/or control over others.
    4. An individual is **‘Accountable’** when they are a nominated person, required and/or expected to justify actions, decisions or lack thereof.
    5. Responsibility may be delegated, accountability cannot.
    6. This section outlines specific safety accountabilities for senior managers down to generic safety accountabilities for all company employees and contractor’s staff.

# Management, Planning & Resource Management

## Introduction

* + 1. It is a requirement and business practice to plan and effectively manage the availability of all necessary facilities, equipment, tools, materials, documentation, maintenance data, regulatory standards and personnel, including training, to ensure the safe and timely conduct of all aspects of Brook operations.
    2. The planning of all such operations and work patterns shall take into account human performance limitations.

## Responsibility

* + 1. Management personnel responsible for a particular operation or process shall ensure sufficient resource is available for the planned activity.
    2. These personnel include but are not limited to;
       1. Senior Management
       2. Post Holders / Nominated Persons
       3. Base / Department Managers
       4. Chief Pilot / Chief Engineer
       5. Commercial management

## Routine Planning

* + 1. With the Region department or base working within the normal scope of work the necessary facilities, equipment, tools, materials and data shall all be available at the required levels specified by the applicable standards and regulations.
    2. In areas such as Flight Operations and Aircraft Maintenance a manpower plan will be maintained to ensure that sufficient personnel are available to meet the varying operational commitments.

## Temporary / Unplanned events

* + 1. When an unplanned significant task or a temporary increase in routine.
    2. Operations is experienced an MOC or process review must be undertaken. This provides the assurance that the additional requirements are all addressed and in place or planned before work commences to avoid any unnecessary risk or introduction of a safety hazard.

## New Business / Contract

* + 1. During the invitation to tender phase of any new contract or business opportunity a pre contract meeting shall be held with all relevant disciplines to determine the magnitude and interfaces required to assure the necessary resources are in place to fulfil the demands of such new business.
    2. New contracts shall be risk assessed for their impact on the current organisation and shall have a gap-analysis carried out on them to ensure all audit criteria necessary are captured.

## Human Factors and Critical Tasks

* + 1. When planning operational or maintenance work, the limitations of human performance and critical tasks must be taken into account to ensure safe working standards.
    2. For full details of the operational planning processes refer to the applicable procedures contained within the relevant approved manuals.
    3. See Chapter 2, Section 1

# Brook Communication Charter

## Safety Promotion

* + 1. Timely and effective communication is an important element of the SMS, and through a variety of means, is used is to promote the growth of a positive safety culture by;
       1. Publishing the company specific safety policies and a safety mission statement which is distributed throughout the company.
       2. Encouraging active participation in a confidential, non-punitive employee reporting and feedback system.
       3. Ensuring safety reports submitted by employees are handled in a manner consistent with a “just culture”, and that feedback is provided to employees.
    2. The methods to communicate safety concerns throughout the business may include but are not limited to;
       1. Newsletters.
       2. Bulletin boards.
       3. Intranet website.
       4. Safety investigation reports.
       5. Posting of applicable Safety Management Action Log.
       6. Safety bulletins, alerts, etc.
    3. Reporting is an essential element of the SMS and all employees are encouraged to utilize the methods listed below to report incidents, accidents and areas for improvement;
       1. Air Safety Report’s
       2. Ground Occurrence Report’s
       3. Accident Report’s (HSE)

# Safety Performance Indicators

## Introduction

* + 1. To sustain a proactive SMS the following items should be reported, recorded, analyzed and communicated as a minimum to promote awareness of Safety performance: the following metrics should be communicated:
       1. Total Recordable Injury Rates:

These are the rates calculated for any recordable incident that occurs within the operations. It is calculated against 200,000 man hours worked to provide a statistic and comparable metric

* + - 1. Air Accident Rate:

These are the rates calculated for any serious incident or air accident that the company suffers. This metric is calculated against 100,000 flight hours.

* + - 1. Safety Management Team open assignments:

We have a legal obligation to close out as efficiently as possible any and all open Safety Management Team assignments. This metric is to be used to highlight any overdue findings that have exceeded the originally stated remedial action time frame.

* + - 1. Hazard identification:
         1. Assess any accidents, incidents or occurrences
         2. Ensure that any future changes are satisfactorily mitigated for.
         3. Review any industry related knowledge to predict of there are any hazards in need of re- assessment, or if new hazards are in need of a predictive assessment.
         4. Recent accidents and incidents.
         5. Safety lessons learned by frontline employees.

## Client Specific Communication

* + 1. Any accidents, incidents or occurrences, lost work cased, restricted work cases, or fatalities will be reported to the Safety Manager as soon as possible but no later than 24hours.

# Risk Management

## Introduction

* + 1. Generic Operational risks assessments will be managed through Aircraft and Mission registers. These risk assessments will be periodically reviewed and managed.
       1. Risks that are deemed “Acceptable” are to be signed off at local management level.
       2. Those risks that have been quantified as “Acceptable with Mitigation” will be passed to the Safety Management team for review and sign off.
       3. For risks considered as “Unacceptable” then further action is required to reduce the risk to “as low as reasonably practicable” before being accepted with mitigation – STOP the process and forward to Safety Management for further review and support.
    2. When a new risk is identified and the risk needs to be documented and controlled by the Safety Manager. A copy of the Risk Assessment must be forwarded to the Safety Team for monitoring. This will then be subject to further review.

## Risk Mitigation Controls:

* + 1. All control barriers used in risk mitigation must be against a company procedure, process, and document or technical data controlled through the document control process. Each of these documents will have a nominated owner assigned.
    2. As a measure of continuous improvement; Risk assessments and their controls will be included as part of the on-going Audit process by Safety Manager

# Management of Change

## Introduction

* + 1. Management of change (MOC) is a system or process for managing risk associated with the introduction of change within Brook aviation. Communicating those changes effectively, what, how, when and progressed through to completion within an agreed timescale. Such changes may include operational, organisational and infrastructure.
    2. Significant or complex changes within the business may require detailed planning and project management whereas minor changes may simply require procedural updates and communication regardless of the nature all such changes require to be effectively controlled.
    3. Significant changes are those which have a notable impact on the operation and can be considered outside the scope of day-to-day business as usual practices. Significant changes shall follow the MOC process documented within this element of the SMS.
    4. Specific situations requiring MOC include, but are not limited to changes in;
       1. Aircraft tasking.
       2. Software or electronic systems.
       3. Manning levels.
       4. Operating limits.
       5. Processes and procedures.
       6. Facilities and infrastructure.
       7. The organisational structure.
       8. Security precautions.
       9. Emergency controls.
    5. Within Brook, each employee has a duty to consider the impact of any prospective change on safety and service delivery.
    6. Major changes within the business require detailed planning and project management. A major change is one which could lead to an accident or serious incident, financial damage, loss or damage to reputation, the environment or a significant increase to our security risk.
    7. Regardless of whether the change is major or minor, all such changes require effective control and use of the MoC process.
    8. Keys to an effective MoC are:
       1. Identifying who is responsible and accountable for the change as owners and stakeholders
       2. Identifying the potential risks created by the change
       3. Identifying the potential safety effects of the change
       4. Identifying what processes within the organisation will be used to manage the risks identified in the change
       5. How the change will be managed
       6. Clearly communicating what is changing
       7. Communicating the basis for change effectively (i.e. a communications plan)
       8. Identifying and confirming when the change is effective

## How we do it

* + 1. We start from recognizing that a change is required, this should lead to a brainstorming activity conducted by a Safety Action Group (SAG) from all areas of the business affected by the change.
    2. MoC documentation is essential for providing a front-end risk assessment, assigning ownership to action items, tracking them to closure and verifying their implementation. Documenting the MoC serves several purposes including but not limited to:
       1. Describing the change
       2. Identifying stakeholders and their assumptions
       3. Identifying the change team members accountable for the change
       4. Identifying and assessing the risks associated with the change
       5. Identifying and publishing the issues to be managed as part of the change process
       6. Ensuring resources are available to manage the risks associated with the implementation of the change
       7. Tracking the actions through to closure
       8. Verifying effectiveness of risk controls
       9. Providing an auditable trail for review
    3. The MoC document may act as a stand-alone project document for the MoC, or alternatively for a large project. the MoC should be a sub-set of the overall project plan. For a large project the project plan should be referenced in the MoC.
    4. The steps within the MOC are illustrated by the following diagram:



* + 1. This MoC form is to be used for all MoC activities. Depending on the type of change, not all of the boxes are required to be filled out and due to the design of the form, if required, extra rows can be easily added. The form is split into manageable steps which can be easily referenced and located, each of these steps is explained below alongside an example MoC

STEP 1: Overview of the change

The change should be clearly described and reasons should be given for why we are making the change, what type of change it is and who the stakeholders are. The facilitator will provide the reference number.

| **STEP 1: Overview of Change (Example)** | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1.1 Type of change: | | | | | | | | | | |
| ☒ Equipment | ☒  Procedure/Process | | | * Personnel | | | * Materials | | | ☒  Infrastructure |
| 1.2 General Information | | | | | | | | | | |
| Reference No.: | | | 0001 | | | Date Raised: | | 18th June 2016 | | |
| Originator: | | | Operations Manager | | | MoC Owner: | | Region Director | | |
| Region/AOC/Base/Department: | | | SAR | | |  | |  | | |
| 1.3 Description of the proposed change: | | | | | | | | | | |
| Introduction into service of Very Pistol and Cartridges | | | | | | | | | | |
| 1.4 Why make this change: | | | | | | | | | | |
| New type of pistol required to fulfil contract | | | | | | | | | | |
| 1.5 Stakeholders: | | | | | | | | | | |
| * Business Development | | ☒ Flight Operations | | | ☒ Airworthiness | | | | ☐  Engineering/Mx | |
| * Supply Chain | | * Quality & Safety | | | * Human Resources | | | | ☒ Finance | |
| * IT | | ☒ Document Control | | | ☒ Regulator | | | | * Manufacturer | |
| ☒ Third Party | | ☒ Client(s) | | | * Unions | | | | ☒ SAR | |
| 1.6 Definitions and assumptions: | | | | | | | | | | |
| Assumptions – a firearms permit is required for the pistol base; and the chief pilot will hold the permit | | | | | | | | | | |

STEP 2: Control of the change

All changes must be monitored and Records of all documents associated with the change should be noted and stored; for example, a communication plan or any associated documents supplied from the Regulator. If there are any approvals required in order to process the change, both internal and external, these should be noted and tracked to achievement. All Safety Action team members should be identified along with other key stakeholders. At key points throughout the change, the process should be reviewed for compliance by the Quality and Safety Department

| **STEP 2: Control of the Change (Example)** | | | | | |
| --- | --- | --- | --- | --- | --- |
| 2.1 How will the change be monitored? | | What system will be used to monitor and ensure that this change is effective?  Specify: | | | |
| 2.2 Records | | *Please list or link any documentation that will be generated and describe how will it be disseminated and stored?*  Firearms permit record | | | |
| 2.3 External Documents | | *Please list or link any documents been provided by the OEM, Regulators etc associated with the change.*  Firearms permit application | | | |
| 2.4 What approvals are required? | | Internal Approvals | | | Point of contact for the Approval: |
| AOC ☒ | | |  |
| Base ☐ | | |  |
| Department ☐ | | |  |
| External Approvals | | |  |
| Client ☐ | | |  |
| Regulator ☒ | | |  |
| Other ☒ | | |  |
| Specify: Police | | |  |
| 2.5 Change Team Members | Name   1. Safety Manager 2. Operations Manager | | | Department  Operations | |
| 2.6 Key stakeholders | Internal   1. Chief Pilot 2. Supply Chain | | | Department  Operations Supply Chain | |
| External  1. Police 2. | | | Client, regulator, union etc Local Police Service | |
| 2.7 Compliance review (Q&S): | | | | | |
| *A general compliance review which should consider if there are any extra audits or change(s) to audit checklists required during change?*  Full trial required before introduction | | | | | |
| Participants | | | Date | | |
| Safety Manager | | | 20th June 2022 | | |
| Chief pilot | | | 20th June 2022 | | |
| 2.8 Are any Brook Publications affected and updates required? | | | | | |
| Publication | Date submitted and ref | | | Description | |
| Operations Manual  MCM | 21st June 2022 | | | Update to equipment list | |
|  |  | | |  | |

STEP 3: Risk Management of the change

It is essential that any existing hazards and risks within our risk management system are reviewed to ensure any effects of the change to these are recorded and monitored. These should be referenced in Step 3. Next, all activities within the MoC should be identified along with any potential risks; these need to be assessed and assigned an owner. Each of these risks then need to be controlled via actions, these actions should also be assigned owners and managed. These actions should be assessed for their effectiveness and be given a target date if not yet in place.

| **STEP 3: Risk Management of the Change (Example)** | | | | | | | | | | | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 3.1 Review of existing Risk Assessments (Please review existing hazards and risks within SMAL 2 and note any that are affected by this change) | | | | | | | | | | | | | | | | | | | | | |
| 1. | Hazard | | | | | Aircraft getting airborne in an unsafe condition | | | | | | | | Risk | | Safe flight compromised | | | | | |
| Owner | | | | | Operations Manager | | | | Residual Risk | | | | 0B | | Risk Reference | | | Risk 833 | | |
| 2. | Hazard | | | | |  | | | | | | | | Risk | |  | | | | | |
| Owner | | | | |  | | | | Residual Risk | | | |  | | Risk Reference | | |  | | |
| **ERC MATRIX** | | | | | | | | | | | | | | | | | | | | | |
| **Q2 - How many effective controls are in** | | | | | | | | **Q1 - If the Change Process around this risk is not managed effectively, what is the most credible outcome?** | | | | | | | ***Example of equivalent operational scenarios (accident, injury, damage)*** | | | ***Example of equivalent non- operational scenarios (security, environmental, reputational,***  ***financial)*** | | | |
| **place to mitigate this risk and will remain** | | | | | | | |
| **unaffected throughout the Change Process?** | | | | | | | |
| ≥3 | | 2 | | | 1 | | No |
| effective | | effective | | | effective | | effective |
| controls | | controls | | | control | | controls |
| 50 | | 102 | | | 502 | | 2500 | Catastrophic Accident or Loss | | | Fatality or PTD, Class A aircraft accident, loss of facility | | | | Loss of control, mid air collision, uncontrollable fire, explosion, primary structural failure, CFIT/(W), fall from height (>2m) | | | Actual threat to security of life, uncontained environmental disaster, global reputational damage and financial loss of  >$10M | | | |
| 10 | | 21 | | | 101 | | 500 | Major Accident, Injury or Damage | | | Serious injury, Class B aircraft accident, facility degraded | | | | Rotors running (or high speed) ground collision, ditching, injuries due turbulence, falling from height (<2m), PTD injuries, building evacuation | | | Possible threat to security of life, environmental event involving external agencies, regional reputational damage or financial loss of  $1M < $10M | | | |
| 2 | | 4 | | | 20 | | 100 | Minor Accident, Injury or Damage | | | Minor injury, Class C or D aircraft accident, minor facility damage | | | | Damage due to towing incidents, weather damage including lightning strike/blade sailing, LWC and MTC injuries | | | Non-life threatening security impact, company-managed environmental impact, local reputational damage or financial  loss of <$1M | | | |
|  | | | | | | | |  | | |  | | | |  | | |  | | | |
| *Relative Risk Value (RRV)* | | | *Resulting Safety Activity* | | | | | | | | | | | | | | | | | | |
| 2500 - 500 | | | Stop Change Process or implement additional effective controls | | | | | | | | | | | | | | | | | | |
| 102 - 20 | | | Establish and record risk indicators to be monitored constantly throughout Change Process | | | | | | | | | | | | | | | | | | |
| 10 - 2 | | | Monitor and review risk frequently throughout Change Process | | | | | | | | | | | | | | | | | | |
| 1 | | | Monitor and review risk regularly throughout Change Process | | | | | | | | | | | | | | | | | | |
| 3.2 Risk Assessment | | | | | | | | | | | | | | | | | | | | | |
| Item | | | | Activity | | | | |  | | | | | | | | | | | | Relative Risk Value (RRV) |
| 1. | | | | Procurement of pistol | | | | | Potential Risk: | | | Failure to gain license for weapons | | | | | | | | | 502 |
|  | | | |  | | | | | Owner: | | | Operations Manager | | | | | | | | |  |
| 2. | | | | In service support | | | | | Potential Risk: | | | Repair/maintenance and disposal policy | | | | | | | | | 102 |
|  | | | |  | | | | | Owner: | | | Operations Manager | | | | | | | | |  |
| 3.3 Risk Treatment | | | | | | | | | | | | | | | | | | | | | |
| Item | | | | Action (control) | | | | |  | | | | | | | | | | | | |
| 1. | | | | Obtain license for weapons | | | | | Owner: | | | | Operations Manager | | | | Target Date: | | | 30th June 2022 | |
| Effectiveness: | | | | Effective | | | |  | | |  | |
| Escalation required? | | | | No | | | | Status: | | | Closed | |
| 2. | | | | Repair/maintenance and disposal policy required | | | | | Owner: | | | | Operations Manager | | | | Target Date: | | | 30th June 2022 | |
| Effectiveness: | | | | Effective | | | |  | | |  | |
| Escalation required? | | | | No | | | | Status: | | | Clsoed | |

STEP 4: Communication of the change

It is very important to communicate the change that is taking place, you need to assess which stakeholders need to know, and decide on a communication focal point. There will be a number of different types of communications that will go out as the change progresses and it is important that you note when the first communication went out here.

| **STEP 4: Stakeholder Communication** | | |
| --- | --- | --- |
| Stakeholders | Communication Focal Point | Date of 1st Communication |
| ☒ Flight Operations | Operations Manager | 18th June 2022 |
| ☒ Airworthiness | Chief pilot | 20th June 2022 |
| * Engineering/Mx. |  |  |
| * Supply Chain |  |  |
| * Quality & Safety |  |  |
| * Human Resources |  |  |
| ☒ Finance | Finance Manager | 20th June 2022 |
| * IT |  |  |
| ☒ Document Control | Document Control Manager | 21st June 2022 |
| ☒ Regulator |  | 18th June 2022 |
| * Manufacturer |  |  |
| ☒ Third Party | Local Police Service | 18th June 2022 |
| ☒ Client(s) | Contract Manager | 18th June 2022 |
| * Unions |  |  |

STEP 5: Project Management

If a project plan is required for the change then there is a need to reference this project plan and provide a link to it so that it is easily accessible. The Project Manager should be named.

| **STEP 5: Project Management** | | | |
| --- | --- | --- | --- |
| *Please insert a link to the existing project plan for this change*  Project Plan not required | | | |
| Project Approval Authority: | Not Applicable | Project Manager: | Not Applicable |

STEP 6: Review of the Change

Once the change has been completed all change team members must review the MoC and sign off their approval of the completion. The change must be reviewed for its effectivity; any unexpected effects and the lessons learnt should be recorded and taken forward to future MoC activities. If there is a project plan associated with this change then the Project Manager should confirm via sign off that this has been completed, the Risk Assessment Review must also be signed off as complete prior to the MoC being closed by the MoC Owner.

| **STEP 6: Review of the Change (Example)** | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 6.1 CHANGE TEAM MEMBERS APPROVAL OF COMPLETION | | | | | | | | | |
|  | Name | | | | Sign | | | Date | |
| 1. | Safety Manager | | | |  | | | 30th June 2022 | |
| 2. | Operations Manager | | | |  | | | 30th June 2022 | |
| 6.2 Final Review | | | | | | | | | |
| Is a further review required? | | Yes ☐  No ☒ | Periodicity | 1 Month ☐ | | 3 Months ☐ | 6 Months ☐ | 9 Months ☐ | 1 Year ☐ |
| Is the change effective? | | | Yes |  | | | | | |
| Are modifications required? | | | No |  | | | | | |
| Are there unexpected effects on other areas? | | | The timescal initially expe | es to obtain the permit were longer than expected – 6-8 weeks instead of 3-4 ted | | | | | |
| Lessons learnt for future projects? | | | Will apply for | such permits earlier in future | | | | | |
| Project Plan Review  (if applicable) | | | Please confirm t  PRINT | hat the project plan associated with this change has been completed | | | | |  |
|  |  | SIGN |  | DATE |  |
| Risk Assessment Review | | | Please confirm  PRINT | that all risks have been managed and updated where applicable in the Brook Risk Assessment  System | | | | | |
|  |  |  |  | 30th June 2022 | |
|  |  | SIGN |  | DATE |  |
| MoC Closed by: | | | PRINT |  |  |  |  | 30th June 2022 | |
|  |  | SIGN |  | DATE |  |

## Storage of Management of Change Documents

* + 1. The Management of Change documents will be tracked and stored within a centralised location.

## Review of a Management of Change

* + 1. The MoC is a living document, which permits development as the project progresses. The MoC owner is responsible for managing the process through to closure of all the action items, and closure of the MoC.

# Compliance Monitoring

## Introduction

* + 1. In order to ensure the effective application of common requirements, a system of regular supervision and inspection of compliance with those common requirements and with the conditions specified must be established.
    2. The Compliance Monitoring Function ensures that the activities of Brook Aviation are monitored for compliance with the applicable regulatory requirements, and any additional requirements as established by the company and clients, and that these activities are carried out properly under the supervision of the relevant manager.
    3. The purpose of independent evaluation (audit) is to ensure that applicable risk controls continue to conform to the associated processes and are effective in maintaining risk within acceptable levels.
    4. This process includes the ability to:
       1. Identify new hazards.
       2. Measure the effectiveness of safety risk controls.
       3. Ensure compliance with company and regulatory requirements.
       4. Ensure processes are in place to promote continuous improvement such as;
          1. manage significant systemic changes
          2. Implementation of new systems, organisations, products, or services.
          3. Modifications to fundamental components of existing systems, organisations, products, or services.
          4. Implementation of new procedures.
          5. Modifications to fundamental components of existing procedures.
    5. Independent evaluations (audit) shall be conducted annually to a defined program by the safety manager.

## Department Quality Control

* + 1. Each Manager shall ensure processes are in place to promote continuous improvement such as;
       1. Manage significant systemic changes
       2. Implementation of new systems, organisations, products, or services.
       3. Modifications to fundamental components of existing systems, organisations, products, or services.
       4. Implementation of new procedures.
       5. Modifications to fundamental components of existing procedures.
    2. A cultural check by interview or survey to test for the effectiveness of staff understanding of the SMS system.
    3. A record of these reviews shall be documented and include the following:
       1. Which area was assessed?
       2. When the assessment was conducted
       3. Who performed the review?
       4. List of findings
       5. List of required corrective actions
       6. Information associated with the implementation of corrective actions

## External Evaluations

* + 1. It is anticipated that external entities will evaluate the SMS program of various units within the company. These might include governmental agencies (auditing against regulatory requirements) and/or clients (auditing against contractual requirements) and other agencies performing certification reviews.
    2. It is the responsibility of Safety Manager to ensure the audit Data Base is updated; all findings are recorded and allocated to persons responsible within two weeks following the completion of the audit.
    3. The report may be summarised for distribution, but as a minimum shall include;
       1. Which areas were audited?
       2. Any checklist or reference material used to conduct the audit
       3. When the audit was conducted
       4. Who performed the audit?
       5. List of findings and required corrective actions
       6. Information associated with the implementation of corrective actions, including any obligations to report back to the external organisation

## Quality Objectives

* + 1. Deliver quality products / aircraft / services to our customers
    2. Deliver more zero accident flight hours to our clients, than industry standard Maximise customer service by minimizing downtime, aiming for zero downtime Achieve excellent customer satisfaction, aiming for zero customer complaints

## Documented Procedures

* + 1. All flight operations, ground operations, engineering and safety critical process are to be identified and documented.
    2. The documents are to be controlled by document control procedures.

These following sections (14-22) define the processes required to maintain the SMS, including a general description of the tools and techniques utilised to manage, maintain, record, report and communicate matters that influence safety management, including the manner in which they directly interface.

# Quality Documents

Fundamental to an effective SMS are the controlled and consistent operating procedures. These procedures are subject to continuous improvement and essential to support safe operations. The Engineering and Operations Compliance monitoring Function are also essential elements to maintain our aviation regulatory approvals.

The ownership of procedures are allocated throughout the business to nominated management personnel.

The Quality System documents are structured as follows:



## The SMS Manual

* + 1. This manual describes the Global Operations SMS.

## The Expositions

* + 1. These expositions are written demonstrations of compliance with individual regulatory requirements.
    2. Company expositions include, but are not limited to:
       1. The Operations Manual
       2. The Continued Airworthiness Exposition
       3. The Maintenance Control Manual
    3. With the exception of the Operations and Design manuals which are self-contained, the expositions reference the more detailed company procedures.

## The Company Procedures

* + 1. There are a wide range of procedures for specific processes. These include for example:
       1. Safety Procedures
       2. Maintenance Procedures
       3. Operations Procedures
       4. Supply Chain Procedures
       5. Emergency Response Plan
       6. Aircraft Maintenance Programmes etc.

## Quality Documents Improvement & Change Control

* + 1. While stability and consistency in the documents is sought, the Quality Documents discussed above are amended when necessary to reflect process improvements. These process improvements may be driven from
       1. Risk management
       2. Management of Change Process
       3. Auditing
       4. Legal requirements
    2. All changes no matter of their origin required to be controlled and formally accepted prior to introduction to the operational environment.
    3. These changes should be initiated using a document change request and submitted for action.

## Deviations from Company Procedures

* + 1. Deviation from the company procedures are only acceptable if agreed by the appointed Safety Manager following the procedures for such agreed, set out in Safety Procedures.
    2. All such deviations should be formally controlled using the concession process to formally record any agreed deviation including any limitations on applicability, timescale etc.

# Control of Records

## Introduction

* + 1. It is a mandatory requirement within aviation to retain records of aircraft operational and maintenance conditions together with staff specific information to endorse competence.
    2. In addition performance and change management require to be documented in order to provide a record of action taken in support of regulatory compliance and to provide a basis for the promotion of continuous improvement.
    3. Examples of records to be retained
       1. Management review minutes
       2. Safety Performance Review
       3. Operational performance statistics / Key Performance Indicators
       4. Contract Review
       5. Aircraft maintenance records Personnel flight / duty time Staff training records
       6. Tooling and ground equipment servicing / calibration records Facility records (energy and water consumption)
       7. Waste management
       8. Audit results
       9. Safety case reports
       10. Hazard & Risk assessments
       11. Incident / Accident reports
    4. All such records should be stored in a means that makes them easily retrievable and negates the possibility of loss.

## Retention Policy

* + 1. Each regulatory approved function of Brook holds an individual exposition or manual in which retention periods for specific records are documented.
    2. Where a lack of a defined retention policy is available such documentation should be retained for a minimum period of 7 years.

# Audit management

## Introduction

* + 1. The independent audit is the function of the Compliance Monitoring whereby the effectiveness of company systems is monitored by an audit process and feedback is provided by the Safety Manager to the Accountable management personnel as appropriate.
    2. The Brook audit system and data base, fulfills the regulatory requirements for independent audit.

## Management of Audit Findings:

* + 1. SM will manage the audit findings and will be responsible to follow and control.

## Management of Findings Extensions:

* + 1. For all internal audit findings a process for managing extensions has been introduced. Up to 2 extensions may be permitted up to a maximum open time of 6 months.
    2. When you first extend a finding the request should come from the finding owner prior to the finding going overdue and the auditor can extend the finding and enter a new extension stage – Extension 1 – Auditor Approval.
    3. The finding owner can request a second extension; this would again be sent to the auditor who would then have to discuss the extension with SM before granting it. If granted then the target date cannot exceed 6 months and a further extension stage should be added called Extension 2 –Safety Manager Approval.
    4. If the finding remains unanswered by its 3rd due date it will then go overdue and as a result it will be escalated to the accountable manager. All overdue findings are reported via the Monthly Safety Report.

# Safety Reporting & Incident Investigation

## Introduction

* + 1. The Safety Reporting and Investigation processes included in the Safety Management System contain the following functions;
       1. Safety Reporting
       2. Investigation
       3. Safety Action Group
       4. Error management
       5. FDM
    2. Together these functions ensure that accidents, incidents and deviations from normal operating procedures are recorded, investigated and result in corrective action where required.

## Safety Reporting & Investigation

* + 1. Brook operates a safety reporting system which gathers reports on accidents, incidents and potential hazards. The gathered reports are analyzed and used to provide in service feedback to the risk assessments. Reports deemed significant will be the focus of an incident investigation by the Safety Manager
    2. Safety reports are;
       1. Air Safety Report – by aircrew to report air incidents.
       2. Accident reports
    3. These reports when completed by staff are submitted to the Safety manager where they are entered onto the incident database.
    4. The Safety manager will review each incident as they are filed and determine;
       1. Whether the incident requires reporting to external bodies under a mandatory reporting scheme. If so an external correspondence shall be promptly generated.
       2. Whether the incident requires further investigation. If so then the investigation process shall be initiated.

# Event Management and Event Investigation Guidelines

A significant part of our commitment to the highest level of safety, and the goals of achieving zero aviation and workplace accidents, zero harm to people and zero harm to the environment, is an efficient and consistent Event Management process. The company seeks to understand how people are likely to perform in relation to the environment in which they work and to ensure that we set them up to get it right; making sure appropriate processes are in place to manage errors when they happen. The overall aim of Event Management is to encourage staff to report errors, near-misses or hazards in order to understand contributing factors, thus enabling appropriate interventions to be put in place to prevent recurrence and reduce the future incidence and consequence of human error. It is important to examine not just ***what*** happened but, more importantly, ***why*** it happened in order to determine the underlying causes and allow us to identify a strategy that reduces, or ideally eliminates it from occurring again. Event Management comprises:

* demonstrable management commitment;
* a reporting mechanism.
* a consistent and thorough investigation process (outlined below)
* clear allocation of corrective safety actions
* procedural assurance of corrective safety actions;
* analysis of data to provide trends, frequencies and to establish associated costs of error;
* feedback of findings and Lessons Learned to staff.

To this end, the Company and all staff are committed to:

* recognising safety as the prime consideration at all times;
* applying human factors, error and risk management principles in all areas of the workplace;
* encouraging reporting of all errors, near-misses and hazards;
* applying Just Culture processes to ensure an open, honest and learning organisation;
* working within the regulatory framework and not deviating unless authorised to do so and/or safety dictates otherwise;
* ensuring compliance with procedures, quality and safety standards and regulations by all staff, all of the time;
* actively participating in maintaining and improving the safety culture of the Group.

The success of an Event Management process is reliant on a robust and reliable Event Investigation capability.

Event Investigation plays a crucial role in the management of risk associated with errors, enabling analysis of how the organisation operates and underpins any discussion on how processes, behaviour and culture may be enhanced whilst ensuring that aviation safety is not compromised.

Wherever an investigation is deemed appropriate, it will be conducted by the Safety manager or by a skilled person appointed by him for the purpose of carrying out a specific investigation.

All staff are to be encouraged and recognised for providing essential safety-related information. However, it must be clearly understood that there is a visible line that differentiates between acceptable and unacceptable behaviour.

# Accident & Serious Incident Investigation

When an accident or serious incident occurs, the accident investigation process is set in motion in accordance with state accident investigation procedures. The Safety Manager will assure that an internal investigation can be conducted by an appropriately qualified accident investigator alongside the state investigation.

## ERE Classification of Reported Events, Near-Misses and Hazards

* + 1. All staff are required to report incidents, near-misses and hazards to the Safety manger. When aviation safety reports are raised they will be assessed and Elevated Risk Events identified for further investigation. The following classes of event will be identified:

**Table 1: Classes of Incidents and Accident**

| **Class of**  **Event** | **Relative Risk**  **Value** | **Description** | **Action Required** |
| --- | --- | --- | --- |
| **Non-ERE** | Low | Any event which could not escalate into an accident, even if it may have operational consequences,  e.g. diversion, delay or minor serviceability. | report to be completed for tracking and for historical trend purposes |
| **ERE Level 0** | Low  Remaining controls effective to mitigate an escalation | Events identified on the ERE list but which have a low relative risk or are associated with an existing investigation | report to be completed for tracking for historical trend purposes  Where a technical or other investigation is associated with the event, the investigation output must be appended to the report entry. |
| **ERE Level 1** | Minor Controls were  not effective to prevent an incident | Event, other than an accident, which affects or could affect the safety of the operation, which includes actual minor injury, minor damage, regulatory non- compliance or potential for damage or injury.  OR  Any event with human factors or potential systemic deficiency | Minor investigation should be carried out.  The investigation should identify all causal and/or contributory factors. Recommended Safety Actions must be raised which address all identified causal and contributory factors  The final report and any recommended safety actions will be the subject of a SAG. All actions resulting from the SAG will be monitored for tracking and  closure. |
| **ERE Level 2** | Major Ineffective controls to prevent a serious accident | Event with the potential to cause death or serious injury to a person, or serious damage to an aircraft or property, or potential for regulatory action against the company. | Major in-depth investigation is required by Safety Manager.  The investigation should identify all causal and/or contributory factors. Recommended Safety Actions must be raised which address all identified causal and contributory factors  The final report and any recommended safety actions will be the subject of a SAG. All actions resulting from the SAG will be  monitored for tracking and closure. |
| **Accident or Serious Incident** | High | CAAI (National Airworthiness Authorities) definition for an aircraft accident. | Accident and serious incident processes iaw and National procedures.  Safety Manager Investigation will identify investigator to conduct internal accident investigation |

* + 1. Unless otherwise agreed an investigation will be conducted for all Level 1 and 2 EREs.
    2. The investigation determination should normally be made within 24 hours of the event being reported and the investigation then commenced as soon as possible. the following detail to be determined :
       1. Start date of the investigation
       2. Name of investigator(s)
       3. Estimated completion date of investigation (updated as required).
    3. The investigation must be completed including owners and target completion dates. All actions should be tracked and monitored.

## Brook Elevated Event Risk Process

* + 1. The chart below summarises the ERE investigation determination and completion processes:



|  | SAG accepts / rejects Safety Actions |  |
| --- | --- | --- |
|  | Safety Actions entered with agreed owners and completion dates |  |

## Event Investigation Principles

* + 1. The key principles to investigations within Brook are as follows:
       1. to identify all systemic safety deficiencies and investigate the human elements involved
       2. to gather data concerned with the circumstances of an event, collate and analyse the data to determine what happened, how it happened and why it happened and to establish causal/contributory factors to prevent re-occurrence
       3. to carry out an investigation as soon as possible after an event to ensure preservation of data
       4. to follow a standardised process as detailed in Table 1
       5. to not attribute culpability or apportion blame
       6. to identify safety actions\* and make other recommendations† in order to prevent reoccurrence
       7. agree ownership of all safety actions and track progress to completion
       8. to make a ‘Stop Work’ call if the investigation process identifies the need to do so.

(\*) Safety Actions – specific and deliberate actions which have been identified as having a direct influence on system improvement, related to the event under investigation.

(†) Recommendations – wider actions which may have a beneficial effect on system improvement, identified during the investigative process, but not related directly to the event under investigation.

## Investigator Responsibilities and Protocol

* + 1. Investigators key responsibilities are to:
       1. investigate incidents as required,
       2. interview all individuals involved as soon as possible after the event,
       3. ensure that all interviewed individuals are offered the option of having a representative/colleague present,
       4. documenting all contributory and causal factors identified and listing all safety actions required to be taken to prevent recurrence and identifying further recommendations for consideration
       5. maintain appropriate confidentiality of all investigation reports
       6. declare any conflict of interest or any factors which might compromise the independence of the investigation.

## Report Review

* + 1. Following the production of the draft report, it should be reviewed by the Safety Manager to ensure that the investigation report:
       1. covers all areas of significance and relevance
       2. identifies casual and contributory factors
       3. identifies ‘SMART’ safety actions designed to address causal and significant contributory factors.
    2. Experience has shown that frequently the recommendations emanating from an investigation do not address the root cause of the incident, or are vague and not specific to the issue(s).
       1. What needs to be changed?
       2. What does the change need to accomplish?
       3. Is the scope of the recommended change realistic?
       4. Can it be done is a reasonable timescale?

## Reporting Tracking and Close-Out

* + 1. Following review by the Safety Manager, a SAG must be convened to consider the investigation report.
    2. The SAG should consider the actions identified and recommendations made in the report and confirm that they address the root cause(s) of the incident. The SAG is at liberty to add additional recommendations and actions. The SAG must assign owners to all safety actions identified and set timely close-out dates. The actions must be entered into the company follow-up system for tracking. The SM must be identified as the owner of the Follow Up stage of all investigation safety actions in follow up system.
    3. In addition to reviewing the report, the SAG must ensure that the Risk Assessments relevant to the incident are still relevant, in particular:
       1. no new threats have been identified;
       2. existing controls remain effective;
       3. where controls have failed, remedial action is being put in place
       4. existing risk ratings remain appropriate.
    4. If the SAG does not support any of the safety actions or recommendations identified in an investigation, the reason for rejecting the action must be made clear and the SM must be informed.
    5. Only when all agreed safety actions and recommendations have been assigned an owner and target completion, can the investigation be considered ‘complete’ and the related event be closed.

## Flight Data Monitoring (FDM)

* + 1. A Flight Data Monitoring program is operated within the company. FDM uses flight data monitoring equipment installed on the aircraft. Following each flight the parameters are analyzed to identify any deviations from standard operating procedures.
    2. FDM records are confidential. In the event of deviations from normal procedure the FDM officer will contact the crew concerned directly to discuss the infringement and how it may be avoided in future.
    3. Only in cases of flagrant and repeated infringement would the issue be raised to higher management for disciplinary action.

## FDM: lessons learned are promulgated to staff via;

* + 1. Flight Safety Information newsletter
    2. Operational circulars
    3. Continuation training
    4. Read & Sign notes

# Emergency Response Management

## Introduction

* + 1. If the loss associated with accidents or serious safety/environmental incidents is to be minimized it is essential that the local response by company personnel is prompt and appropriate. This requires the correct actions to be considered in advance and rehearsed sufficiently frequently to become familiar.
    2. Brook crisis management and emergency response system seeks to manage incidents at the lowest practical level while enabling the flow of information to the highest relevant level. This is so that needs may be assessed and the appropriate resources allocated in a timely way.

## Methodology

* + 1. The primary response to an incident will usually occur at the operating level.
    2. An Emergency Response Management Team (ERMT) will include the following positions:
    3. CEO, OM, CP, CAO.
    4. When necessary to prevent escalation the ERMT may be activated so that it can bring its greater experience and resources to bear in terms of expertise, authority, logistics etc.
    5. In major incidents involving multiple injuries, fatalities or kidnapping (or any other scenario involving significant corporate risk) the ERMT may use resources out of the company to bear.

## Plans

* + 1. A detailed ERP shall be created for and maintained at Brook’s operation office.
    2. The operation office will hold a portfolio of all the detailed Emergency Response Plans.
    3. The ERP should be available from the Brook global server and in hard copy at the Operation office.

## Exercising

* + 1. ERP must be exercised regularly to ensure that the necessary staff remains familiar with the required protocols and processes.
    2. In addition to client or regulatory requirements to carry out simulated exercises, the company will also initiate exercises at every level to ensure that all interfaces and interactions work effectively.
    3. Following any exercise a report should be raised showing how the exercise went and, in particular, highlighting any shortfalls or weaknesses. A copy of the report should be archived in the company’s global server.
    4. There are three levels of exercise which may be conducted;
       1. Desktop:

An exercise normally contained within one room, using an agreed scenario where the participants simply talk through the response using the ERP. This enables the participants to reinforce their understanding and become familiar with their roles and documentation.

* + - 1. Intermediate:
      2. A Simulation exercise:

Participants are given a scenario and react to it using their ERP. External organisations and companies are simulated by direct inputs or role players.

* + - 1. Real Time/Live:

An exercise using a formulated ‘real’ scenario where all the participants are working through the response to the simulated emergency. All relevant external organisations are fully involved, although some role playing may be included to increase realism.

# Competency

## Introduction

* + 1. Anyone performing safety related work must be competent to perform the task. To be competent you must have the necessary training, technical knowledge, skills and experience and qualifications to do a specific job properly. Competence is not a general reflection on an individual’s overall capabilities.
    2. Just because an individual is not yet competent to complete a specific task does not make the individual an incompetent person. Conversely, competence at one task means little regarding competence to do another, unless the tasks are very similar.
    3. There are two primary obligations if assigning or accepting a safety related task;
       1. You should know your limitations and not go beyond them.
       2. If you are assigning people to do safety related work you should ensure that they are competent to perform that work.
    4. Each job specification should have an associated list of competence requirements. From examining the job, taking particular note of any safety related activities the job entails, the knowledge, skills, experience and necessary qualifications should be derived.
    5. Before someone is assigned to a role they should be assessed to decide whether or not they satisfy the competence requirements for the role. The assessment should be carried out by the individuals’ manager (or prospective manager). The results should be documented and retained on file.
    6. Pilot qualification is assured through a formal regulatory licensing system. The assessment of pilot competence and the implementation of the recurrent training to maintain competence are the responsibility of the company and the Chief Pilot in specific.
    7. Qualification of engineers is assured through a formal regulatory licensing system and a system of company approvals. The assessment of engineering competence and the implementation of the recurrent training to maintain competence are the responsibility of the company and the AMO.
    8. The following items represent the minimum required safety related training activities at all business level:
    9. **All new** employees receive safety orientation briefings. The minimum required topics include:
       1. Induction process
       2. Review of safety policies.
       3. Review of safety reporting processes.
       4. Review of fire prevention and evacuation procedures.
       5. Review of possible safety hazards found within the workplace.
       6. Usage of personal protective equipment (if applicable).
    10. **Managers with direct reports**
        1. Management staff receive a general introduction and overview of the group SMS, which enables them to communicate the group safety policy, and processes to their direct reports.
    11. **Frontline employees**
        1. Provided that employees are trained on their safety responsibilities, are familiar with the methods to communicate safety concerns and are provided with safety information as a result of the SMS program, there are not any additional SMS initial or recurrent training requirements.

# Key personnel: Safety Accountability Terms of Reference

## Accountable Manager:

* + 1. Is accountable for:
       1. The SMS program within the company.
       2. Providing the necessary resources to implement and maintain the SMS program.
       3. Providing sufficient resources for safe operations taking into account human factors principles.
       4. Appoints a member of their staff to be responsible for ensuring the processes needed for the SMS program are established, implemented, and maintained.
       5. Convene safety performance reviews.
       6. The promotion of pro-active safety culture through research, safety projects & initiatives.
       7. Promoting the SMS
       8. Publishing the Safety & Compliance policy.
       9. Setting safety targets and objectives.
       10. Ensuring that managers are committed to safe operations.
       11. Enabling and maintaining a ‘just culture’ throughout the organisation.
       12. Ensuring that operations and maintenance carried out meets the standard required by the relevant regulations.
       13. Ensuring that all personnel are competent for their role and receive any necessary training.
    2. **Training and competency:**
       1. Must be acceptable to the CAA.
       2. Must have completed company SMS introduction.

## Safety Manager:

* + 1. Is accountable and responsible for:
       1. The strategic Implementation of the Safety Management System, as applicable to company operations and encouraging the involvement of the staff.
       2. Ensuring that the Safety Management, Quality and HSE, policies and procedures are understood by operations staff and that everybody is actively involved in ensuring a safe and efficient service to the client.
       3. Encouraging the reporting of all safety related incidents or improvement ideas.
       4. Developing and implementing operational standards and procedures to meet the company safety targets and objectives.
       5. In respect of Safety, the recruitment, training and appointment of safety personnel to meet regulatory and contractual requirements.
       6. The promotion of pro-active safety culture through research, safety projects & initiatives.
    2. **Training and competency:**
       1. Must be acceptable to the CAA.
       2. Must have completed company SMS introduction.

## Head of Flight Operations

* + 1. Is accountable and responsible for:
       1. Implementation of the Safety Management System, as applicable to Flight Operations, and encouraging the involvement of their staff.
       2. Ensuring that the Safety Management, policies and procedures are understood by Flight Operations staff and that everybody is actively involved in ensuring a safe and efficient service to the client.
       3. Encouraging the reporting of all safety related incidents or improvement ideas.
       4. Developing and implementing operational standards and procedures to meet the Regional safety targets and objectives.
       5. In respect of Flight Operations, the recruitment, training and appointment of staff and suitable aircrews to meet regulatory and contractual requirements.
       6. Formulating and approving Flight Operations procedures to ensure that operations are carried out to meet both company standards and regulatory requirements.
       7. Implementation of effective corrective actions in response to incident and audit findings.
       8. The promotion of pro-active safety culture through research, safety projects & initiatives.
    2. **Training and competency:**
       1. Must be acceptable to the CAA.
       2. Must have completed company SMS introduction.

## Offshore Flight Operations Manager(if applicable):

* + 1. Is accountable and responsible for:
       1. Implementation of the Safety Management System, as applicable to operations, and encouraging the involvement of their staff.
       2. Ensuring that the Safety Management, policies and procedures are understood by operations staff and that everybody is actively involved in ensuring a safe and efficient service to the client.
       3. Encouraging the reporting of all safety related incidents or improvement ideas.
       4. Developing and implementing operational standards and procedures to meet the company safety targets and objectives.
       5. In respect of operations, the recruitment, training and appointment of operations staff and suitable aircrews to meet regulatory and contractual requirements.
       6. Ensuring that operations are carried out to meet both group standards and regulatory requirements.
       7. Implementation of effective corrective actions in response to incident and audit findings.
       8. The promotion of pro-active safety culture through research, safety projects & initiatives.
    2. **Training and competency:**
       1. Must be acceptable to the CAA.
       2. Must have completed company SMS introduction.

## Head of Engineering;

* + 1. Is accountable and responsible for:
       1. Implementation of the Safety Management System, as applicable to engineering, and encouraging the involvement of engineering staff.
       2. Ensuring that the Safety Management and HSE policies and procedures are understood by engineering staff and that everybody is actively involved in ensuring a safe and efficient service to the client.
       3. Encouraging the reporting of all safety related incidents or improvement ideas.
       4. Ensuring that facilities and office accommodation provide an appropriate working environment, meet group standards and regulatory requirements.
       5. Developing and implementing maintenance standards and procedures to meet the Regional safety targets and objectives.
       6. Provision of sufficient competent personnel to plan, perform, supervise, inspect and certify the work planned, taking into account human factors principles.
       7. Ensuring engineers training requirements are implemented and maintained.
       8. Formulating and approving engineering procedures to ensure that activities are carried out to meet both company standards and regulatory requirements.
       9. Implementation of effective corrective actions in response to incident and audit findings.
       10. The promotion of pro-active safety culture through research, safety projects & initiatives.
    2. **Training and competency:**
       1. Must be acceptable to the CAA.
       2. Must have completed company SMS introduction.

## Company Managers, Chief Pilot, & Chief Engineers:

* + 1. Are responsible for:
       1. Ensuring that work is carried out in a safe manner by appropriately trained and competent staff.
       2. Provide a work environment in which hazards are adequately controlled when elimination is not feasible.
       3. Run local safety meetings to elicit feedback.
       4. Conduct and performance of staff i.a.w company policy.
       5. Promoting the company’s Safety Management, Compliance Monitoring and HSE Policies.
       6. Participating and contributing to SAG’s as required
       7. The promotion of pro-active safety culture through research, safety projects & initiatives.
    2. **Training and competency:**
       1. Must be acceptable to the CAA.
       2. Must have completed company SMS introduction.

## All Company Employees are responsible for;

* + 1. Complying with company processes and procedures
    2. Ensuring they intervene to prevent unsafe conditions developing.
    3. Reporting potential hazards
    4. Reporting incidents, accidents and near misses
    5. Being aware of human factors and human factor limitations.
    6. Familiarizing themselves with the Safety Management System.
    7. Familiarizing themselves with the information available in respect of hazards, equipment, procedures and processes relevant to their tasks.
    8. Identifying Safety & Compliance improvements.
    9. Cooperating with audits and investigations
    10. The promotion of pro-active safety culture through research, safety projects & initiatives.
    11. **Training and competency:**
        1. Must have completed a company SMS introduction.

## The Staff of a Contractor or Sub-Contractor are responsible for;

* + 1. Familiarizing themselves with the information provided by Bristow in respect SMS, hazards, equipment, procedures and processes relevant to their work for Brook.
    2. Ensuring that they comply with Brook process and/or for reporting accidents, incidents and safety issues.
    3. The promotion of pro-active safety culture through research, safety projects & initiatives.
    4. **Training and competency:**
       1. Must have completed a company SMS introduction.

# Document Control

## Revision Record

| **Revision** | **Date** | **Written by** | **Checked by** |
| --- | --- | --- | --- |
| Initial Issue | 10/9/2022 | Itay Aviram |  |

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| Safety Manager |  |  |  |

## Summary of Change

| **Section** | **Description of Change** |
| --- | --- |
| Entire Document |  |
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## List of Holders

| **Location** | **Holders** |
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|  | Brook global archive |
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