

## APPENDIX A: POLICY STATEMENTS

### CORPORATE SAFETY POLICY STATEMENT

#### Policy

Ghana Civil Aviation Authority (GCAA) is committed to developing, implementing and improving strategies, management systems and processes to ensure that all activities uphold the highest level of safety that meet national, regional and international standards.

Our fundamental Safety Beliefs are:

1. Safety is a core business and personal value.
2. Safety is a source of our competitive advantage.
3. Accidents and serious incidents could be prevented through a proactive Safety Risk Management and the implementation of Just Culture.
4. All levels of management are accountable for our safety performance starting with the Director-General.

Our commitment to SMS is premised on;

**VISION:** Achieve the highest degree of safety through effective Safety Management Systems in Air Navigation Service.

**MISSION:** Proactively manage safety risks in Air Navigation Services by implementing, maintaining and continuously improving our Safety Management Systems.

Our safety policy expresses the organization's commitment to the following principles;

- a. Embed a safety culture that recognizes the value of effective safety management.
- b. Define clear safety roles, accountabilities and responsibilities for all staff;
- c. Ensure the provision of adequate resources for training to achieve an effective SMS;
- d. Identify hazards and minimize the risks associated with our operations;
- e. Ensure that third party supplied systems and services meet required safety standards;
- f. Develop and improve our safety processes that meets world-class standards, legislative and regulatory requirements;
- g. Establish and measure our safety performance against realistic objectives and targets;
- h. Continuously conduct safety and management reviews of the SMS; and
- i. Develop and implement quality management systems in line with its principles.

#### SIGNED



**STEPHEN WILFRED ARTHUR (REV.)**  
**AG. DIRECTOR-GENERAL**





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## FATIGUE POLICY STATEMENT

The Ghana Civil Aviation Authority (GCAA) recognizes fatigue as a critical safety hazard in 24-hour Air Navigation Services (ANS) operations. Fatigue cannot be eliminated but can be effectively managed through a documented Fatigue Risk Management System (FRMS).

GCAA is committed to:

1. Acceptance of accountabilities, responsibilities and authorities by Top management towards the Fatigue Risk Management Systems that ensures sufficiently qualified staff and resources are available to meet FRMS requirements.
2. Maintaining operational alertness and performance within safe limits at all times.
3. Ensuring that all rostered duties, rest periods, and working conditions enable personnel to perform safety-critical functions safely.
4. Providing adequate resources, training, and leadership to support fatigue management.
5. Promoting a just and open reporting culture where fatigue hazards are reported without fear of reprisal.
6. Periodic review of the FRM processes to ensure relevance and appropriateness.

This policy applies to all GCAA Air Navigation Service (ANS) units operating under continuous (24/7) schedules, including Air Traffic Management (ATM), Aeronautical Information Services (AIS) and Air Traffic Safety Engineering (ATSE). All other functions not covered by the FRMS will comply with prescriptive work-time and rest-period regulations.

The Fatigue Risk Management Systems (FRMS) aims to ensure the following objectives;

- a. operational alertness by maintaining adequate levels of alertness among personnel to reduce fatigue-induced errors and accidents as low as reasonably practicable.
- b. identification and mitigation of fatigue hazards, and implementation of controls to reduce associated risks.
- c. continuous monitoring by use of data-driven methods to continuously assess fatigue levels and safety performance indicators.
- d. promotion of fatigue safety culture by encouraging open reporting of fatigue incidents and fostering awareness through training.
- e. demonstration of compliance with regulatory requirement.

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## JUST CULTURE POLICY

### Preface

Our Safety Culture is premised on employees who are key to and best placed to highlight potential risks and offer solutions. It is therefore a joint responsibility to safeguard each other and ourselves by being proactive thus reducing our risk of serious incident or accident.

### Just Culture Policy Statement

The development of a strong Safety Culture is built on the application of a Just Culture where open and honest reporting is supported, acknowledged and in which:

- i. individuals are not punished for actions, omissions or decisions taken by them that are commensurate with their experience and training but which result in a reportable event;
- ii. gross negligence, willful violations and destructive acts are not tolerated.

To achieve this goal, it is imperative to have uninhibited reporting of all accidents, incidents, events, hazards, and other information that may compromise the safe conduct of our operations. Thus

1. Reporting is free of any form of reprisal. The main purpose of reporting is for risk control and accident and incident prevention, not the attribution of blame.
2. No action will be taken against any employee who discloses a safety concern/information through the reporting system, unless such disclosure reveals, beyond any reasonable doubt, an illegal act, gross negligence, a deliberate or willful disregard of regulations or procedures laid down by the organization.
3. The method for collecting, recording and disseminating safety information guarantees the protection to the extent permissible by the Data Protection Act, 2012 (Act 843), of the identity of those who report safety information. The identity of any person making a report will not be disclosed unless required by law.
4. The organization will provide employees full support during any external investigation by the police or judicial authorities following related incident or accident.

### Principles

GCAA adheres to a set of Just Culture Principles.

1. Just Culture leads to open reporting and puts a high value on open communication.
2. Risks are openly and honestly discussed between operational management and employees promoting a hunger for safety knowledge.
3. Just Culture is about balancing safety and accountability through discussion of safety issues and mistakes, while accepting that individuals will be held accountable for their actions.

4. Just Culture is about learning safety lessons to prevent reoccurrence.
5. A Just Culture is not a 'No Blame' Culture.

### **Acceptable and Unacceptable Behaviours - Where we draw the line?**

It is apparent that deciding whether someone's actions are acceptable or not, is entirely dependent upon the context of the situation. Therefore, in determining what is acceptable or unacceptable emphasis shall be on a case by case basis employing the appropriate model, by subject matter experts in making a decision that warrants any disciplinary action.

The organization however shall not tolerate behaviours resulting in unsafe acts;

- i. Gross negligence – when employees fail to use the reasonable level of skills expected of them to engage in an act or omission with a serious disregard or indifference to an obvious risk resulting in harm, injury or damage to other persons or property, regardless of whether the risk was fully appreciated by them.
- ii. Reckless conduct – when there is conscious disregard of an obvious risk.
- iii. Intentional (willful) violations – when an employee knew or foresaw the result of the action, but went ahead and did it anyway.

The Just Culture Policy therefore forms a solid foundation of our Safety Culture and employees are encouraged to promote the understanding of it.

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## **APPENDIX I: SAFETY OCCURRENCE REPORTING SYSTEMS**

### **STATEMENT BY THE DIRECTOR-GENERAL**

#### **Just Culture**

The organization adopts a Just Culture in the interest of safety as espoused in the Just Culture policy. This means the organization supports the implementation of Just Culture in all its operations. A culture in which:

- i. individuals are not punished for actions, omissions or decisions taken by them that are commensurate with their experience and training but which result in a reportable event;
- ii. gross negligence, willful violations and destructive acts are not tolerated.

#### **Confidentiality of Reports**

It is fundamental to the purpose of the reporting of incidents and accidents, that the knowledge gained from the investigation of these occurrences is disseminated so that we may all learn from them. Without prejudice to the proper discharge of its responsibilities, the organization will not disclose the name of the person submitting the report or of a person to whom it relates unless required to do so by law; or the person concerned authorizes disclosure. Should any safety follow-up action arising from a report be necessary, the organization will take all reasonable steps to avoid disclosing the identity of the reporter or of those individuals involved in any reportable occurrence.

#### **Assurance Regarding Prosecution**

The organization gives an assurance that its primary concern in relation to our reporting system (G-VOCORS & G-MARS) is to secure free and uninhibited reporting and it will not be its policy to institute proceedings in respect of unpremeditated or inadvertent breaches of the law which come to its attention only because they have been reported under the scheme.

#### **Data Protection**

The reporting systems will be conducted in accordance with the Ghana Data Protection Act, 2012 (Act 843). For the purposes of Data Protection, the Organization will process, record and store the information received and obtained in any safe and secure format necessary to facilitate its use in accordance with its Data Protection Policy.



**Possible Action by the Organization**

Where a reported occurrence indicates unpremeditated or inadvertent lapse by an employee, the organization would act responsibly to share the view that free and full reporting is the primary aim of reporting and ensures that every effort should be made to avoid action that may inhibit reporting.

The organization shall ensure that every effort should be made to avoid punitive actions that may inhibit reporting of the occurrence except to the extent that, action is needed in order to ensure safety.

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**STEPHEN WILFRED ARTHUR (REV.)  
AG. DIRECTOR-GENERAL**





## A. INTRODUCTION

### 1. OBJECTIVE

- 1.1. The objectives of the occurrence report system are;
  - a. not to blame or punish any individual but to identify flaws and shortcomings in the system, initiate corrective measures to prevent occurrences and incidents to be repeated, and collect data on incidents/accidents,
  - b. that incidents and other safety related occurrences are assessed, to determine the safety performance of the system.
  - c. to identify and investigate risk areas where the ANS system could contribute to safety infringement, and take appropriate actions;
  - d. assess and monitor how technical and operational changes introduced to the ANS system affects flight safety.
- 1.2. The safety performance monitoring provides means by which the organization can verify that it is meeting its safety performance targets. An effective monitoring programme increases the probability of detecting weaknesses in the system defences before an active failure leads to an accident or serious incident.
- 1.3. One of the baselines in the SMS is that every safety related occurrence shall be investigated as soon as possible. The purpose is to identify the cause and duly take appropriate action to avoid re-occurrence.
- 1.4. It shall also be used to disseminate the experience within the organization. Such investigations shall include, if appropriate, procedures, processes, technical systems and equipment.
- 1.5. The investigation is done by the safety team or by a qualified investigator.
- 1.6. The investigation process is described in the Safety Occurrence Investigation Process.

### 2. REQUIREMENTS

- 2.1 The safety occurrence reporting systems requires that the organization;
  - a. develop and implement appropriate data collection procedures, including a safety occurrence reporting and investigation system,
  - b. develop and implement procedures for the analysis and assessment of the data collected.
  - c. specify the safety performance indicators to be used to measure safety performance targets;
  - d. decide on safety objectives;



### **3. RESPONSIBILITY**

Each individual member of staff has a responsibility for submitting a report of an occurrence. The responsible managers shall submit copies of occurrence reports to their Head of departments and the SSQA Manager. The SSQA Manager shall analyze and assess the impact of occurrence and investigation reports on safety, and make recommendations to the Director-General (DG).



## **B. GCAA VOLUNTARY AND CONFIDENTIAL REPORTING SYSTEMS (G-VOCORS)**

### **1.0 OBJECTIVE**

- 1.1 The key objective of Ghana Civil Aviation Authority (GCAA) Voluntary and Confidential Reporting System (G-VOCORS) is to enhance the safety of our activities through the collection of reports on actual or potential safety deficiencies that would otherwise not be reported through other channels. Such reports may involve occurrences, hazards or threats relevant to the safety of our aviation activities.

This system does not eliminate the need for formal reporting of accidents and incidents according to the organization Standard Operating Procedures (SOPs), as well as the submission of mandatory occurrence reports to the relevant regulatory authorities.

- 1.2 The G-VOCORS is a voluntary, non-punitive, confidential occurrence and hazard reporting system administered by the SSQA Manager. It provides a channel for the voluntary reporting of occurrences or hazards relevant to our organization's activities, while protecting the reporter's identity.

### **2. SCOPE**

The G-VOCORS covers areas such as Air Traffic Management (ATM) Operations; Aeronautical Information Management (AIM) Operations; Air Traffic Safety Engineering (ATSE) Operations and Information Communication Technology (ICT) Operations.

### **3. WHO CAN MAKE A VOLUNTARY REPORT?**

If you belong to any of these operational areas or departments, you can contribute to aviation safety enhancement through the G-VOCORS by reporting on occurrences, hazards or threats relevant to our organization's activities:

- a) Air Traffic Controllers
- b) Air Traffic Safety Electronics / Engineering Personnel
- c) AIM Personnel
- d) ICT Personnel
- e) Other Civil Aviation or Airport Personnel
- f) Any other person



#### **4. WHEN TO MAKE A REPORT**

You should make a report when:

- a) You wish for others to learn and benefit from the incident or hazard but are concerned about protecting your identity;
- b) There is no other appropriate reporting procedure or channel; and
- c) You have tried other reporting procedures or channels without the issue having been addressed.

#### **5. HOW THE REPORTS ARE PROCESSED?**

- 5.1 The G-VOCORS pays particular attention to the need to protect the reporter's identity when processing all reports. Every report will be read and validated by the SSQA Manager. The SSQA Manager may contact the reporter to make sure they both understand the nature and circumstances of the occurrence / hazard reported and to obtain the necessary additional information and clarification.
- 5.2 When the SSQA Manager is satisfied that the information obtained is complete and coherent, the manager will de-identify the information and enter the data into the G-VOCORS database. Should there be a need to seek input from any third party, only the de-identified data will be used.
- 5.3 An appropriate feedback shall be initiated by the SSQA Manager upon the receipt of the G-VOCORS reports. The SSQA Manager will endeavour to complete the investigative process within fifteen (15) working days upon receipt of the report, if additional information is not needed. In cases where the SSQA Manager needs to discuss with the reporter or consult a third party, more time may be required. In the absence of the SSQA Manager, the acting manager will process the report. Reporters are assured that every G-VOCORS report will be processed.

#### **6. INFORMATION SHARING**

- 6.1 Relevant de-identified reports and extracts may be shared within the organization as well as with external aviation stakeholders as deemed appropriate in accordance with the data protection rules. This will enable all concerned personnel and departments within the organization as well as relevant external aviation stakeholders to review their own operations and support the improvement of aviation safety as a whole.



6.2 If the content of a G-VOCORS report suggests a situation or condition that poses an immediate or urgent threat to aviation safety, the report will be handled with priority and referred, after de-identification, to the relevant organizations or authorities as soon as possible to enable them to take the necessary safety actions.

**7. WHO TO CONTACT?**

You are welcome to contact the SSQA Manager to enquire about the G-VOCORS or to request a preliminary discussion with the SSQA Manager before making a report. The SSQA Manager or designated representative can be contacted as follows:

<b>NAME</b>		<b>DEREK KOFI LARTEY</b>
<b>DESIGNATION</b>		<b>AG. SSQA MANAGER</b>
<b>CONTACT</b>	<b>MOBILE</b>	<b>+233 204382810</b>
	<b>OFFICE</b>	<b>+233 302 769397</b>
		<b>+233 302 776171 EXT 1424</b>
	<b>ALT. NUMBER</b>	<b>+233 203197886</b>
<b>EMAIL</b>	<b>PERSONAL</b>	<b>dlartey@caa.com.gh</b>
	<b>OFFICE</b>	<b>sms@caa.com.gh</b>



## **C. GCAA MANDATORY REPORTING SYSTEMS (G-MARS)**

### **1. OBJECTIVE**

- 1.1 The objective of the G-MARS even though lists the majority of reportable occurrences, it cannot be completely comprehensive. Any other occurrence, which is judged by those involved to meet the criteria, should also be reported.
- 1.2 This includes Accidents and Serious Incidents, Air Navigation Service (ANS) occurrences which pose an actual or potential threat to flight safety, or can compromise the provision of safe ANS services.

### **2. SCOPE**

It covers areas such as:

- a. Air Traffic Management (ATM) Operations
- b. Aeronautical Information Management (AIM) Operations
- c. Air Traffic Safety Engineering (ATSE) Operations
- d. Information Communication Technology (ICT) Operations

### **3. WHAT CONSTITUTE A MANDATORY REPORT?**

The contents of this policy shall not preclude the reporting of any occurrence, situation or condition which, if repeated in different but likely circumstances; if allowed to continue uncorrected; could create a hazard to aircraft safety.

#### **A. Air Traffic Management (ATM) Operations**

1. Near collision incidents (encompassing specific situations where one aircraft and another aircraft/the ground/a vehicle/person or object are perceived to be too close to each other)
  - a) separation minima infringement;
  - b) inadequate separation;
  - c) "near-CFIT" (Near-Controlled Flight into Terrain);
  - d) runway incursion where avoiding action was necessary.
2. Potential for collision or near collision (encompassing specific situations having the potential to be an accident or a near collision, if another aircraft is in the vicinity)
  - a) runway incursion where no avoiding action is necessary;
  - b) runway excursion;
  - c) aircraft deviation from ATC clearance;



- d) aircraft deviation from applicable Air Traffic Management (ATM) regulation:
  - i. aircraft deviation from applicable published ATM procedures;
  - ii. unauthorized penetration of airspace;
  - iii. deviation from aircraft ATM-related equipment carriage and operations, as mandated by applicable regulation(s).
3. ATM-specific occurrences (encompassing those situations where the ability to provide safe ATM services are affected, including situations where, by chance, the safe operation of aircraft has not been jeopardized). These shall include the following:
  - a) inability to provide ATM or Air Traffic Services;
  - b) inability to provide Airspace Management Services;
  - c) inability to provide Air Traffic Flow Management Services;
  - d) failure of Communication function;
  - e) failure of Surveillance function;
  - f) failure of Navigation function;
  - g) failure of Data Processing and Distribution function;
  - h) failure of ATM system security;
  - i) violation of Remotely Piloted Aircraft Systems (RPAS) into restricted airspace.
4. ATM Communication, Navigation and Surveillance - significant malfunction or deterioration of service.
5. A situation where an aircraft was or could have been endangered by impairment of any member of ground staff (e.g. ATC, "AD" (aircraft dispatchers), Maintenance, etc.).
6. ATC overload.
7. Failure or unplanned shutdown of a major operational ATC computer system, requiring reversion to manual back-up and resulting in disruption to the normal flow of air traffic.
8. Missed Approaches or Go-Around.
9. Rejected (Aborted) Take-off.
10. Take off from or Landing / Attempted Landing on a closed or engaged runway, on a taxiway or unassigned runway.
11. Bird Strike
12. Presence of Animals or unauthorized personnel or vehicles on the maneuvering area during aircraft movement.
13. Any occurrence or circumstances within the other sections (scope of the policy) that has consequences or effects on Air Navigation Service.



## **B. Aeronautical Information Management (AIM) Operations**

1. AFTN / AMHS line failure causing the inability to transmit and accept flight plan via the AFTN / AMHS.
2. Fire emergencies at the facility
3. Malfunction of any other aeronautical equipment.

## **C. Air Traffic Safety Engineering (ATSE) Operations**

1. ATM Equipment - specific occurrences (encompassing those situations where the ability to provide safe ATM services are affected, including situations where, by chance, the safe operation of aircraft has not been jeopardized). These shall include the following:
  - a. failure of Communication function;
  - b. failure of Surveillance function;
  - c. failure of Navigation function;
  - d. failure of Data Processing and Distribution function;
  - e. violation of Remotely Piloted Aircraft Systems (RPAS) into restricted airspace.
  - f. failure of or malfunction of technical equipment.
  - g. high level of CNS/ATM Cyber threat and attack
  - h. inappropriate access control of computer system
  - i. computer network intrusion
  - j. failure of backup and recovery system CNS/ATM critical systems

## **D. Information Communication Technology (ICT) Operations**

1. High level of Cyber threat and attack
2. Insider Threat situations
3. Inappropriate access control of computer system
4. Computer network intrusion
5. Failure of backup and recovery system
6. Failure of internet access
7. Breakdown of real time computer and network redundancy system
8. Software malfunction
9. Failure of computer and printers
10. Failure of biometric access control system
11. Database injections, inaccessibility and failures
12. Malfunction of any other computer systems



#### 4. HOW THE REPORTS ARE PROCESSED?

Every G-MARS report will be processed and validated by the responsible manager of the unit. The responsible manager may contact the reporter to make sure he understands the nature and circumstances of the occurrence/hazard reported and to obtain the necessary additional information and clarification.

The responsible manager shall refer such reports which need to be investigated to the SSQA Manager. The investigated report shall be returned to the responsible manager for further action.

Such reports must remain a confidential material in order to prevent other third parties from accessing them without proper authorization/approval.



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## APPENDIX J: SAFETY OCCURRENCE INVESTIGATION POLICY

### 1.0 BACKGROUND

#### 1.1 General

Investigation is a process conducted for the purpose of accident / incidents prevention which includes the gathering and analysis of information, the drawing of conclusions, including the determination of causes and contributing factors and when appropriate, the making of safety recommendations.

The investigation of safety occurrences often reveals that there were a number of warning signs, or precursors, which could have been observed before the incident or accident. Investigation of occurrences can allow the identification of such warning signs, and the dissemination to staff of information that could enable similar warning signs to be recognized in the future before they lead to safety occurrences.

Identifying the lessons to be learned from a safety occurrence requires an understanding of not just what happened, but why it happened. A complete understanding of why an occurrence happened requires an investigation that looks beyond the obvious causes and focuses on identifying all contributory factors, some of which may be related to weaknesses in the systems defences or other organizational issues.

#### 1.2 Objectives

The objectives of the investigation process shall be, not to blame any individual but to better understand the events leading to the occurrence and to:

- a) Establish the primary causes
- b) Identify actions to prevent recurrence
- c) Provide an accurate and factual description of the circumstances and the lessons to be learned.

#### 1.3 Scope

Minor occurrences can be an indication of potentially serious hazards. Therefore, all occurrences shall be investigated. These investigations do not need to be a full investigation but just a review of the circumstances about the



occurrence to find out the cause. All occurrences where separation is lost shall be fully investigated.

## 1.4 Responsibilities

- 1.4.1. The SSQA Manager is responsible for informing the responsible manager concerning the commencement of the investigation procedure about an occurrence.
- 1.4.2. The shift head is responsible for collecting and securing facts concerning the occurrence when reports are submitted.
- 1.4.3. The responsible manager may conduct a preliminary investigation based on the report to be able to take remedial actions if necessary.
- 1.4.4. The SSQA Manager or his designee shall carry out all investigations. However, depending on the type and seriousness of the occurrence, other expertise may be required.
- 1.4.5. The SSQA office shall at all times have qualified investigators.

## 2. INVESTIGATION PROCEDURE

### 2.1 The Investigation Process

#### 2.1.1 Preparation

1. The size and complexity of the investigation process will depend on the nature and seriousness of the occurrence being investigated.
2. Collect all facts about the occurrence e.g. flight plan, strips, voice recording, position log and other pertinent information.
3. Keep record of all pertinent information and documents.
4. Assess the facts and classify the occurrence accordingly.
5. Suggest to the responsible manager about the need to conduct investigation or not.
6. Inform relevant persons about the decision.

#### 2.1.2 The Investigation

1. Commence investigation
2. When interviewing the persons involved, be clear about the object of the investigation. The main objects are to:
  - i. clarify what happened (facts);
  - ii. find reasons why it happened;
  - iii. find suggestions for actions to prevent recurrence.



- iv. Inform the interviewed person about the procedures for the investigation.
- v. Provide feedback to parties involved.
3. The investigation must be conducted and concluded within fifteen (15) working days of the report once all outstanding issues relative to the report have been duly sorted.

### 2.1.3 The Report

1. Drafts of the report shall be submitted to the head of the unit and persons involved to enable them to comment on the report.
2. Collect and process all comments before finalizing the report.
3. Finalise the report including all appendixes.
4. The parties involved are entitled to add supplementary comments if disagreement prevails.

### 2.1.4 Closing of Report

1. When all concerned parties have had the opportunity to comment on the report, the final report shall be submitted to the responsible manager.

### 2.1.5 Distribution

1. The report shall be disseminated within the organization to enable other personnel to benefit from the findings and learn from the occurrence.
2. A copy of the report will be made available to the Accountable Manager when requested.

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**AG. DIRECTOR-GENERAL**





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