Response to CAP 1284

British Gliding Association

Addressing the questions put in the CAP, our responses are:

***Question 1**: Do you agree that private pilots do not generally take part in recreational flying if they feel unwell? Please answer yes or no. If you do not agree, please explain why.*

Yes. This is also the position for all every other medical certification system (except that of the Soviet Air Force which required pre-flight medical clearance). It is a clear responsibility of every pilot not to fly if unwell, fatigued or for any similar reason. Pilots have to make a judgement of many factors prior to a flight, weather, airfield state, aircraft serviceability etc, and personal fitness is yet another consideration.

***Question 2:** Do you agree that the probability of private pilot incapacitation in flight is extremely low? Please answer yes or no. If no, please provide evidence.*

Yes. From a BGA report of fatal and serious injury accidents 1974-2012;

Fatal and Serious Accidents 1974-2012	Fatal	Serious		Fatal	Serious
Collision	21	3	Aerotow	2	4
Winch	36	65	Integrity	8	12
Field	1	36	Other	9	7
Technical	6	3	**Medical**	**4**	**1**
Stall/spin	31	61	No cause	8	
Under/overshoot	1	15			
Hit terrain	5	9			
			Totals	132	240

During the same period the BGA flew some 5.5 million hours giving a medical accident rate of less than 1:1,000,000 hours flown. For much of that period (1974-2001) the BGA accepted a self-declaration for solo or mutual pilots. This actual accident rate is lower than might be predicted using the incapacity rates acceptable to the DVLA thereby confirming the positive answer to question one.

***Question 3:** Do you believe that we should proceed with the proposal to allow private pilots with the UK PPL or NPPL to fly provided they meet DVLA Group 1 Ordinary Driving Licence medical standards, with no GP or AME involvement in the process? Please answer yes or no. If no, please provide evidence.*

Yes. But only for a pilot flying solo or with another pilot. However the other pilot is defined by the BGA as one competent to recover the aircraft in the conditions of the proposed flight. This includes advanced students and a pilot whose licence had lapsed for a technical reason. For taking responsibility for inexperienced passenger or pupils the BGA considers that the higher standard of the unrestricted NPPL is appropriate (see response to question seven). This policy with similar and earlier variants has been in force in the BGA since 1967 and is well accepted by the membership provided that there is a liberal interpretation of the definition of another pilot.

***Question 4:** To minimise the risk of private pilots not being fit to fly (through illness or degeneration of senses) do you believe that we should require private pilots to self-certify themselves through, for example, signing a form? Do you believe they should submit this*

information to us at regular intervals aligned with the validity of current medicals? (e.g. five, two or one year, dependant on age)? Please answer yes or no to both points.

No. This would introduce additional bureaucracy with no benefit to safety. Any failure to complete the paperwork would be a lawyer's delight. The BGA believes that the possession of a driving licence is sufficient evidence of fitness to DVLA Group 1 standard. For youngsters who may not yet hold a driving licence a declaration similar to that used by the DVLA can be required at club level and is valid until age 25. Older drivers who may have lost their licence though alcohol or other traffic offences should seek a NPPL under existing rules when their case will be reviewed by their GP.

Question 5: *Based on the evidence presented, or other evidence which you can reference, do you believe an upper age limit should be included on the proposed change to the medical requirements for private pilots? Please answer yes or no.*
If you do believe an age limit should be imposed on this new requirement, what do you think the age limit should be? Please give an exact figure and rationale.

Yes where passengers are involved. Cardio-vascular incapacity risk increases exponentially with age. For a healthy population this exceeds the 2% level required by the DVLA for Group 2 professional drivers by the age of seventy five years. At no age does the incapacity risk level exceed that required by the DVLA for private Group 1 drivers. Therefore for older pilots still wishing to be responsible for inexperienced passengers or pupils, the additional tests required by an EASA medical should be applied. A similar rule has been applied by the BGA for twenty years and is supported by the membership.

Question 6: *Do you believe that private pilots who have a history of significant psychiatric condition (i.e. that requires medication) should be assessed by their GP rather than use a self-certification system? Please answer yes or no and provide reasons.*

No. The management of psychiatric disease in pilots is difficult but serious psychotic illness is fortunately rare. BGA experience is an incidence of 1 for every 20,000 member years. Minor cases are common but are relatively unimportant. A simple question on treatment as proposed would result in many minor cases being investigated but serious psychotic cases have no insight and do not disclose their adverse history. General practitioners do not have the expertise to assess aeromedical disposal, they can only give an account of the disease. An AME is unlikely to recognise mental disease during a short office visit. So the difficulty is to know about the problem in the first place. In BGA experience most serious cases come to notice because concern is expressed by club officials, colleagues, friends or family. Once known the management can be individual and this would involve both the GP and club officials. An essential provision is a reserve power to limit or even exclude a troublesome individual pilot notwithstanding any medical certificates that they might hold.

Question 7: *If the medical requirements are changed as proposed, should the number of passengers a private pilot carries be restricted? Please answer yes or no.*
If yes, do you think this should be restricted to a) one, b) two, c) three, d) four or e) five?

Yes. The State has a responsibility for third parties. If a pilot dies alone in an aircraft, it is classed as a fatal accident, but the fatality caused the accident and there is no loss of expectation of life. Therefore the responsibility for the carriage of inexperienced persons should be matched by higher medical standards. The view of the BGA is that the existing NPPL corresponding to the DVLA Group 2 professional driver standard provides a satisfactory assurance for passengers or early pupils. With this the existing NPPL rules meet the needs of the BGA because no large gliders now exist.

Question 8: *Do you believe that private pilots taking advantage of our proposed change to medical requirements should have to fly with a safety pilot? Please answer yes or no.*

No. While a pilot otherwise unfit to carry passengers would be medically safe while with a safety pilot, it complicates the question of captaincy when responsible for passengers. With no passengers it simply increases the chance of a casualty.

Question 9: *Do you believe that the medical requirements for flight instructors, ie the NPPL medical group 2 standard, should be changed from the current system? Please answer yes or no.*

No. The current medical requirements for gliding and SLMG instructors have proved satisfactory.

Question 10: *Do you believe that the UK PPL holder wishing to take advantage of the proposed new medical requirements should be limited to flying aircraft with a Maximum Take-Off Mass of 5,700kg or less? Please answer yes or no.*

Yes. The State has a responsibility to protect persons on the ground. The mass of the aircraft is a significant risk factor because light aircraft do not penetrate buildings. Statistical evidence comes from the well documented military records which were published in a series of books by Colin Cummings. A paper was presented to the International Congress of Aviation and Space Medicine; Madrid 2003, by our medical adviser and his abstract is copied here:

THE RANDOM GROUND RISK FROM AIRCRAFT ACCIDENTS

The risk of third party casualties on the ground secondary to aircraft accidents has influenced the state regulation of pilots. A high standard of medical fitness is justified to protect the public and according to ICAO the same Class 2 applies to a small sailplane as to a 5.7 tonne airplane. This study is a review of 6972 military aircraft losses suffered by the United Kingdom Royal Air Force between 1946 and 1996. The losses were subdivided into non-flying, those occurring in the vicinity of airfields, and those over land or at sea. These losses were also analysed by type, and hence weight of aircraft. Overall there were 121 third party deaths and 108 injured, this compares with the 4424 aircrew deaths. When the 727 aircraft weighing less than two tonnes were considered separately, there were 202 aircrew killed with eight others on the ground. Two of these were on airfields and remaining six were all military personnel in an observation post struck by a low flying aircraft. There were no random civilian casualties arising from those 386 accidents which were both over land and away from airfields. The smallest aircraft to penetrate a building and cause a civilian casualty was Harvard [T-6] trainer, weighing 2,500 Kg. The conclusion is that aircraft of less than two tonnes present a minimal third party ground risk and that pilot medical fitness standards can be relaxed for the solo flying of lightweight air sports aircraft.

Question 11: *Do you believe that the UK PPL holder wishing to take advantage of the proposed new medical requirements should be limited to the licence privileges of an NPPL holder? Please answer yes or no.*

Yes. The mass of the aircraft is a risk factor. All powered aircraft which operate under BGA control are less than two tonnes so the NPPL mass limit is acceptable.

Question 12: *Do you believe that the medical requirements for the CPL(B) should be changed? Please answer yes or no. Please also provide reasons for your answer.*

Yes. The BGA agrees that all measures must be rational and proportionate. Balloons crash slowly and there have been many accidents when the pilot was incapacitated (falling out during a rough landing) and passengers survived the subsequent uncontrolled flight. Therefore medical measures do not contribute to balloon safety.

Question 13: *Do you believe the proposal to change the medical requirements for UK PPL and NPPL holders should be extended to EASA PPL holders flying non-EASA aircraft in the UK? Please answer yes or no.*

Yes. The risk is no different. Driving licences are issued to common standards by EU nations.

Question 14: *Do you have any other specific comments which you would like to be considered as part of this consultation?*

The minimum age for solo flight in gliders is 14 years. There has to be a special provision for healthy youngsters who do not yet hold a driving licence. The BGA permits a declaration similar to that as used by the DVLA up to the age of 25 years and this has proved satisfactory.

Question 15: *Do you believe that the figures used to describe the time and cost benefits are accurate for the average private pilot? Please answer yes or no. If no, please provide your view on what realistic figures would be.*

Yes.

Question 16: *Can you identify any other specific benefits of this proposal?*

This CAP 1284 is greatly to be welcomed. There will be a reduction of cost, paperwork and administration. The BGA first implemented self-certification by solo pilots fifty years ago and has the evidence to support our comments.

Pete Stratten
Chief Executive
British Gliding Association