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(A)TO 18540Kg 15,9%

to ZF 14970Kg 11,2%

LD 17282Kg 14,5%

Incident to the ATR72 registered F-HBCM operated by Chalair on 21/09/2024 at Caen

The below summary focuses on flight crew operational procedures.

Take-off with an erroneous centre of gravity

SCENARIO

- During flight preparation, the captain communicated changes in weight and index to the ground staff for finalization of the LTS.
- Ground staff incorrectly corrected the DOI in the software by omitting the minus sign.
- This error led to an incorrect passenger seat allocation approved by the captain who did not identify the mistake.
- o Cabin crew noticed an unusual distribution of passengers but did not
- inform the captain, who had just validated the weight and balance.
- After takeoff, the captain noticed the flight controls were heavy and an abnormal trim value; the error was confirmed by the airline operations center and a corrected passenger seat allocation was sent before landing, which was uneventful.

CONTRIBUTIVE FACTORS

To the undetected DOI insertion error

- o Incomplete training of ground staff in the use of the flight preparation software used to generate the LTS.
- o Time pressure due to the reduced stopover time.
- Software interface allowing modification of a DOI by any operator.
- Minus sign not prominent in the computerized LTS.
- o Positive or negative DOI depending on the aircraft, which may lead to a sign or value insertion error.

OPS SAFETY LESSONS

@Crew: communication to detect errors

o Importance of crew coordination in case of doubt or questioning.

@Operations manager: training and use of the LTS software

- o Importance of software configuration, especially when its use is delegated to agents less familiar with it than OCC staff.
- o Training of ground staff.



For detailed information please view the full report

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