Tools for Building a Sustainable and Effective Safety Culture

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CONTENTS

Regulations and References

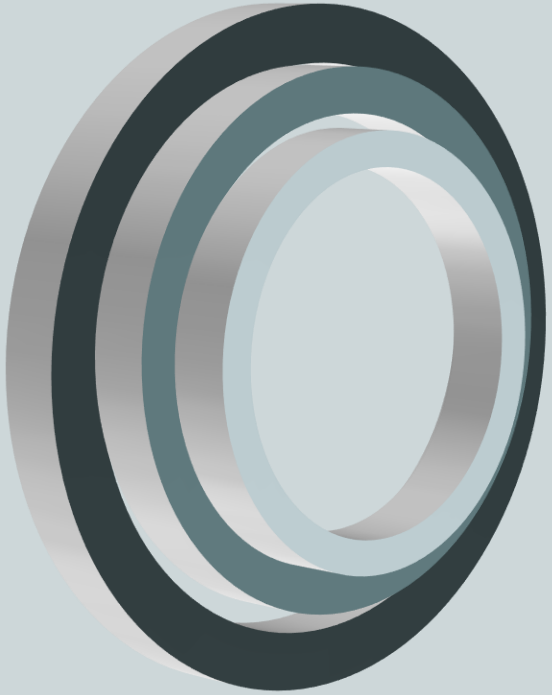
Regulations:

- **Annex 19 to the Chicago Convention- Safety Management**
- **Annex 13 to the Chicago Convention- Incident and Accident Investigation**
- **ICAO DOC 9859 - Safety Management Manual**
- **NAMCAR Part 140 – Safety Management**

References:

- ***Drift Into Failure From Hunting Down Broken Components to Understanding Complex Systems by*** Sydney Dekker
- ***Behind Human Error by*** David D Woods

Introduction



1. Its **more than a label**, its not what you say its what you do.

2. **Values, behaviours,** and **attitudes** regarding safety issues, shared by every member at every level of an organization

3. What **experiences, perspectives, and procedures** are present with regards to safety in an organization

OBJECTIVES

- Understand the need for a safety culture
- Learn tools for a safety culture
- What is good Safety Reporting
- Understanding Just Culture and Human Error

Understand the need for a safety culture

1. The 2 ways of looking at safety
2. Blunt end vs Sharp end
3. Production versus Protection
4. Drift into failure
5. Improve SSP and SMS

1. Two ways of viewing safety

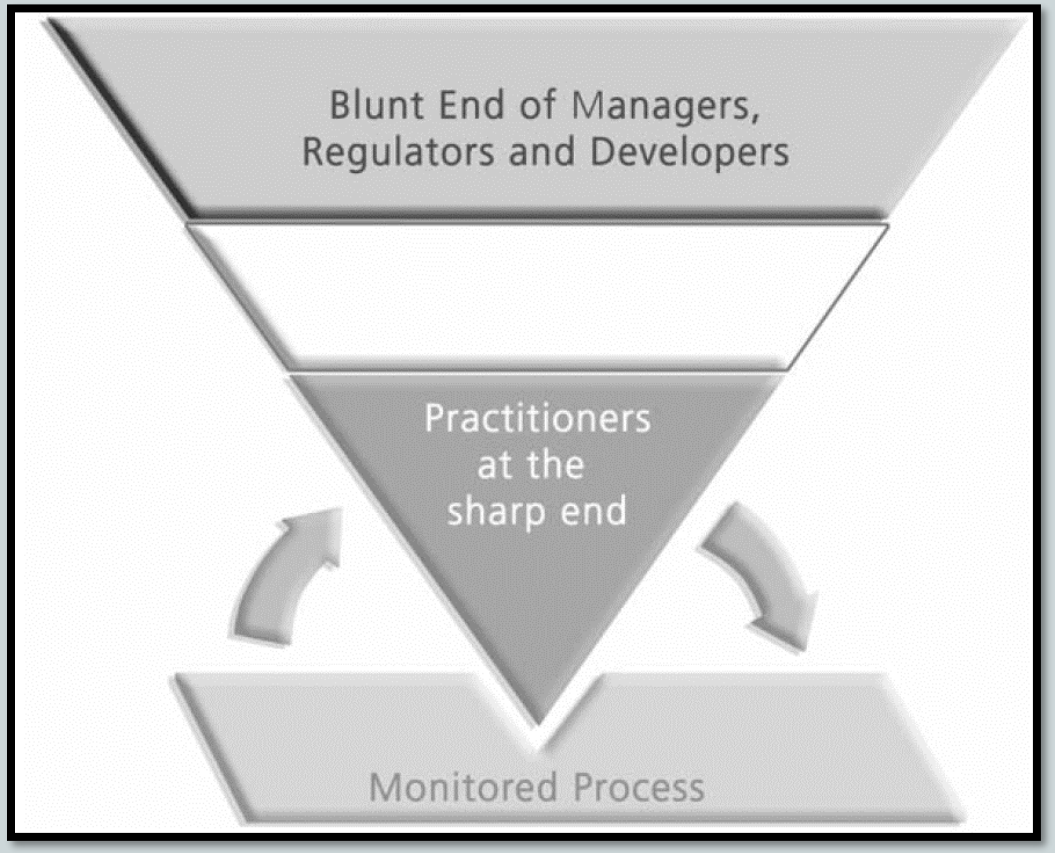
I have safety

- My system is safe
- Static approach
- Stagnant culture

I am working at being safe

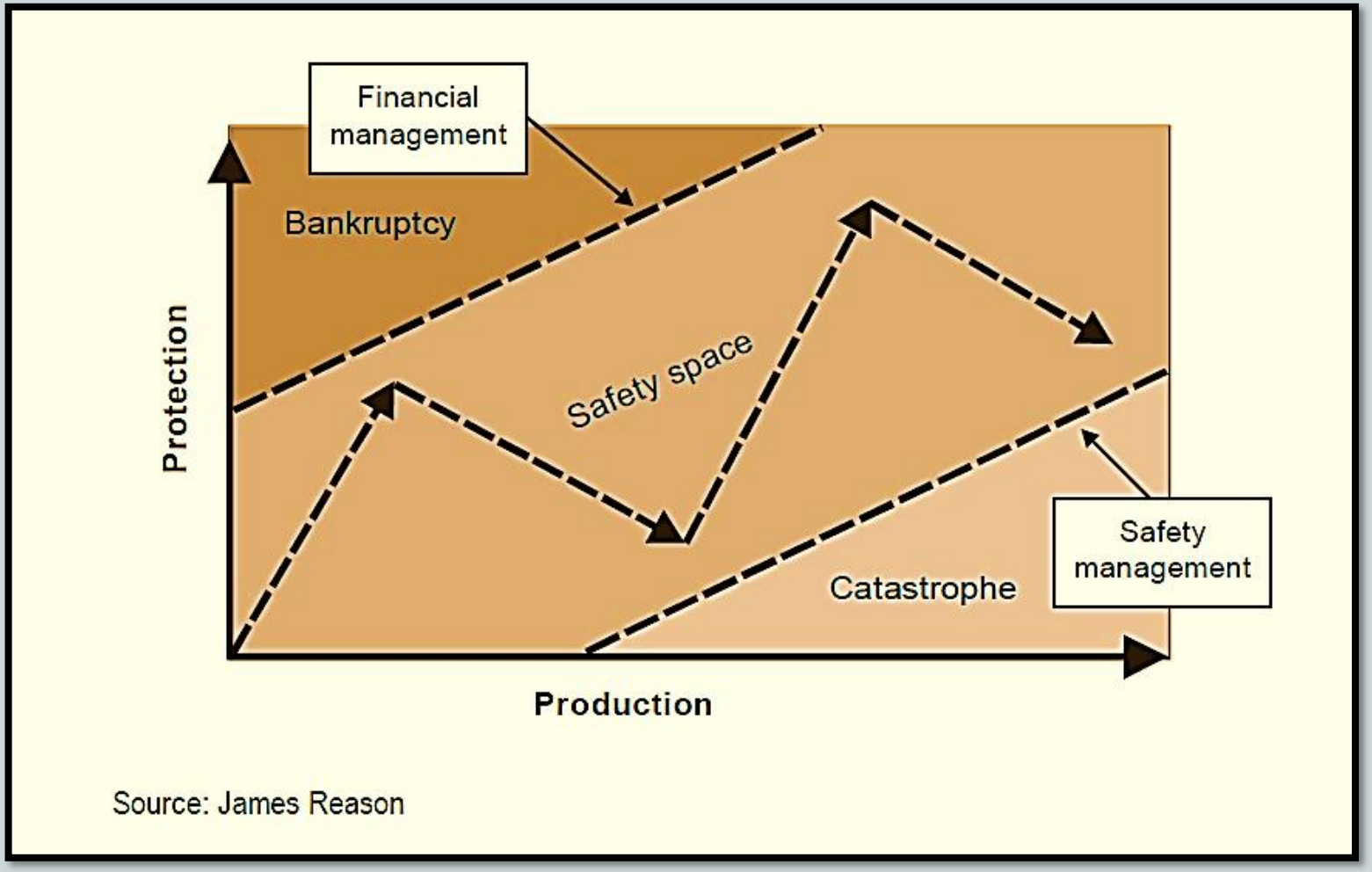
- My system is complex
- Dynamic approach
- Learning culture

2. Blunt end versus sharp end



- **Sharp end** practitioners **adapt to cope with complexities** of processes they monitor, manage or control.
- Strategies of people at the sharp end are **shaped by the resources and constraints** provided by blunt end of system.

3. Production versus Protection pressures



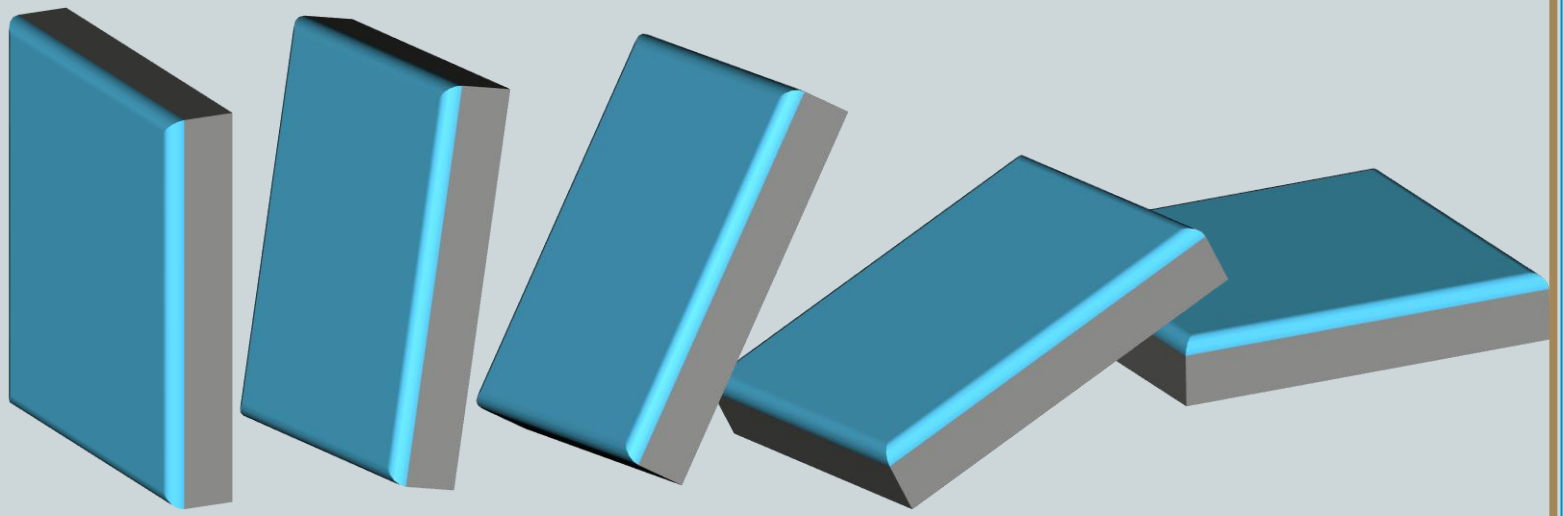
Source: James Reason

4. Drift into failure

"**Accidents** are the effects of a **systematic migration** of **organizational** behavior under the influence of **pressure toward cost-effectiveness** in an aggressive competitive environment"

Source: Jens Rasmusen

Where you think your system is versus where you are.



Where you think you are.

Where you are.

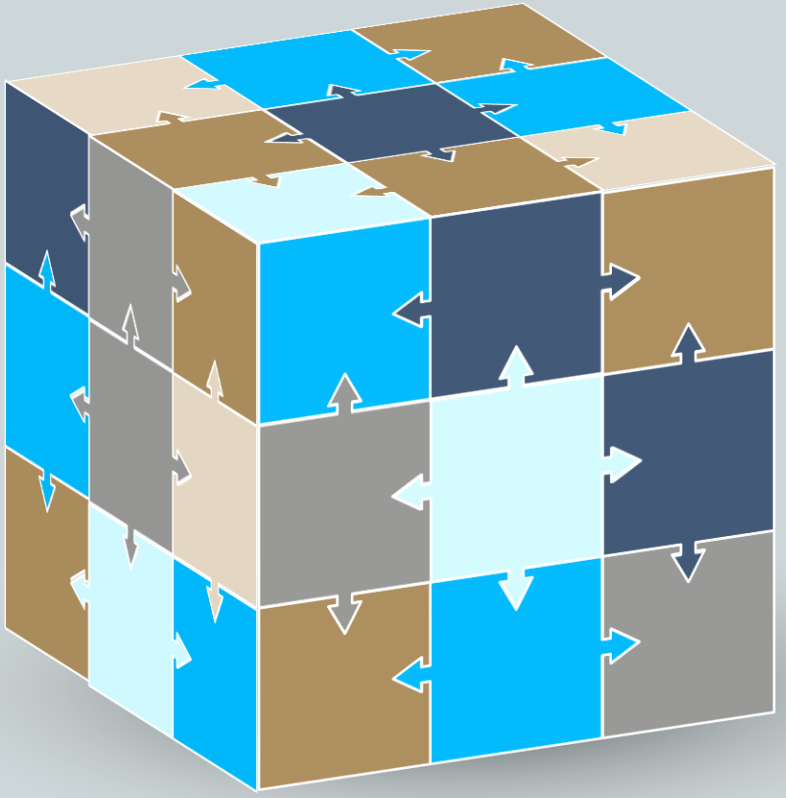
5. Improves SSP and SMS

- **SSPs** and **SMSs** are **sustained by safety data** and **safety information** that is necessary to address existing and potential safety deficiencies and hazards

Tools for a Safety Culture

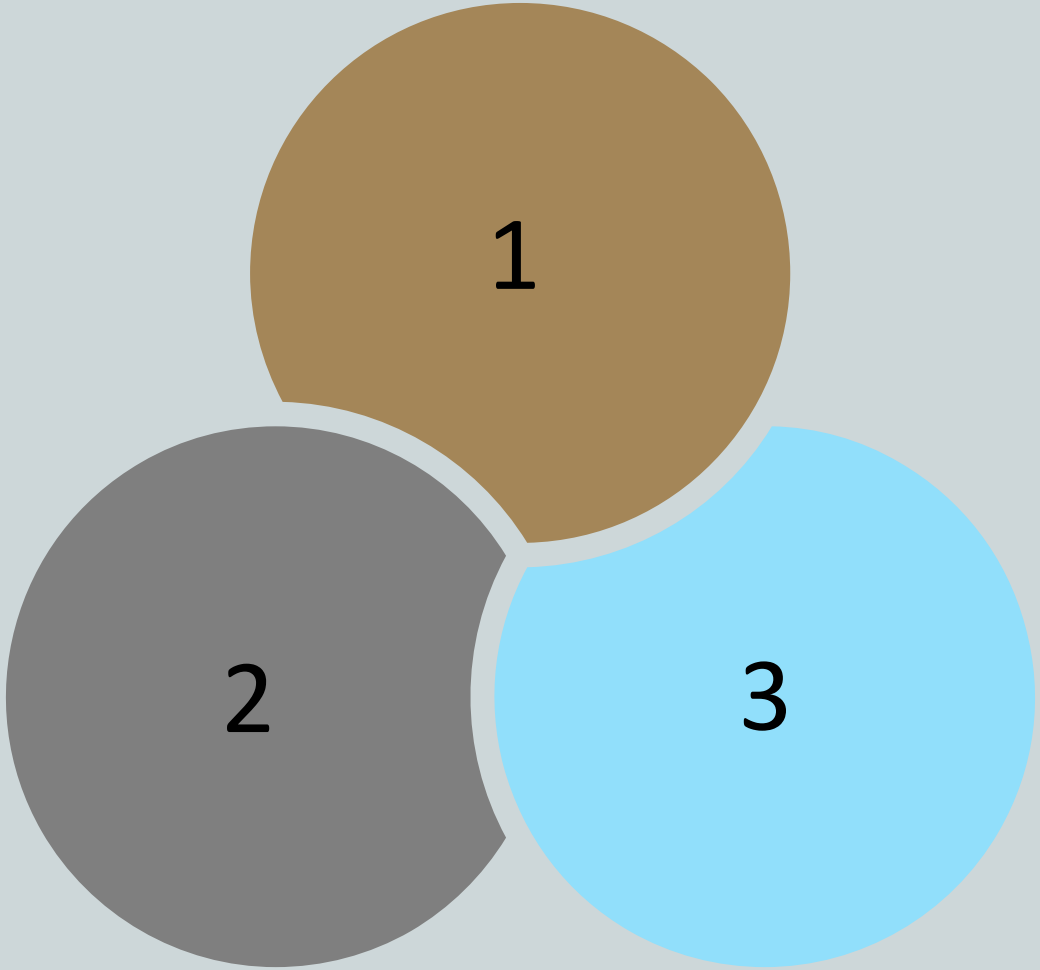
1. Informed Culture
2. Flexible Culture
3. Learning Culture
4. Reporting Culture
5. Just Culture

Safety reporting



- Why report
- Prerequisites
- Types of reporting
- Effective reporting
- Report management
- Info management

Why is reporting important

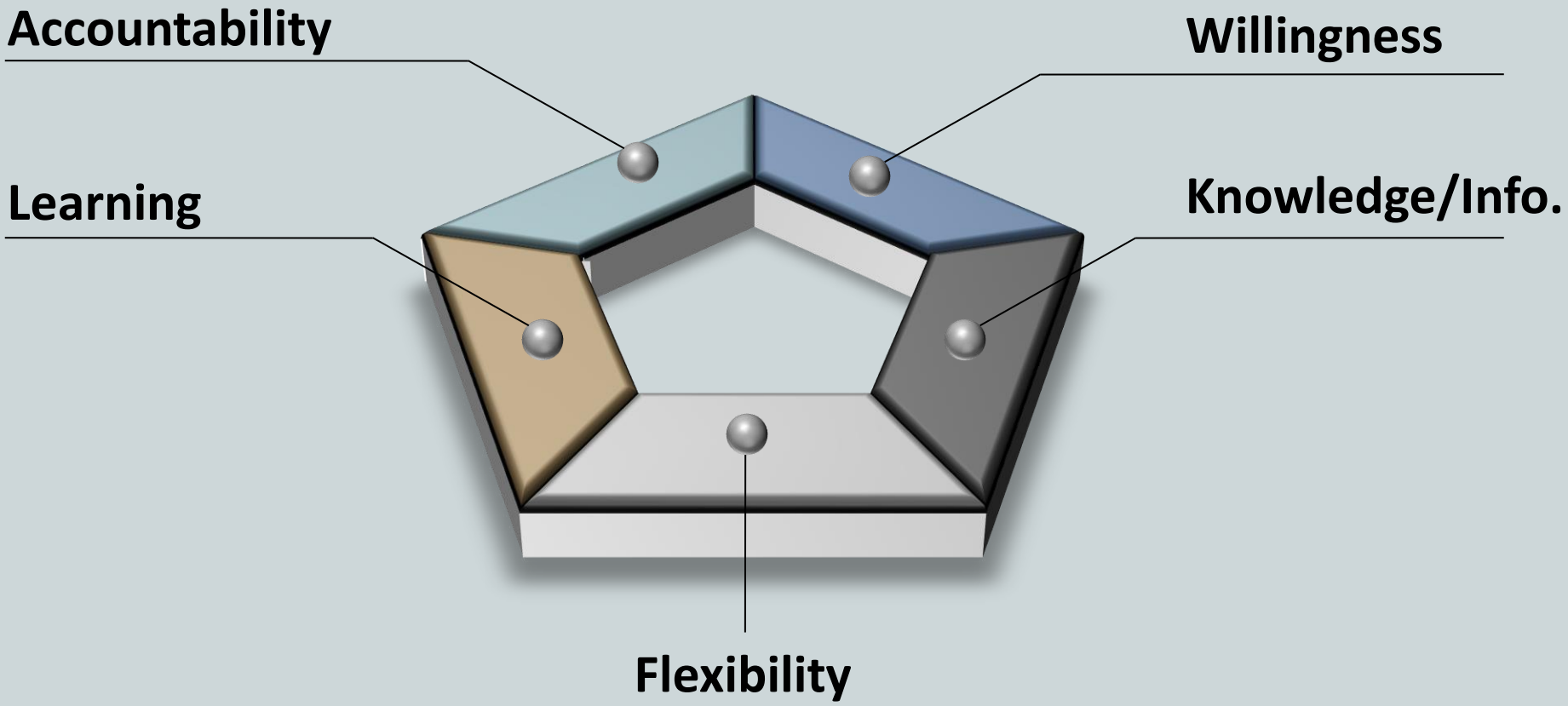


1. **No plan is too good to consider all possibilities.**

2. **A way for sharp end practioners to inform blunt end operators what is going on.**

3. **Feedback mechanism to identify deficiencies and re-engineer operations.**

Prerequisites for successful reporting



Types of Safety reporting programs

Mandatory

- As defined by Annex 13 and Annex 19

Voluntary

- Personnel submit reports without any legal requirement to do so

Confidential

- Identity preserved
- Anonymous

Effective Safety reporting

1 TRAIN THE MESSENGERS

2 EASE OF REPORTING

3 TIMELY, ACCESSIBLE AND INFORMATIVE FEEDBACK

4 PROTECTION

5 VEHICLE FOR CHANGE

4 steps in safety reporting management

Reporting

Events, circumstances, & conditions

Storage

Standardization & ease of access

Analyses

Data into information & intelligence

Info Exchange

What you do not know does not exist

Management of Information

	Pathological	Bureaucratic	Generative
Information	Hidden	Ignored	Sought
Messengers	Shouted	Tolerated	Trained
Responsibilities	Shirked	Boxed	Shared
Reports	Discouraged	Allowed	Rewarded
Failures	Covered up	Merciful	Scrutinized
New Ideas	Crushed	Problematic	Welcomed
Resulting Organization	Conflicted Organization	Red-Tape Organization	Reliable Organization

JUST CULTURE

- A culture of **trust** and **accountability**
- **No punishment** for actions, omissions, or decisions taken that are commensurate with experience & training, but **gross negligence**, **willful violations,** and destructive acts are not tolerated
- A culture where the **boss is allowed to hear bad news**

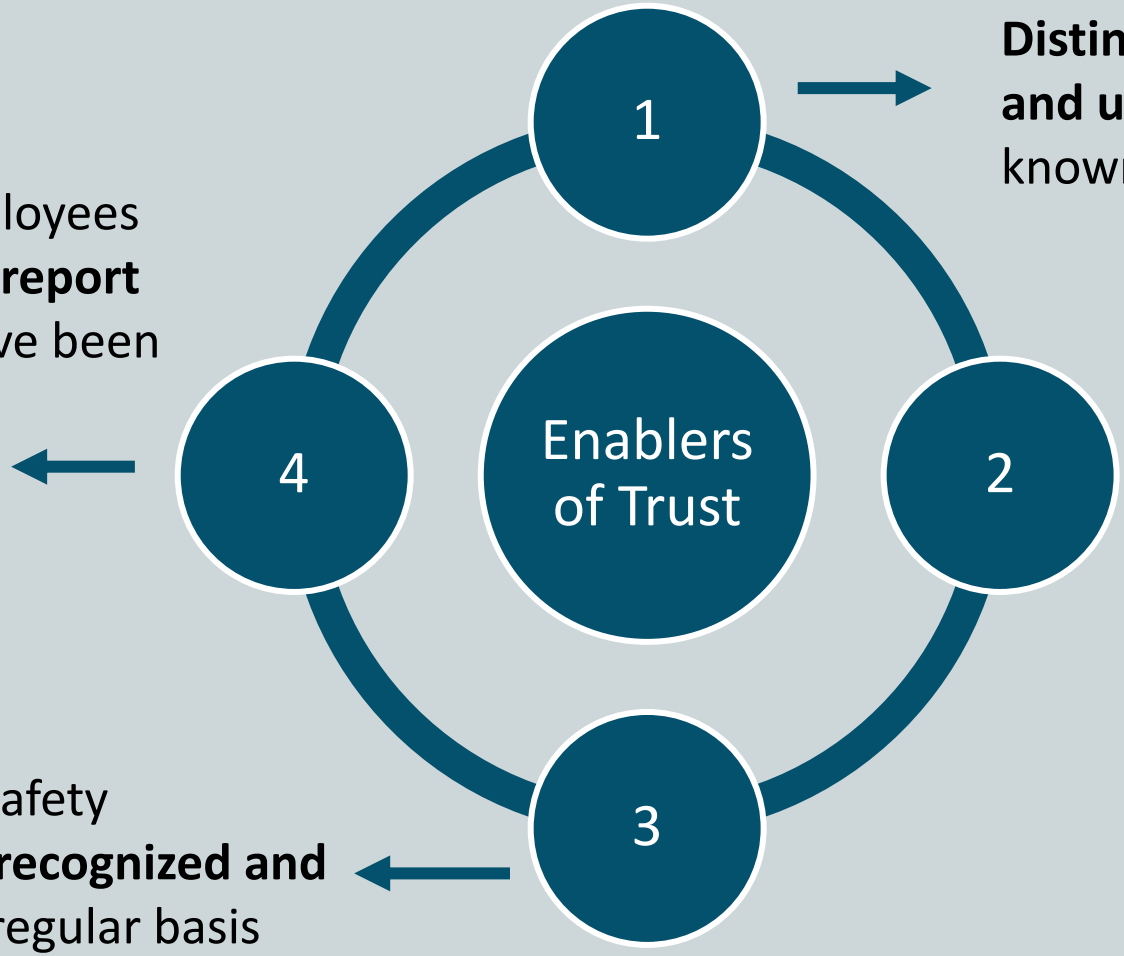
JUST CULTURE

- Errors and unsafe acts will **not be punished** if error was unintentional

- Those who act reckless or take **deliberate** and unjustifiable risks will be subject to **disciplinary action**

- There is a **clear line** between **acceptable** and **unacceptable** behavior

JUST CULTURE



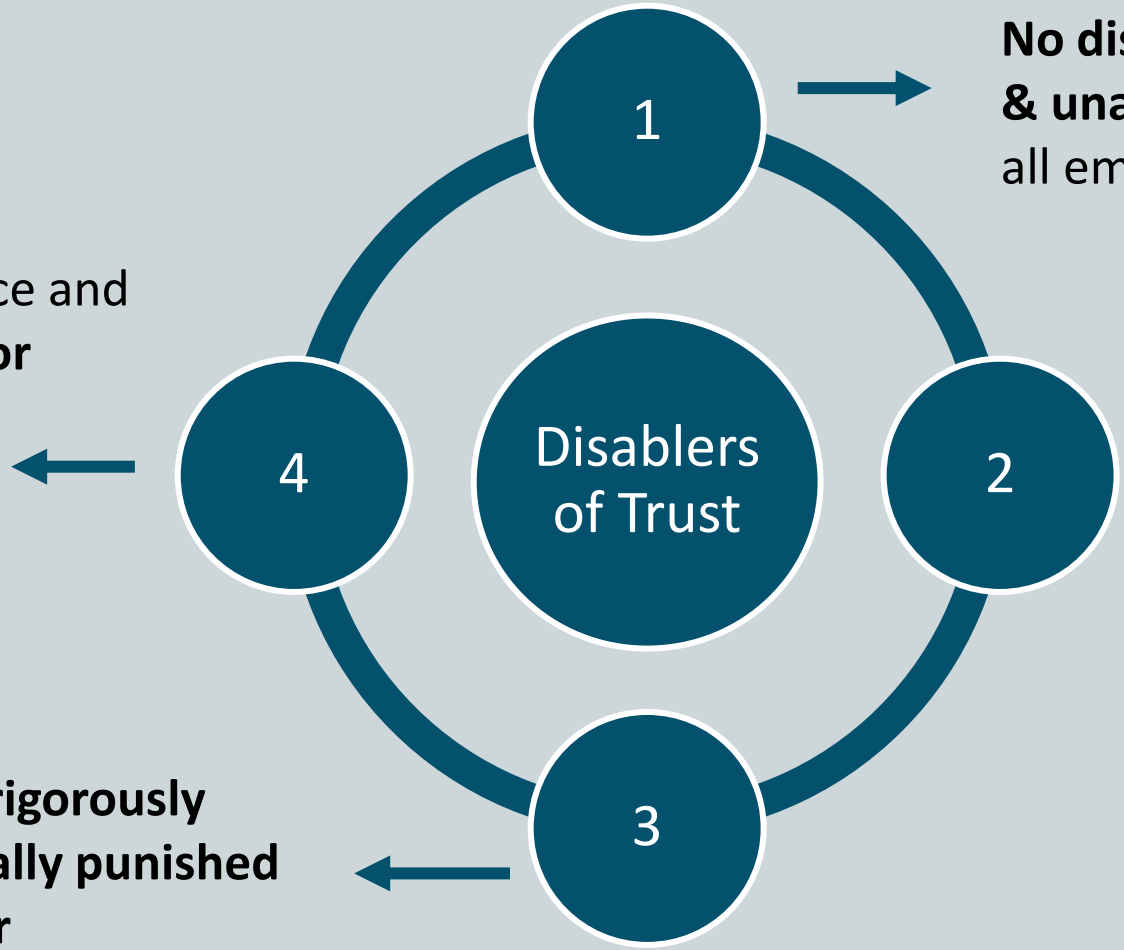
Distinction between acceptable and unacceptable behavior known to all employees

Occurrences (including I&A) investigations consider **both individual as well as organizational factors**

Good Aviation Safety Performance is **recognized and rewarded** on a regular basis

Willingness among employees and operational staff **to report** events in which they have been involved.

JUST CULTURE



No distinction between acceptable & unacceptable behavior known to all employees

Accident and incident investigations **only focus on individual factors**

Employees are **rigorously and systematically punished for human error**

Good safety performance and safe behavior is **taken for granted**

Human Error

"If professionals consider 1 thing **"unjust,"** it is often this:

Split-second operational decisions get evaluated, turned over, examined, picked apart, & analyzed for months—**by people who were not there** when the decision was taken, and **whose daily work does not even involve such decisions."**

Source: Sydney Dekker

Human error

1st Stories

- "Human error" as cause
- Saying what people should have done is a satisfying way of describing failure
- Telling people to be more careful will make problem go away

2nd Stories

- "Human error" as consequence
- Saying what people should have done does not explain why they did what they did
- Only by constantly seeking out vulnerabilities can organizations enhance safety

Human error

1st Stories

- First story is ultimately barren
- Are bolstered by hindsight bias
- Tries to find a culprit

2nd Stories

- Richer info source for better counter measures
- Reveals that enemy of safety is complexity
- Capture complexities & helps to find ways of taming them

Human error

"Progress is **learning how to tame the complexity** that arises from achieving higher levels of capability **in the face of resource pressures**"

Source: Sydney Dekker

In Conclusion …

View on safety

Safety is something an organization does

Safety Reporting

Fundamental indicator of safety culture

Human error

It is a consequence not a cause

Just Culture

It facilitates safety reporting

Thank you for listening.

Q&A

Q & A Session