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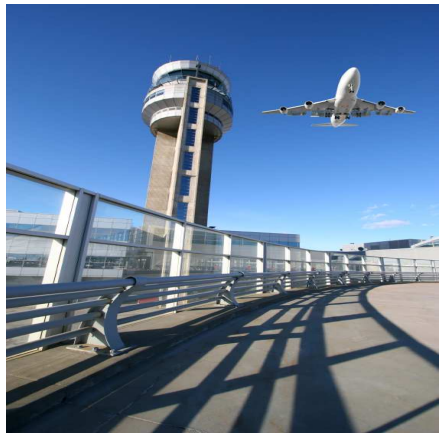

Making Change
A Real-World Evolution In Safety

"A journey of 1,000 miles begins with a single step"

Overview

- The Company – Ground Service Environment
  - 12,000 people in over 200 International locations
- The company's goal –
  - Move toward a more holistic approach to safety management
  - Move away from traditional responses to occurrences
  - Move toward prevention and positive actions
  - Move toward identifying precursors, use of experience and fair judgment
- The challenges
  - Cultures within cultures
  - Past practice
  - People
- The first step in the journey of a 1,000 miles
  - Introduction of new ideas….from experienced “outsiders”

Presentation By

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- 30+ years in FAA - air traffic control, aviation safety, accident investigation, litigation support, and emergency operations
- US Airline Transport Pilot, Instructor Pilot, and 121 Dispatcher
- Former Consultant for Department of Justice – Aviation Litigation
- Current Civil Expert for ATM & Flight Operations - NATO, Brussels
- Certified EUROCONTROL Safety Auditor & ICAO USOAP Auditor
- Dual citizen – Ireland & US

Why Us?

- Unique background:
  - International firm representing 10 nationalities and eight languages working in five countries in North America, Europe and the Middle East.
  - Staff with 100+ years with US FAA in ATC, Flight Standards and Accident Investigations
    - Lead or supported over 150 major fatal accident investigations worldwide
    - Thousands of ATC occurrences
  - Former Air Traffic Controllers, Airline and General Aviation pilots, Airline Operations, Flight and Ground Safety
  - Party to NTSB investigations
  - Supported FBI, military, and US Secret Service investigations
  - Established first working SMS at a US General Aviation airport
  - Extensive experience with techniques that did not work

The Client's History

- A focus on rote methodology
- "Just follow the procedures" (but get the job done anyway)
- Gotcha approach – Procedures that conflict with real world
- Termination to fix the problem

To Change Culture
Start With Perspectives

- Before you can have a “Just Culture,” you need to know what your culture is – how it got there – and what drives it.
- To create a “just culture” sometimes you may need to start from the very beginning.
- Starting Perspectives & Conversations
  - Safety is driven by occurrences - almost always seen in the negative.
  - Safety is an intangible and measured differently by different organisations.
  - Dealing with High Risk – and getting away with it – does not mean you are safe.
  - Focusing on “what happened” is easy and results in easy fixes - “Fire the idiot!” – but accomplishes little.
  - Focusing on “why it happened,” is the Holy Grail and much more difficult - but can provide long term cultural and safety benefits.

The Path We Followed
Gradual Introduction To Change

- We did not focus on current operations
  - Conducted general discussions on what is safety
- Introduced a perspective of “safety vs. the operation” and its impact on the success of the company. Discussed:
  - Is safety really **THE** most important thing?
  - Where does safety fit into an organization vs. the operation?
  - How do we measure it?
- Reviewed methods of “investigating” occurrences
  - The beginning of a change in culture
  - Are we focused on “what” or “why”?
  - The impact on people

Introduced Influence Of External Changes

- Change in NTSB accident reporting focus –
  - The old way - "The pilot/controller/mechanic failed to…."
  - The new way - "The organization failed…"
- The NTSB perspective of organizational contribution continued -
  - Continental 2574 (9/11/91) Contributing Cause ***…was the failure of Continental…management to…insure compliance with…procedures…and failure of FAA…to detect and verify compliance with approved procedures."***
  - ValuJet 592 (5/11/96) Contributing Cause…***the failure of ValuJet to properly oversee its contract maintenance program…the failure of the FAA to require smoke detection and fire suppression systems…"***

Explored Classic Perspectives Of Safety With A New Twist

- How we view ‘safety’ can alter behaviour and goals.
  - It can be much more than making sure “nothing happens”
- We asked - Is safety the most important thing within an organization or is the survival of the organisation the most important?
- Consider –
  - Survival involves cost control, efficiency, and consumer and employee confidence –
    - all negatively impacted by injuries, damage to property, lost employee time, and customers going elsewhere.
  - Reductions in occurrences and accidents enhances efficiency and benefits the customers and the organisation.
- So the functions are related – no one cares how safe we are if we’re not in business.
    - We need to manage risk safely to optimize the operation and stay in business, serve the customer and collect a paycheck.

Continued To Introduce Conceptual Changes

- How an organisation approaches an investigation will set the tone – and impact effectiveness. . ***Only people who wear a badge and carry a gun really do "Investigations" – If you "think like a cop," your results will be limited and you will do long term damage within the organization.***

- The key points in investigations
  - Each **event** will be different and require a different path.
  - But the **approach** will always follow a similar path – let the data lead you – and don't get trapped into a "process."
  - Doing investigations requires training and practice –
    - ✓ The best investigations are accomplished when you don't need to do an investigation.
    - ✓ If you've never done a serious investigation this is not the time to "wing it."

Slowly Change Focus
Look Ahead – Not Behind

- An Occurrence/Accident is an indication of the failure of part of the safety system – or the safety net.
- An Occurrence Review (or investigation) is a rapid assessment of operational risk. The goal should be to answer the following two questions, ***which will reshape how an investigation is focused and conducted:***
  - ✓ Did some part of our system fail which could happen again tomorrow at another location and cause a similar event?
  - ✓ What can we/should we do immediately to reduce our risk and make sure this does not happen again?

We Introduce “The Holy Grail”

Search for WHY – not WHAT – to learn HOW

- If you’re searching for WHAT happened you are conducting an investigation;
- If you’re focused on WHY an event occurred you are doing safety analysis;
- When you discover WHY it happened, you will have begun to identify precursors!
- Now you will be able to explain HOW to prevent a reoccurrence and you’re managing risk.

WHY Leads to HOW

- Remember our goal –
  - Preventing a reoccurrence, NOT just to “find the guilty party.”
- Once we know why an event happened can finally start to work on preventing reoccurrences based on actual data! The true safety Holy Grail!
- The best tool to formulate a process on HOW to prevent the event from reoccurring is to utilize your best resources –
  - Talk to the people who are actually doing the job.
    - Odds are the folks who do the job will have a good idea of how to keep it from happening again.

Must Address The 300-kg Gorilla In The Room

- "Accountability" and "Responsibility – the genesis of Finger Pointing
- Safety Management Systems now identify the "Accountable Official" or the "Accountable Manager"
  - Is there a clear understanding of what that means?
  - Consider - If an individual complied with all the instructions, ***but the instructions were incorrect or incomplete,*** where does the problem lie?
  - Consider we insist there is not enough staffing but then we go below minimum staffing for leave or breaks and something happens.
- These issues and concepts, which are integral to a Safety Culture and Just Culture, should be fully explored and understood within an organization – and that takes time and consistent follow-up.

Examples of Lessons Learned From Failures And Successes - 1

- People are fragile – handle with care.
- *There is such a thing as a "System Error" and events can be the result of decisions and procedures, not just an individual's actions – or lack of actions – and can involve management decisons or directions to employees.*
- If the cause of the event seems simple, look closer.
- *Beware of your own attitude during an investigation. If you "think like a cop," your results will be limited and you will do long term damage within the organization.*

Examples of Lessons Learned From Failures And Successes - 2

- External pressures affect fact finding -
  - Political urgency to find out "What happend out there!"
  - There is a natural urge to "fix it" which, unfortunately, generally precedes knowing exactly what to fix.
- The reality of all investigations -
  - You never get the full (correct) story the first time.
  - There will always be someone who says, "By the way, did we mention..."
  - There is always a risk of internal organizational denial.
  - *Sometimes an accident is just an accident and there is nothing to fix.*

Examples of Lessons Learned From Failures And Successes - 3

- The investigation will be more effective – and beneficial to all - if you create a positive environment ***before*** you need to do an investigation.
- Information is power and can empower everyone. Share information in all directions within the organization.
  - People need to understand the benefit of safety data and the value of event reviews – aka "they need to be able to learn from it."
  - Highlight trends and findings during the course of the year.
    - Focus on success – stay positive even with bad news. Never say, "The employee failed to…." since you have just shut off your best source of safety data, your people.
    - Focus on the operations **and** the Corporate office – everyone shares in the responsibility.

Example of Lessons Learned From Failures And Successes - 4

- Senior Management Perspective
  - Senior managers want to know a situation is under control and the right people are doing the right thing.
    - But when they don't trust the system, second-guessing and micro-management follows.
  - Proactive efforts, explanations of events, development of corrective action plans, enhanced training, outreach efforts – all accomplished for small events on a regular basis – result in the creation of trust by senior managers and the workforce.
  - Use of the "safety argument" internally for labour-management gains/negotiations undermines just culture when you really need it.

Remember The People During The Investigation Process

- In dealing with people, first, **do no harm**!
  - The people involved in an event – *no matter what their role* – are upset or scared, physically or emotionally hurt and – no matter what their behavior - they are worried that they may have done something that caused the event.
  - Treat them with care and kindness. Consider them "wounded" and take care of them – *no matter what their role* – and DO NOT JUDGE THEM. The odds are good that subsequent facts will prove your first impression was wrong.
- People are a great source to discover WHY something happened but:
  - Our memory is not always the best,
  - The "facts" we recall are driven by perceptions,
  - People generally want to please so, if we don't know something, very few will say, "I don't know." But many will, *unknowingly*, make up an answer.

So Where Does It All Lead?

- A gradual change in culture
- The solution is a safety culture that, in time, becomes:
  - comfortable with reporting events
  - conducting analysis of data
  - discussing identified areas of concerns and risk with its people
  - taking action before an event happens, and,
  - most importantly, monitoring the results and adjusting as necessary.
- So a Safety Culture is a lot more than just reporting incidents
- A Just Culture is a balance of safety and responsibility

Litigation Role: Seen As "The Dark Side"

- A natural conflict between Safety and Justice
- A Safety Culture is based in open reporting of incidents, honest conversation about risk, mitigations, analysis, feedback and training.
- Litigation is focused on finding blame, determining who or what is at fault (responsible).
- There must be a balance so society benefits. Neither a safety culture nor a just culture can be developed independently and organisations and people must also accept responsibility – both before and after an event.

Where Are We Now?
The Good News!

- The safety department gets calls from operations looking for advice!
- Occurrences are handled with the “Coffee Man’s” approach
- 50% of previous directives have been cancelled and people are starting to use their own judgment.
- We’ve taken more than the first step with a lot more to go…but we’re going in the right direction.
- Next – A Video of Success

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