Safety Evolution Guide:

A Just & Open Climate for Reporting and Investigating Occurrences, SoE 1.2

An Evolution Guide for an SMS practice which has been recognised as Optimised by the CANSO Safety Standing Committee

1. OBJECTIVE OF GUIDE

Members of the Civil Air Navigation Services Organisation (CANSO) are committed to the improvement of their services. As part of this commitment, organisations share their practices in efforts transfer learning across the industry.

This guide captures:

- The practices of an Air Navigation Service Provider (ANSP) in one element of the CANSO Standard of Excellence (SoE) in Safety Management System (SMS). The practices of this ANSP have been recognized by their peers as being an optimised practice within the industry (see Figure 1). The optimised practices have been selected on the basis of their novelty, innovation or the recognition of their potential to manage operational risks.

Application of the Guidance

CANSO recognizes that this guidance will not be relevant to all ANSPs. The maturity of any ANSP's Safety Management System will be dependent on their specific context. This context will be a reflection of factors including the size and complexity of the organisation, domestic regulations and the risk appetite of the organisation.

ANSPs do not necessarily need to adopt all the practices and processes promoted by CANSO but may consider the relevance of the practices promoted in this guide to their operational environment.

2. OPTIMISED PRACTICE

This guide addresses an SMS process which was identified in 2019 and 2020 as being optimised, it details how one Air Navigation Service Provider, LVNL, is actively developing a just and open climate for reporting and occurrence investigation. The approach was reviewed by a panel of experts from the Optimised Review Group of the Safety Standing

Committee. The approach meets CANSO's requirements for SoE in SMS Study area 1.2 (see below).

3. SCOPE OF GUIDE

This guide aims to provide an insight into what LVNL has done in terms of establishing a just and open climate for reporting and investigating occurrences, and details why this approach was taken. Examples of the type of activities are included throughout this guide to provide a starting point for other ANSP's wishing to facilitate a similar development of an open climate.

4. APPLICABLE STANDARDS AND REQUIREMENTS

CANSO Standard of Excellence in Safety Management Systems

1.2 A Just and open climate for reporting and investigating occurrences

Objective	Informal Arrangements	Defined	Managed	Assured	Optimised
1.2 A just and open climate for reporting and investigating occurrences NB: A thorough reporting and investigation process must begin with notification, data gathering, reconstruction, analysis, safety recommendation and implementation of remedial actions, resulting in final reporting, exchange of lessons learned and effective monitoring.	Management believes there are no issues with the existing reporting and investigation culture and therefore does not see the need for any activity or dialogue with the staff in this area.	Management and employees have discussed developing a Just Culture to encourage reporting.	The organisation has established policies and procedures to support Just Culture principles. Employees comply with safety data sharing and publication policies. All levels of the organisation understand and accept the difference between acceptable and unacceptable behaviours. Within legal limits, the organisation's safety data are sufficiently protected from external interference. All levels of the organisation systematically apply Just Culture reporting and investigation principles and processes.	The organisation measures the acceptance of Just Culture principles. The organisation follows a clear and published policy that addresses the interface with the judiciary on Just Culture matters. Lessons from within the organisation and across different industry sectors are used to enhance the organisation's approach to Just Culture. There is evidence that the application of Just Culture is unaffected by changes in the organisation.	The organisation has set best practice(s) for safety management for this objective and is willing to share those with other ANSPs/organisations.

Extract from CANSO Standard of Excellence in Safety Management Systems

https://www.canso.org/system/files/CANSO Standard of Excellence in Safety Management Systems.pdf

5. CONTEXT

Twenty years ago LVNL was faced with the aftermath of the Delta incident (1998) where two controllers were fined in court, and one acquitted. In the appeal all defendants were found guilty as charged, however no sentence was imposed. As a result, the number of reported incidents with ATC as cause decreased. Other consequences included was that the verdict was viewed as a legal anomaly and the lack of protection to operational personnel as proven. Only "comfortable" incidents were reported, which resulted in a

lower level of co-operation in investigating incidents, and a degraded organisational learning from incidents (see Figure 1 below). Throughout the organisation, personal relationships became troubled, the development of Safety Management System hampered, and the safety information system degraded.

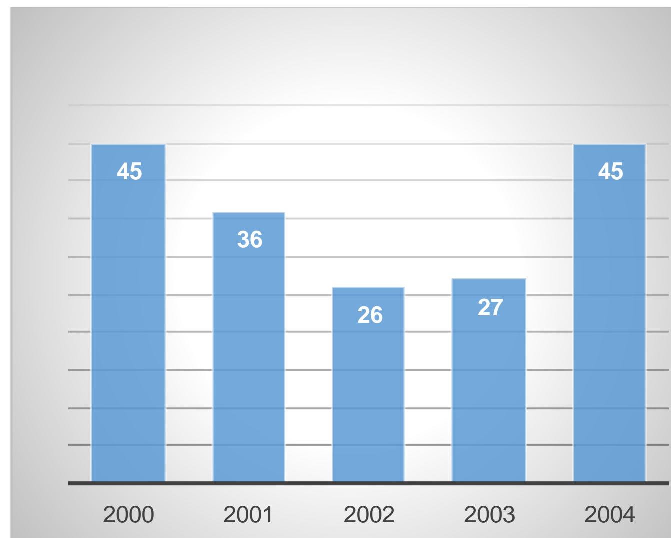

Figure 1 - Number of reported occurrences caused by ATC

LVNL and KLM, and associated professional organisations, began a long journey of conversations with judiciary, aviation police, professional organisations, parliament members, inspectorate officials and policy and legislation makers. All parties agreed that the situation was unfavourable for a healthy reporting environment, however, it was again stated that this was the law and nothing could be done. Some went even so far as to advise that if persons did not wish to run prosecution risks, they should try a different occupation.

The progress of the discussions started to improve when LVNL approached the press regarding the situation. Parliament members were now getting interested and questions to ministers were being asked. As a result, a special committee was set up that got all stakeholders involved around the table, exchanging views and finally concluding that a necessary balance between safety and justice must be struck, as both should enjoy similar high civilisation levels.

Below is a short description of the steps that have been taken and the results that have been achieved to ensure a similar situation would not reoccur.

6. DESIGNING AN OPEN AND JUST CLIMATE

With regard to Safety Culture, the development of Just Culture is the first step (see Figure 2). To be able to learn from incidents, it is a prerequisite that they are reported. All occurrence reports create the opportunity to learn from throughout all layers and departments of the organisation.

Figure 2 – Place of Just Culture in the steps to develop a positive Safety Culture

Just Culture has now taken a prominent place in our safety management systems and regulations. In addition to mandatory reporting of incidents, the European Commission has anchored the principle of Just Culture in a regulation from 2014 with an obligation for organizations to "*shall adopt internal rules describing how just culture principles are guaranteed and implemented within that organization*".

7. IMPLEMENTATION

Steps undertaken

1. Negotiations and discussions within the sector – including airlines and airport - , and discussions in both parliamentary chambers, have been held to outline the positive effect of an open and just reporting climate.
2. Since 2010 all occurrence reports are processed electronically at LVNL. When these reports are filed, it is not mandatory to state the involved persons.
3. The State will not institute legal proceedings as a result of an unintentional or non-negligent violation of a legal provision and does not impose an administrative sanction on an administrative body if knowledge of this violation has been obtained through a report from the mandatory reporting system. This does not apply if there is suspicion of gross negligence or intent with regard to the incident.
4. Data obtained during an internal company safety investigation in the context of a safety management system certified by or pursuant to the Aviation Act cannot be requested for the purpose of a criminal investigation following a mandatory report until after authorization by the court commissioner at the request of the public prosecutor.
5. The State issued a letter to all prosecution offices, instructing them to:
    a. In principle, prosecution is only initiated in the event of accidents, serious incidents (near-accidents), serious danger and systematic violations caused by intent or gross negligence.
    b. No prosecution will be brought against natural persons with regard to violations that have been committed unintentionally or non-negligently and of which the Public Prosecution Service is aware only because it has been reported under Article 7.1 of the (Dutch) Aviation Act. However, in accordance with Article 8, paragraph 3 of Directive 2003/42/EC, criminal action can be taken if there has been intent or gross negligence. Also, if there has been intent or gross negligence, criminal action can be taken if the prosecutor for other reasons, for example by an anonymous tip, became aware of the incident in question. Furthermore, with regard to the

prosecution policy described above, the reservation must be made that the competent court may, following a complaint based on Article 12 Dutch Penal Code, order that prosecution be nonetheless instituted.

   c. If on the basis of the foregoing it is possible to prosecute, the limitation is that the report itself may not be used as evidence in a criminal case against the reporter. However, the report may be used as control information and as evidence in criminal cases against others than the reporter.

6. The public prosecutor sent a written statement (legally valid in a court of law) in 2011 to all aviation parties declaring that: In the event of accidents, serious incidents (near-accidents), serious danger and systematic violations caused by intent or gross negligence, criminal investigation is initiated. The result can then be that prosecution is started, whereby the general danger setting article (5.3) of the Dutch Aviation Act is the final piece and therefore not the point of departure for the prosecution. This article states: It is forbidden to provide air traffic control in such a manner that it causes danger or potential danger to goods or people.
7. Consultations with prosecutor, Aviation Incidents Bureau (ABL) and the aviation sector (4 times per year). In this meeting, discussion takes place on 'Operation' / functioning of the law reporting incidents, many concrete cases are being discussed to judge whether or not gross negligence or wilful misconduct would apply and also "peripheral cases" for which it is not immediately clear at the ABL whether they should be reported to the prosecutor.
8. In case of a serious or major safety event, LVNL informs the prosecutor directly (same level as ABL) and explain the event, so that the prosecution office is immediately informed. This is followed up with conclusions of the investigations when available.

Results within the ANSP

The safety management system of LVNL has matured significantly with an excellent reporting culture, provision of feedback to the reporter, facilitation of open discussions over what happened and why it happened, leading to actually achieving safety improvements.

The Operational Risk Management (ORM) department analyses approximately 2000 incident reports per year. These incidents typically lead to 10 to 15 recommendations per year to further improve safety. Recommendations are made in consultation with our Operational Safety Experts. Thanks to these reports, trend analysis can also be made, internally and externally benchmarks can be made, and we can steer for improvements where necessary. Occurrence reports are necessary to learn from and to continuously improve the operation. Although reporting incidents is mandatory, it is important for the reporter to have the confidence that reporting solely serves to learn from. The sector is aware of the importance of a Just Culture, and - more importantly - how this culture is

maintained. Legal convictions as a result of a report or incident, and without there being any question of intent or gross negligence, are not part of this.

However, LVNL will provide full cooperation to the judicial authorities and aviation police in the case of accidents or physical or material damage.

Because LVNL keeps the prosecutions office informed about occurrences but also about the follow-up and lessons learned, evidence is provided that the just climate actually facilitates the improvement of safety. This legitimises judiciary's preserved attitude for any occurrence that does not involve damage to property or persons

Judicial results

The above explained Dutch setup was used as an example for the creation of the EU REG 376/2014, replicating some of the elements in the Dutch Aviation Act. The Dutch Aviation Act and Instruction to prosecutor's offices are currently being revised to match EU 376/2014, without losing any of their effective meanings or implications.

In the Netherlands, persons reporting an incident have been legally protected since 2006. In short, this protection means that the reporter of an incident does not have to fear prosecution (criminal, administrative or civil) as long as there is no question of intent or gross negligence. Following this, this protection has also been included in European Regulation 376/2014.

8. SUMMARY

The practices in this guide present an example of how one ANSP has designed and implemented a just and open climate for reporting and occurrence investigation. The strategy sets out a number of steps that can be undertaken with various stakeholders to facilitate the development of such climate.

A key component of a successful implementation is to include relevant parties and maintain frequent communication with both the regulatory and prosecution's office..