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
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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 decisions 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 happened 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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