# Safety Culture in Practice



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# MOVIE TIME

# easyJet since 1995



# **CRM**

## **Cockpit Resource Management**

**Crew Resource Management** 

What is it about: **Leadership Communication** 

Objectives:

**Teamwork** 

Commitment to safety
Competence for safety
Cognizance of safety



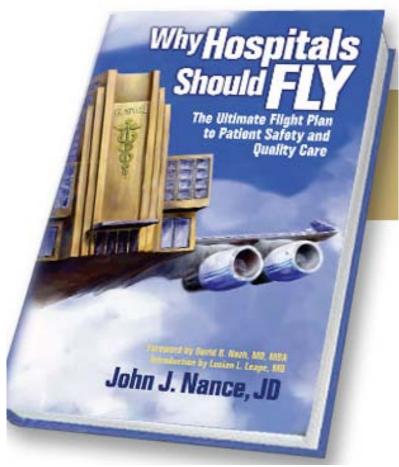
**Company Resource Management?** 

**Safety Culture** 

# Why Hospitals Should FLY

The Ultimate Flight Plan to Patient Safety and Quality Care





**Safety Culture** 

# **Similarity**

Highly qualified people must make a decision in a complex environment within a limited time





The decision made may be...

# A clever decision



# A less clever decision



### **References -Infobesity** Google: Safety Management System: 5 millions references Safety Culture: 1/2 million references **FRMS SMS** Who cares if we are not can Behaviour **Evolution** INFORMED CULTURE FLEXIBLE CULTURE e who manage and op A culture in which system hav wledge about techni of high rations or **ARMS LOSA** ossess the etence to from its which they are and the must be dr nplement n unacceptab Concept

**Practical View** 

# **Safety Culture Communication**

Safety Culture basics belong to All Safety Meetings and Communication



**Safety Bird** 

# We want to learn from reporting

A healthy reporting culture will only be achieved when an atmosphere of trust is implemented, in which people are encouraged (even rewarded) for providing essential safety-related information

James Reason



# 1. Organisational Climate

Objective:

Learn from our errors and errors from others

Challenge:

How can we make highly qualified people
With sometimes a well developed ego
Reporting their mistakes

Create Organisational climate where People are prepared to report their errors or near-misses

Bad news is not only part of life, it is part of leadership.

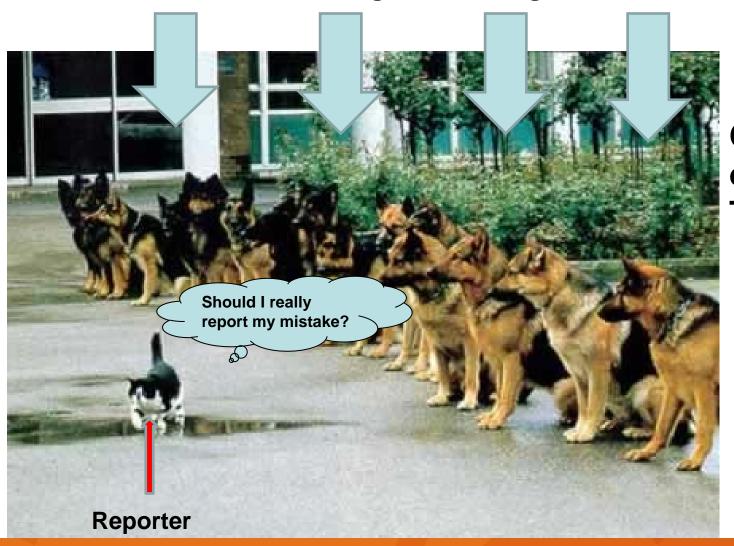
# 2. Do not shoot the messenger



Otherwise
It won't be
long
Until you do
not get any
message

# 3. Make sure that nobody else will shoot the messenger

Colleagues Line Senior Authorities Managers Managers



# Climate of TRUST

# 4. Just culture

# People must also be clear about where the line is drawn between acceptable and unacceptable behaviour

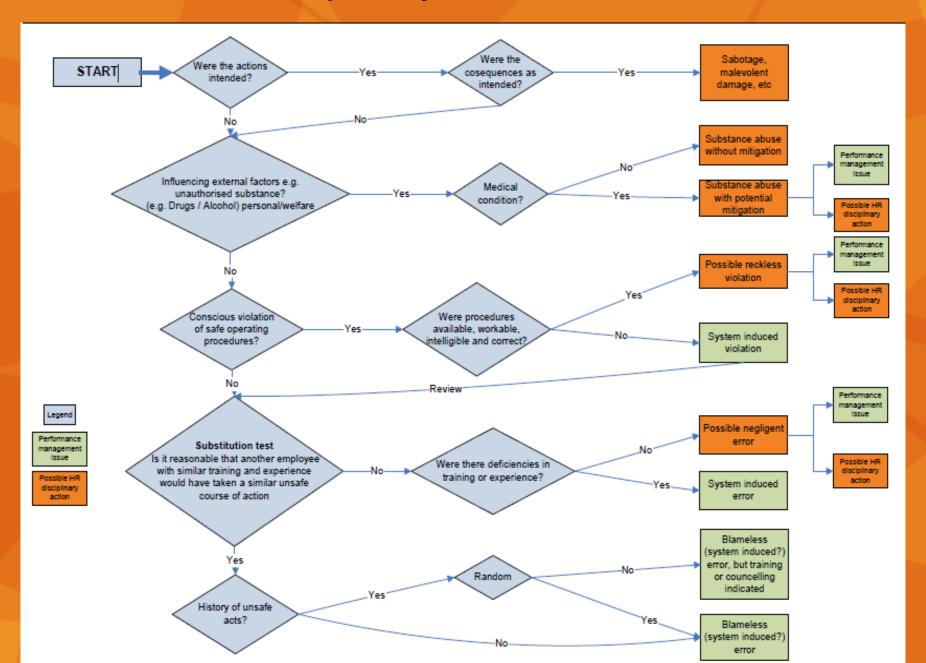
James Reason, just culture





Just a clear line

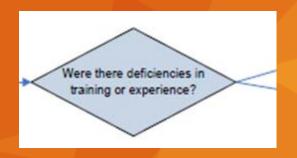
# Culpability test (James Reason)



# **Culpability test ambiguity**



Who will decide if the error was coming from the system (e.g. procedure) or from the person? The Management



And who has line responsibility for the system? The Management

Substitution test
Is it reasonable that another employee with similar training and experience would have taken a similar unsafe course of action

Who will the Management tend to blame? Not himself

→ Management education Every one make mistakes

**Safety Bird** 

# There are 2 types of people in life

Those who make mistakes



Those who make lies



Give the example: Tell about your mistakes as well (yes you, the Management)

# 5. Be Informed



# **Additional basics**

6. Keep Learning



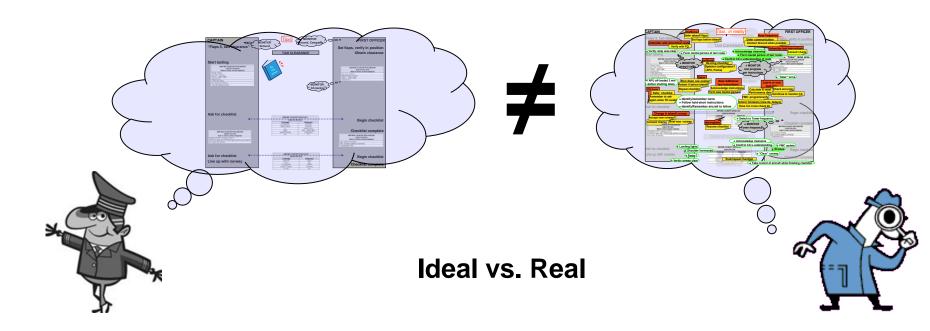
# 7. Be Flexible



Lets look at the research study from Mrs. Loukia D. Loukopoulos NASA Ames Research Center San Jose State University Research Foundation

# Organisational informed culture

- 3 Basic assumptions to operational safety design
  - Technology
  - Training
  - Procedures
- Provides baseline (ideal) system performance
- Operational system performance drifts from compliance (baseline) performance as a consequence of real-life operations – practical drift is inevitable



**CAPTAIN** "Flaps 5, taxi clearance"

MONITOR Ground

**MONITOR** Ground, Company

0 0

#### **FIRST OFFICER**

Set flaps, verify in position

# **Obtain clearance**

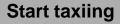
#### BEFORE TAKEOFF PROCEDURE (down to the line) Item to check (action required)

XXX XXXX (XXXXXX) Flight controls (check) Flaps (\_, green light)

xxxxxxx (xx)

#### TAXI CLEARANCE

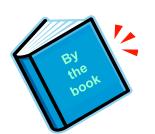
Taxi



BEFORE TAKEOFF PROCEDURE (down to the line) Item to check (action required) Recall (check) XXX XXXX (XXXXXX)

XXXXXXXX (XX) Cabin door (lock) xxx xxxxx (xx xxxxxxx) Takeoff briefing (review)

Flaps (\_, green light)



**MONITOR** 

taxiing

Follow SOPs

#### Ask for checklist

#### BEFORE TAKEOFF PROCEDURE (below the line) Item to check (action required)

ENGINE START switches (CONT) LANDING lights and STROBE light switches (as desired) XXX XXXXX (XX XXXXXXX)

BEFORE TAKEOFF CHECKLIST (down to the line) Challenge Response XX XXXXX XX XX XXXXX Checked

Flight controls XXXXXX XX XX Flaps Set , green light Takeoff Briefing Completed XXX

BEFORE TAKEOFF CHECKLIST

(below the line) Challenge Response XXXXXXXX XXXXX Packs Transponder TA/RA Master Caution Checked XX XXXX

### **Begin checklist**

#### **Checklist complete**

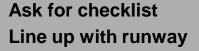
BEFORE TAKEOFF PROCEDURE (below the line) Item to check (action required)

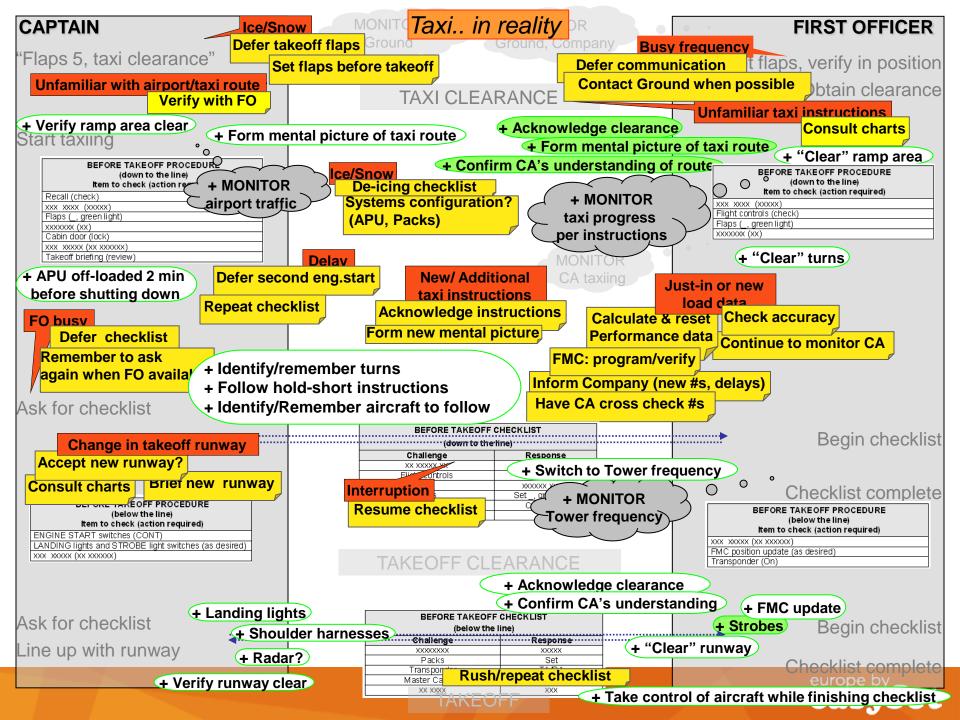
XXX XXXXX (XX XXXXXXX)

FMC position update (as desired) Transponder (On)

**Begin checklist** 

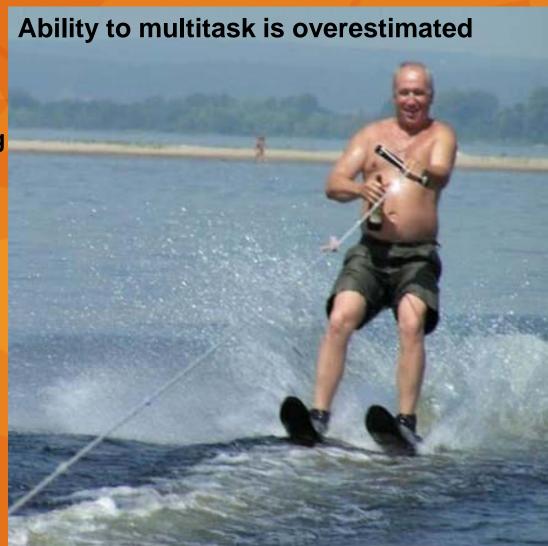
**Checklist complete** 





# The multitasking myth

- Dispel the Myth of multitasking
- Multitasking substantially increase our vulnerability to errors
- •Recognize risk of vulnerability to unintentional omissions
- Design Procedures accordingly



# 8. Focus on the right issues

Speed limit on high way for **1,5 tons** car:



Km/h

Take Off speed for a **600 tons** acft:



**Risk Management:** 

250 Km/h

- Know them
- Understand them
- Control them

**Subject Matter Experts (SME)** 

# 9. Safety First, keep it alive

The Big Boss says: Safety is our number one prioprity



The less big boss thinks: Safety is our n. 1 priority & I want to please my boss too

The even less big boss:

My 1st priorities are safety and to please my chief

The front line guy: I have to please my chief if I want to keep my job

Safety is our N 1 priority
This reminder belongs to
every safety meeting and
communication



**Safety Bird** 



# 10. Keep it Credible

It is hard to convince someone to spend money for something which should ideally never happen

A Safety Manager will always spend too much money when nothing happens

A Safety Manager will always not have spent enough money when something happened

→ Draw the right conclusions and actions

(ALARP concept)

→ Prefer the first case, even if it is a hard mission



**Safety Bird** 

# If you believe that safety is expensive...

What are the costs of an aircraft accident? How do we measure the value of hundreds of people's lives?

Can we ever calculate the millions of CHF worth of damage?

How should we calculate that cost and set it against the inevitable commercial cost of the investments necessary to avoid the tragedy in the first place?

Aircraft physical damage Possible loss of resale value Aircraft loss of use Aircraft loss of investment return Passenger and crew fatalities and/or serious injuries Site contamination and clearance Airline costs for delay **Airport closure** Loss of staff investment Loss of cargo and/or mail and/or passenger baggage Search and rescue and cost of emergency services Airline immediate response **Cost of accident investigation** Third party damage loss of airline income/value/reputation Societal costs **Emergency inspections** Fines, punitive damages, criminal proceedings

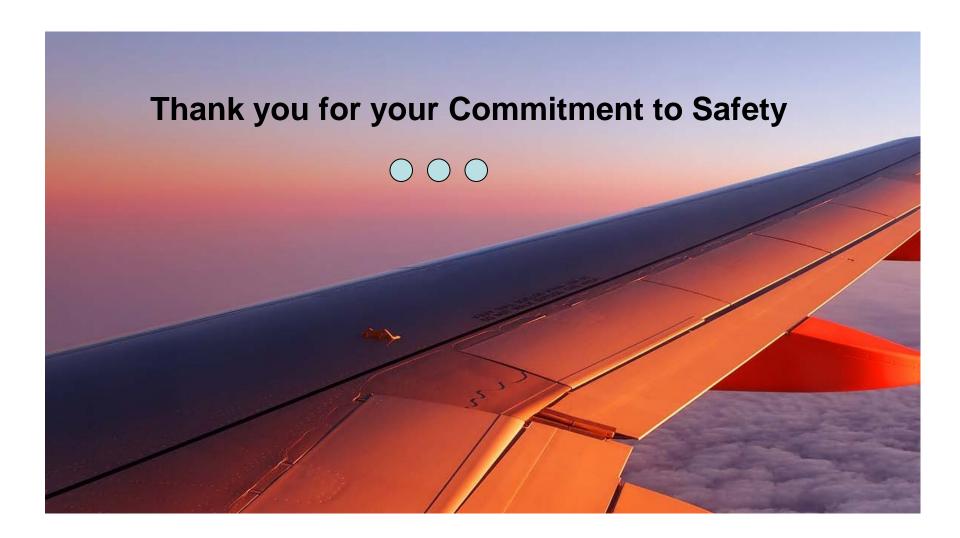
Source: NLR, Netherlands

# Hangar 89, easyJet Headquarter

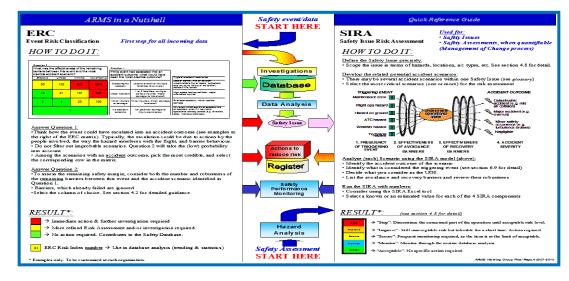


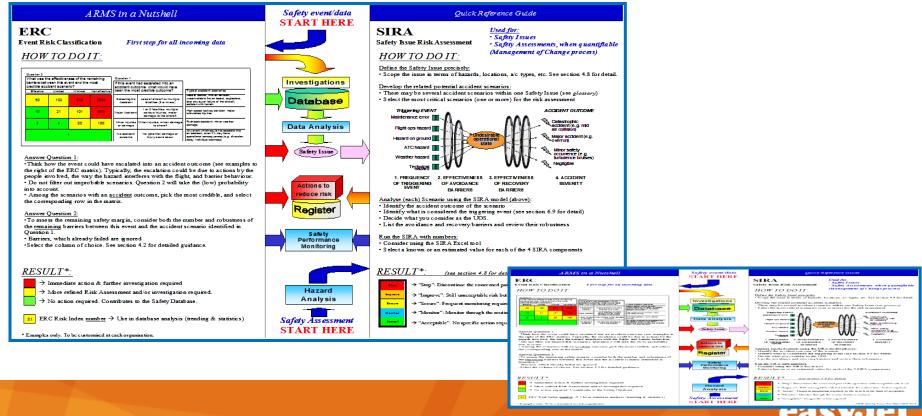
# **Safety Building**





# ERC Event Risk Classification process





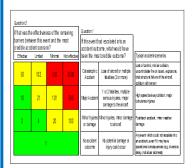
#### ARMS in a Nutshell

#### ERC

Event Risk Classification

First step for all incoming data

#### **HOW TO DO IT:**



#### Answer Onestion 1

- •Think how the event could have escalated into an accident outcome (see examples to the right of the ERC matrix). Typically, the escalation could be due to actions by the people involved, the way the hazard interferes with the flight, and barrier behaviour.
- Do not filter out improbable scenarios. Question 2 will take the (low) probability
- · Among the scenarios with an accident outcome, pick the most credible, and select the corresponding row in the matrix.

#### Answer Question 2:

- •To assess the remaining safety margin, consider both the number and robustness of the remaining barriers between this event and the accident scenario identified in Onestion 1
- · Barriers, which already failed are ignored
- •Select the column of choice. See section 4.2 for detailed guidance.

#### RESULT\*:

- → Immediate action & further investigation required
- → More refined Risk Assessment and/or investigation required.
- → No action required. Contributes to the S afety Database.
- 21 ER C Risk Index number → Use in database analysis (trend ing & statistics)

#### Ouick Reference Guide

#### **SIRA**

Safety event/data

START HERE

Investigations

Database

Data Analysis

Safety Issue

Actions to educe risk

<del>legistel</del>

Safety

Performance

Monitoring

Used for:

· Safety Issues

· Safety Assessments, when quantifiable (Management of Change process)

#### HOWTO DO IT:

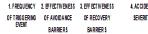
Safety Issue Risk Assessment

Define the Safety Issue precisely: • Scope the issue in terms of hazards, locations, a/c types, etc. See section 4.8 for detail.

#### Develop the related potential accident scenarios:

- There may be several accident scenarios within one Safety Issue (see plossary)
- · S elect the most critical scenarios (one or more) for the risk assessment





#### Analyse (each) Scenario using the SIRA model (above):

- · Identify the accident outcome of the scenario
- · Identify what is considered the triggering event (see section 6.9 for detail)
- · Decide what you consider as the UOS.
- · List the avoidance and recovery barriers and review their robustness

#### Run the SIR A with numbers:

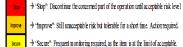
- · Consider using the SIRA Excel tool
- S elect a known or an estimated value for each of the 4 SIRA components



Safety Assessment

START HERE

#### RESULT\*: (see section 4.8 for detail)





→ "Acceptable". No specific action required

ARMS Working Group Final Report 2007-2010

# Sira Safety Issue Risk Assessment process



<sup>\*</sup> Examples only. To be cus tomised at each organisation.

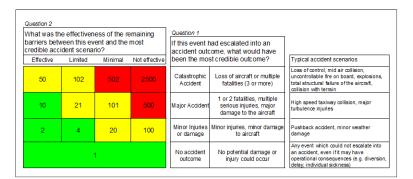
#### ARMS in a Nutshell

#### **ERC**

**Event Risk Classification** 

First step for all incoming data

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- → Immediate action & further investigation required
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- → No action required. Contributes to the Safety Database.
- 21 ERC Risk Index <u>number</u> → Use in database analysis (trending & statistics)
- \* Examples only. To be customised at each organisation.

# Safety event/data **START HERE** Investigations Database **Data Analysis** Safety Issue Actions to reduce risk Register Safety **Performance** Monitoring

Hazard

**Analysis** 

Safety Assessment

START HERE

## **SIRA**

Safety Issue Risk Assessment

#### Used for:

Quick Reference Guide

- · Safety Issues
- Safety Assessments, when que (Management of Change proce

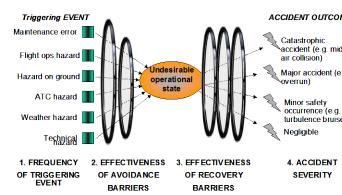
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#### Run the SIRA with numbers:

- Consider using the SIRA Excel tool
- Select a known or an estimated value for each of the 4 SIRA components

#### RESULT\*: (see section 4.8 for detail)



- $\boldsymbol{\rightarrow}$  "Stop": Discontinue the concerned part of the operation until acceptable
- → "Improve": Still unacceptable risk but tolerable for a short time. Action r
- → "Secure": Frequent monitoring required, as the item is at the limit of acce
- → "Monitor": Monitor through the routine database analysis.
- → "Acceptable". No specific action required.