HUMAN FACTORS NEWS

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THEME — REPORTING CULTURE

Welcome

With most crew having completed the initial program it is timely to look at the importance of having a good reporting culture. This culture should be particularly concerned with learning from incidents through the reporting of errors.

Any safety information system depends crucially on the willing participation of the people in direct contact with hazards. An incident should not be seen as a failure by the individual or a crisis in the system, neither by management, nor by colleagues. **An incident is a free lesson, a great opportunity to focus attention and to learn collectively**.

There is a need to learn through safety investigation so people can take appropriate action to prevent the repetition of such events. In addition, it is important that even apparently minor occurrences are investigated, in order to prevent catalysts for major accidents.

There is no problem so complex that it cannot simply be blamed on the pilot.

— Dr Earl Weiner

Incidents occur because we are humans. We all make errors at some time: not because we lack ability, not because we are poorly trained, not because we don't care. We make errors sometimes because that is what humans occasionally do.

Reporting an incident is not something embarrassing or shameful but a good piece of information for the entire organization.

Inside this issue:

Non compliance	2
Something to try	2
Reporting in Australia	3
Staff profile	3
Non-punitive culture	4

Contact us:

Phone: 0412 542 859

E-mail: info@hfts.com.au

Web: www.hfts.com.au

Non compliance

Unintentional non compliance: People do not know how to apply the rule. They act as if there is no procedure. (Poor training or learning)

Routine non compliance: Rules are broken because they are felt irrelevant or because people do not appreciate the dangers. (Poor leadership)

Situational non compliance: It is impossible to get the job done by applying the rules strictly. (Poor systems and procedures)

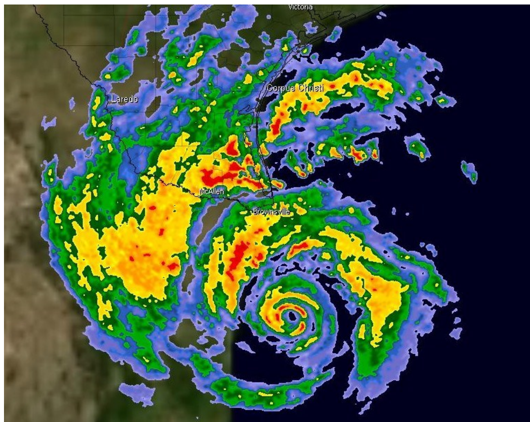
Exceptional non compliance: People have to solve the problem for the first time and fail to follow good practice. (Poor skill development)

Deliberate non compliance: Only a very small proportion of human actions that are unsafe are deliberate and as such deserve sanctions of appropriate severity. (Rogue employee)

That phrase

HIT A NERVE.

Because a small SECRET action (GOOD OR BAD) that gets repeated thousands of times can make a BIG IMPACT.



Something to try

Report the <u>cause</u> of a possible error. You are alerting others of the risk. For example:

1. Due to increased workload caused by deteriorating weather, I found it difficult to maintain a proper lookout for traffic.
2. I found it difficult to concentrate during the latter part of the day. This was possibly due to the high temperature ($+36^{0}$) and high humidity (+80%).
3. Over the last two nights, I have had a total of 12 hours sleep. This has impacted on my decision making ability. It took me longer than normal to calculate waypoints when I was diverted.
4. I couldn't understand ATC instructions when inbound to Townsville due to poor radio reception. I got it right in the end but it was more due to experience than executing good communication practice.

Reporting in Australia

Since the 1950's Australia has had one of the world's most comprehensive aviation occurrence reporting systems. By law, anything that affects the safety of flight must be reported. Refer to the Transport Safety Investigation Act 2003 for the list of immediately and routinely reportable events:

http://www.comlaw.gov.au/Details/F2003B00171

(pages 9 to 14)

AUSTRALIA

Transport Safety Investigation Regulations 2003

Statutory Rules 2003 No.

Staff profile

I have been working in the background of HFTS for some time, but I recently realised I haven't really introduced myself. So for those who I haven't met, my name is Alison Meyer and I am the training manager at HFTS.

My aviation journey started as a flying instructor at BAe Systems in Adelaide before moving onto flying single and twin engine aircraft in charter operations around Australia.

During this time I developed an interest in safety and human factors. I embarked on a Masters in Aviation Management from the University of Newcastle and completed that qualification in 2008.

Around the same time I left flying to begin work as an air safety investigator with Cobham Aviation Australia in Adelaide conducting investigations on incidents involving Boeing 717, BAe 146 and DHC-8 aircraft.

I then moved to the Australian Transport Safety Bureau (ATSB) to help set up their 'Level 5' investigation team, which looks at non fatal serious incidents and accidents around Australia.

An opportunity then arose for me to come onboard with HFTS and help develop the human factors training program for Flight Operations, Engineering and Ground Handling. I'm passionate about aviation safety and believe that effective and meaningful human factors training is the key to taking safety to the next level in our industry.

I have also developed an incident investigation course. My experience has shown that accident investigation courses offer minimal practical guidance for the type of investigations Safety Managers do on a day to day basis. The next course will be run in Adelaide on July 25-26, please contact me (info@hfts.com.au) if you're interested in attending.

So, that's about it from me. I hope to get out and about and meet more of you face to face in the future. In the meantime, I hope you're enjoying the training program.

Incident Investigation Course

Where: Adelaide

When: July 25-26

Who: The course is ideal for safety investigators / managers

Non-punitive culture

Within Australia, it is well known culturally that you do not "dob" in a mate. Therefore, your organisation needs to encourage an open environment of non-punitive reporting, which provides for employee participation in the learning process, and ensures that everyone shares and contributes in a fair and reasonable manner. **It takes courage to be safe!**

A non-punitive culture starts at the top and is a function of the organisational culture at large; it is a culture that needs to be adopted and practised by the organisation as a whole. Every employee, not just those involved in safety, must get involved in the establishment of this culture.

If the latent causes of accidents are to be identified and addressed, errors need to be seen as the beginning of investigations and not the end. Only in exceptional circumstances involving criminal action, intentional or gross negligence, should blame be apportioned. The best people can make mistakes given the same circumstances.

We need to change the mindset of blame being a useful concept. The reporting of unpremeditated or inadvertent errors should not result in disciplinary action being taken against the reporter. Punishment has little or no effect on error rates and actually contributes to increased potential for accidents or incidents through decreased reporting.

Many people, especially ignorant people, want to punish you for speaking the truth. Never apologise for speaking up or for being years ahead of your time. Even if you are a minority of one, the truth is still the truth.

Gandhi

A leader's story

Early in my career, I would keep my real opinions to myself. I didn't want to get in trouble. I thought that if I just complied with the system and kept my mouth shut, I would get ahead.

This was a pretty good strategy for a while. But it didn't really work once people were counting on me to lead.

Why didn't I want to speak up? I could feign altruism by saying, "I didn't want to hurt other people's feelings." But that would be a lie. The truth is that *I was afraid.* It was all about me.

I didn't want to be embarrassed.

I didn't want to be wrong.

I didn't want to lose my job.

I didn't want others to think less of me.

So, I kept quiet. Funny thing is I kept finding myself in situations where I *had* to speak up. If I didn't, someone would pay an awful price for my personal comfort.

Courage Is Not the Absence of Fear