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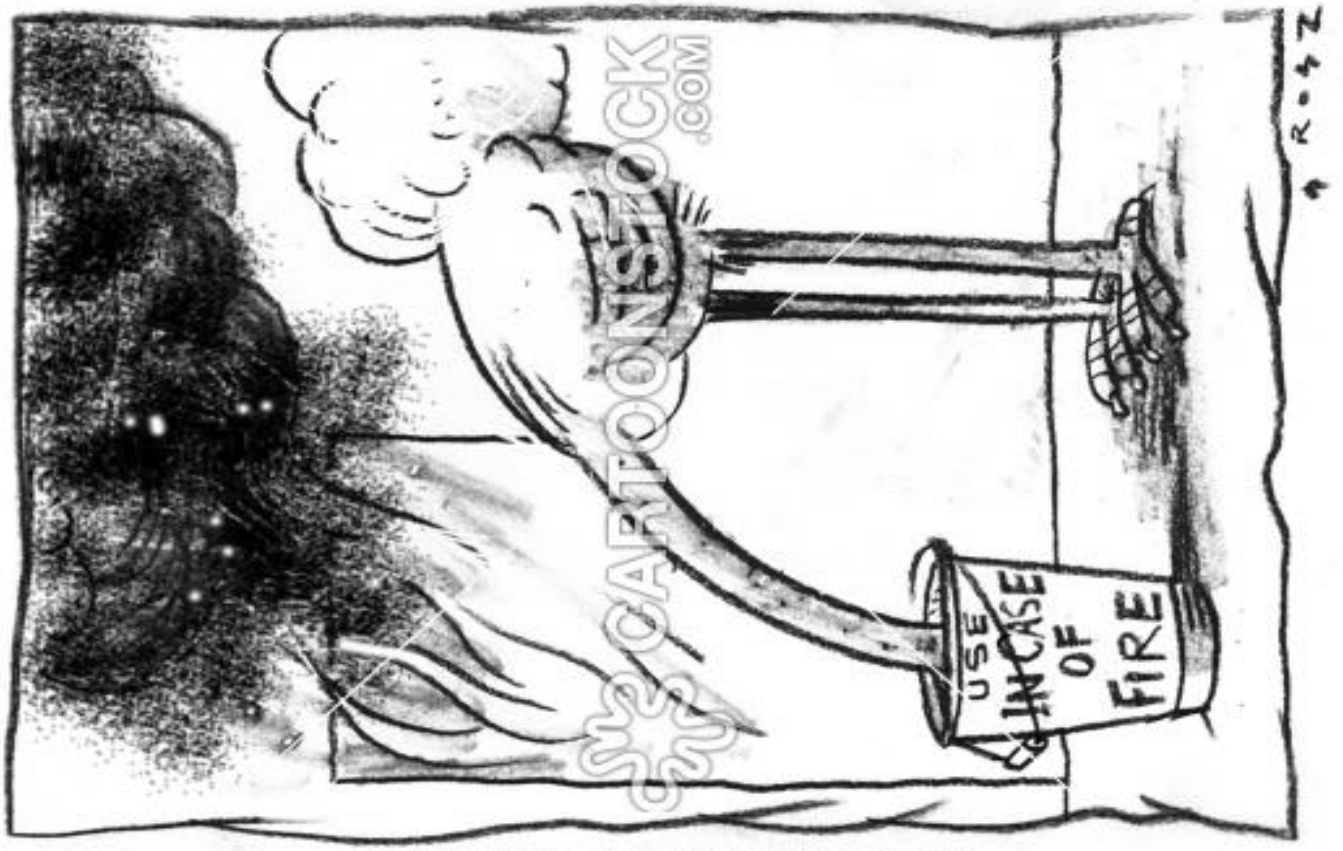
WILLFULL BLINDNESS

‘Why we ignore the obvious at our peril’

Margaret Heffernan



Willful Blindness normalises deviation and violation.

Ignorance of law, willful ignorance

Putting oneself in a place of ignorance to escape liability of the facts

Contrived ignorance, Nelsonian Knowledge

The GFC was all **Willful Blindness**.

“if we don’t do it, someone else will”

There are countless examples of **Willful Blindness**:
oil industry,
mining,
medicine,
governments,
religions, to name a few.

It kills people, ruins lives and costs billions of dollars every year.

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MANAGEMENT CULTURE

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Meetings and Attitudes

Who has attended a meeting where everyone knew that the wrong decision had been made?

Meetings are usually held to optimise the synergy of the group.

The output should be better than the sum of the parts.

Often, there is NEGATIVE SYNERGY

ORGANISATIONAL SILENCE

A group makes a bad decision, and individuals know it is bad, but the group agrees to it.

GROUP THINK

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In aviation, most team managers tend
operate with ORTHODOX MC
carefully handed down f ast.

'The orth is become
CON AL WISDOMS'
tffernan. Willful Blindness

'The way we do things around here'

THE PETER PRINCIPAL

People are promoted to their level of incompetence

Willful Blindness keeps them there

The best fertilizer(manure)
to cultivate
WILLFUL BLINDNESS
in an organisation
“pay the managers a productivity bonus”

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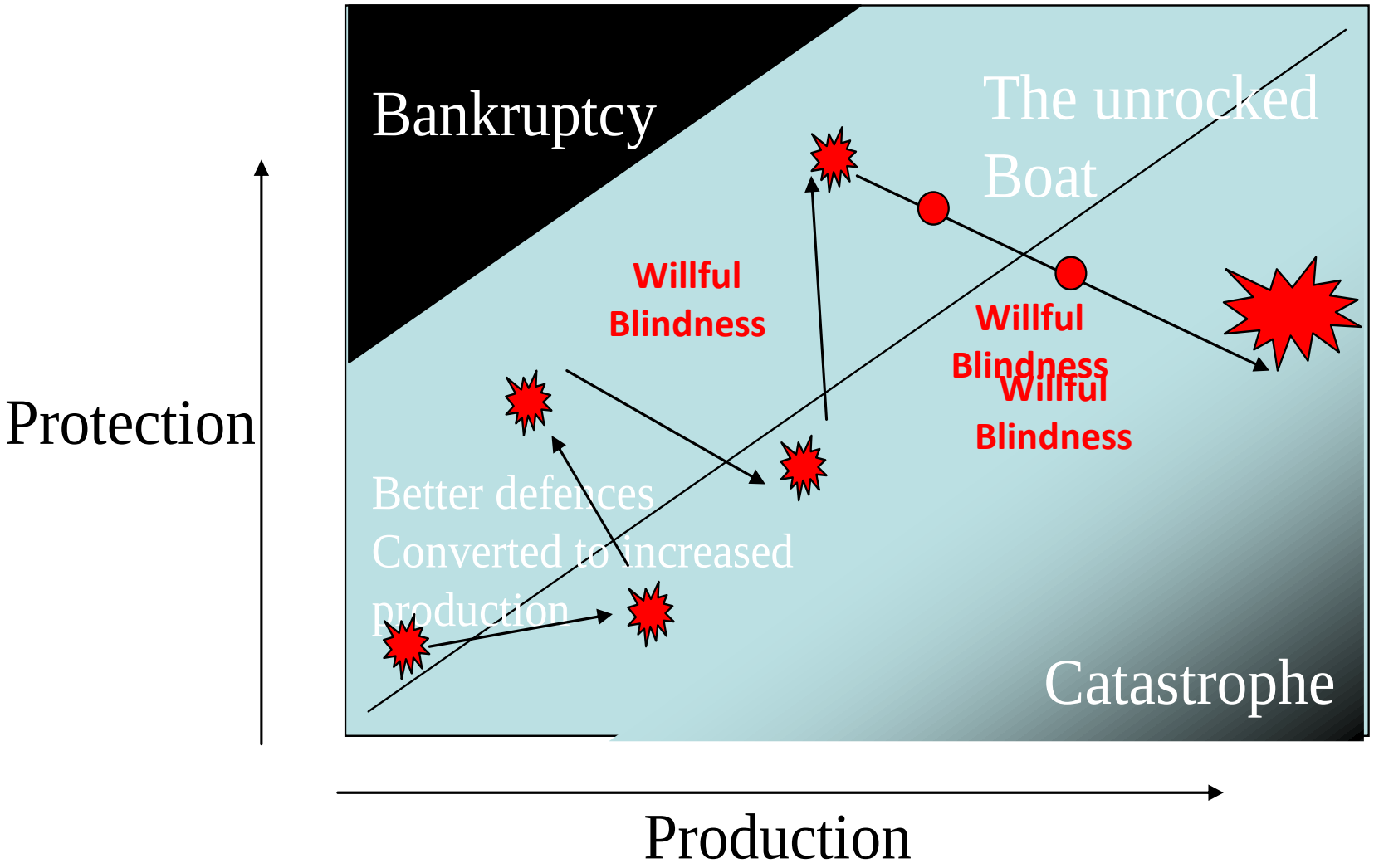
BANKRUPTCY OR CATASTROPHE



Prof. James Reason

WILLFUL BLINDNESS is a HUMAN FACTOR

WILLFUL BLINDNESS is a dangerous, contagious and infectious disease.

It can become psychotic…loss of contact with reality.

In Groups, a shared psychosis.

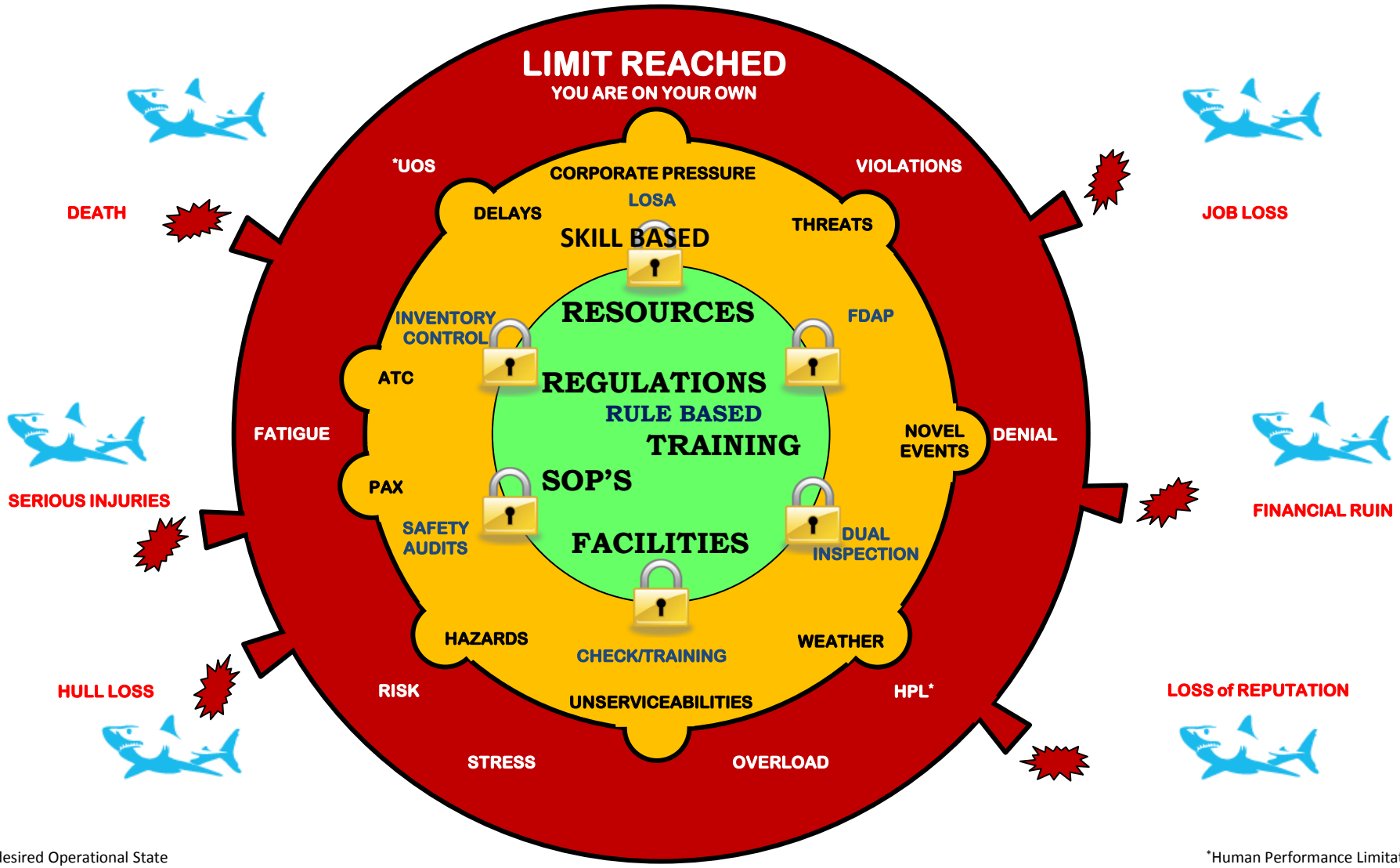
Management that espouses **COMPLIANCE**

but contradicts with **NON COMPLIANCE**

cultivates **WILLFUL BLINDNESS** in employees.

THE CONTAINMENT MODEL

The **CONTAINMENT** Model



*Undesired Operational State

*Human Performance Limitation

For the past 40 years we have witnessed:

- The same regulatory performance criteria
- The same training techniques
- The same checking procedures

ORTHODOX MODELS

ARE STILL

CONVENTIONAL WISDOMS

In my over 40 years within the airline environment I have witnessed examples of systems that create and tolerate poor performance, deviation, violation, and ugly behaviour.

Some individuals are totally immune to any form of CRM or HF training.

PNM'S? and NG'S?

PNM’s performed badly on a day to day basis

But!

Had Angel Behaviour under scrutiny.

Change jobs.

Robert “Bob” Helmreich.

Bob left us in July 2012 and is sadly missed but not forgotten.

He often said that the only way to deal with an impossible case was with a .375 Magnum. The Australian vernacular gave him the name of such a person.

A DRONGO!

Bob loved the expression and used it often to describe the particularly resistant individual.

?

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If you want to find out who they are in an airline, who would you ask?

Thanks to you Bob, we have had LOSA for 14 years.

LOSA shows us beyond reasonable doubt where the main dangers are.

We know for certain, that particular crew behaviours generate **SUPERIOR OUTCOMES**, and conversely, lack of such behaviours turns threats ⟶ errors ⟶ **UOS** ⟶ incidents and crashes.

The "usual suspects' are out there.

Orthodox models are not working.

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Given:

- 65% of major events occur in the approach and landing phase

- certain behaviours of crews contribute to negative outcomes (dangerous/fatal)

is it not time to have an
AHA! moment?

LOSA invariably shows that when a threat is mismanaged and eventually becomes a UOS, the associated observed Behavioural Marker is a 1 out 4 on the UT scale.

Conversely and as expected, where threats and errors are managed well and without fuss, the BM is always a 3 or 4.

Marrying the Markers to the TEM observation events has more than doubled the value of LOSA.

So…

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Does **Willful Blindness** get in the way?

University of Texas Behavioural Markers
P=Pre-departure/Taxi D= Descent Approach and Land

SOP BRIEFING	The required briefing was interactive and operationally thorough	Concise, not rushed and met SOP requirements. Bottom lines were established.	Phase P-D
PLANS STATED	Operational plans and decisions were communicated and acknowledged	Shared understanding about plans- Everybody on the same page	P-D
WORKLOAD ASSIGNMENT	Roles and responsibilities were defined for normal and non normal situations	Workload assignments were communicated and acknowledged	P-D
CONTINGENCY MANAGEMENT	Crew members developed effective strategies to manage threats to safety	Threats and their consequences were anticipated Used all available resources to manage threats	P-D

UT Behavioural Markers
T= Take Off and Climb

MONITOR CROSS CHECK	Crew members actively monitored and cross checked systems and other crew members	Aircraft position, settings, and crew actions were verified.	P-T-D
WORKLOAD MANAGEMENT	Operational tasks were prioritised and properly managed to handle primary flight duties.	Avoided task fixation Did notr allow work overload	P-T-D
VIGILANCE	Crew members remained alert of the environment and position of the aircraft	Crew members maintained situational awareness	P-T-D
AUTOMATION MANAGEMENT	Automation was properly managed to balance situational and /or workload requirements	Automation setup was briefed to other members Effective recovery techniques from automation anomalies.	P-T-D

UT Behavioural Markers
P=Pre-departure/Taxi D= Descent Approach and Land

EVALUATION OF PLANS	Existing plans were reviewed and modified when necessary	Crew decisions and actions were openly analyzed to make sure the existing plan was the best plan	P-T
INQUIRY	Crew members asked questions to investigate and/or clarify current plans of action	Crew members not afraid to express a lack of knowledge. Nothing taken for granted attitude.	P-T
ASSERTIVENESS	Crew members stated critical information and/or solutions with appropriate persistence	Crew members spoke up without hesitation	P-T
COMMUNICATION ENVIRONMENT	Environment for open communication was established and maintained	Good cross talk- flow of information was fluid, clear, and direct	Global

UT Behavioural Markers RATING SCALE

1=Poor	2=Marginal	3=Good	4=Outstanding
Observed performance had safety implications	Observed performance was barely adequate	Observed performance was effective	Observed performance was truly noteworthy

Now is the time that these behaviours become the integral part of of aircrew competencies.

And
all safety critical personnel.

And
of course……..?

MANAGERS.

It means that:

- the hiring skills must look for individuals that have the potential.
- all trainers and checkers possess at least a 3 or 4 in their skill set.
- all crew need to be trained to develop and maintain the competencies.
- operational management possess the competencies.
- the regulators reflect the standard in enforcing the rules and outcomes.

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AND LAST but not LEAST

It also means that **WILLFUL BLINDNESS** must be exposed for what it does. In my opinion it is one of the most significant barriers in our industry.

It has been proven to be so in all other high risk environments.

The priority to fully develop these Human Performance and valuable Behaviours is vital in jumping the gap from now to the future.

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