Accountability at the active failure

Michael D Evans
Safety Engineering Manager Aerospace
BAE Systems Australia

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Just culture
have we gone too far?

- Have we become so focussed on organisational and systemic issues that we no longer hold people accountable for what they did or did not do
- Do people learn if they are not held accountable?

Presentation outline

- Safety culture
- Just culture
- Reason model
- Safety culture and accountability
- Incident decision tree
- Learning process
- Analysis of reporting data
- Accountability at the active failure

Safety culture

Some essential ingredients of a safety culture:

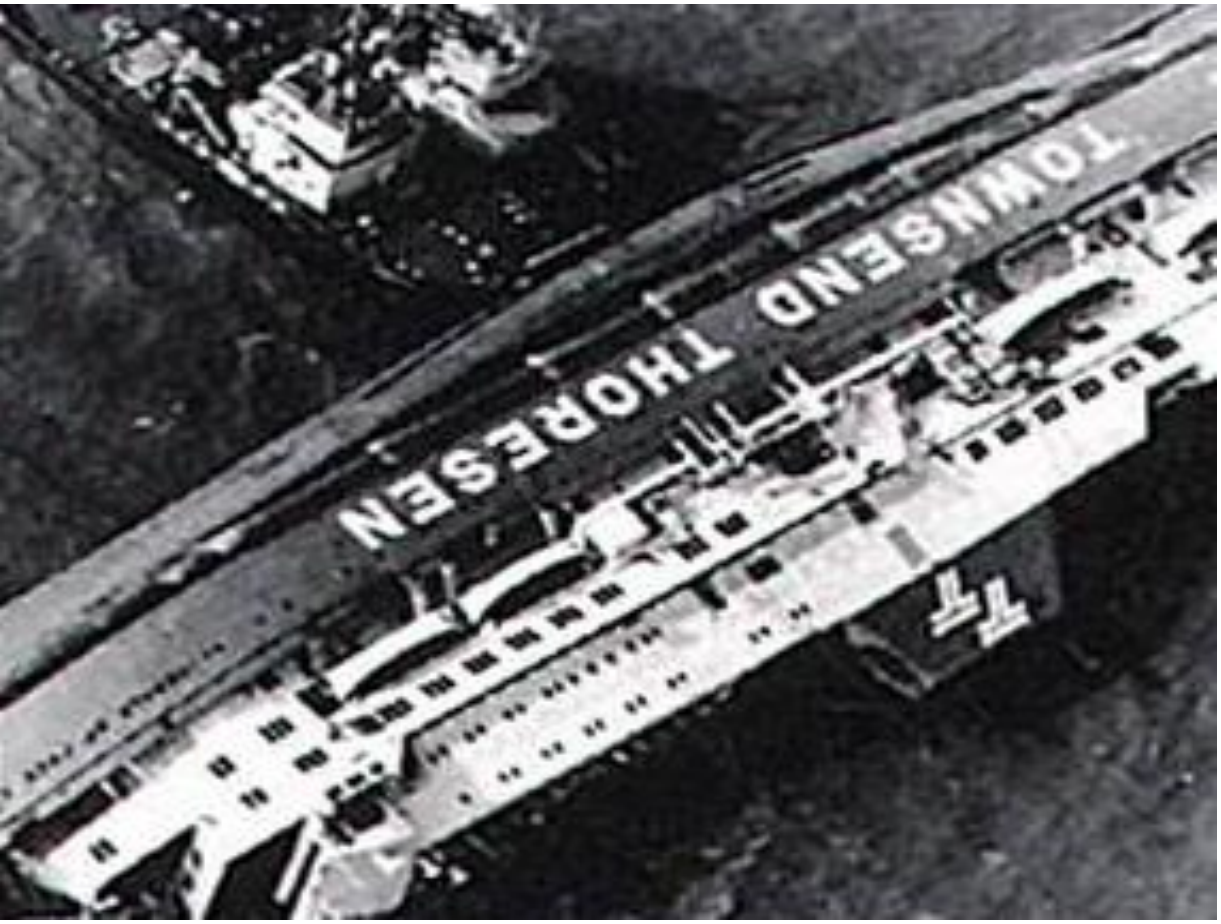
- Good reporting culture
- Just culture
- Good learning culture
- Managements commitment to safety
- Personal accountability.

Evolution of just culture

- Punitive approach to safety – Pre 1990's

- "No blame" approach – 1990's
  - + **Positive**
  - acknowledge that people make "honest mistakes"
  - – **Negative**
  - Failed to confront wilful, dangerous behaviour
  - Did not draw a clear line on culpability

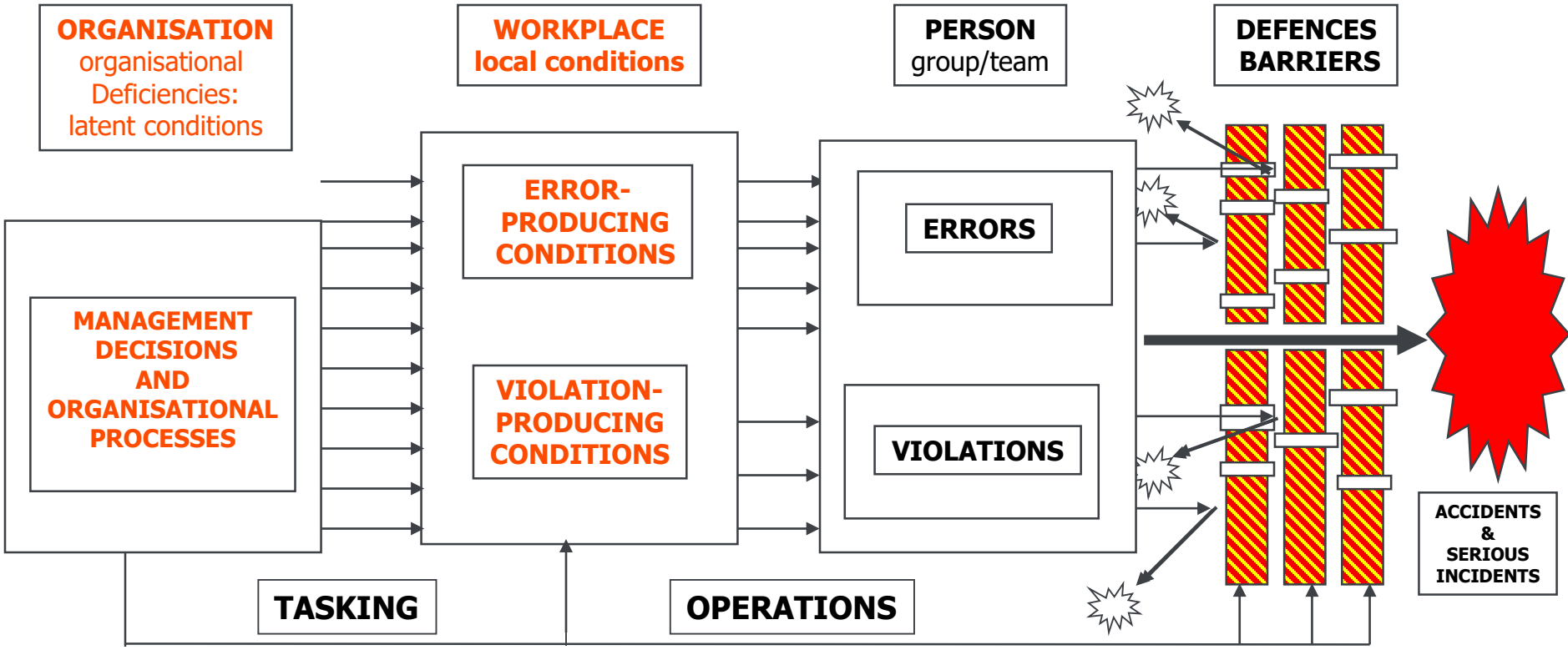
- A "just and fair culture" approach – 2000s
  - + **Positive**
  - Focussed on finding systemic and organisational issues
  - Treated people fairly when they made mistakes and low level violations
  - – **Negative**
  - Moved the focus from active failure



"A culture in which front line operators or others are not punished for actions, omissions or decisions taken by them that are commensurate with their experience and training, but where gross negligence, wilful violations and destructive acts are not tolerated." **(Eurocontrol, 2005)**

Definition of just culture

The Reason model: the organisational accident



LATENT DEFICIENCIES IN DEFENCES

(HOLES IN THE DEFENCES - SWISS CHEESE MODEL)

Adapted from Reason 1990

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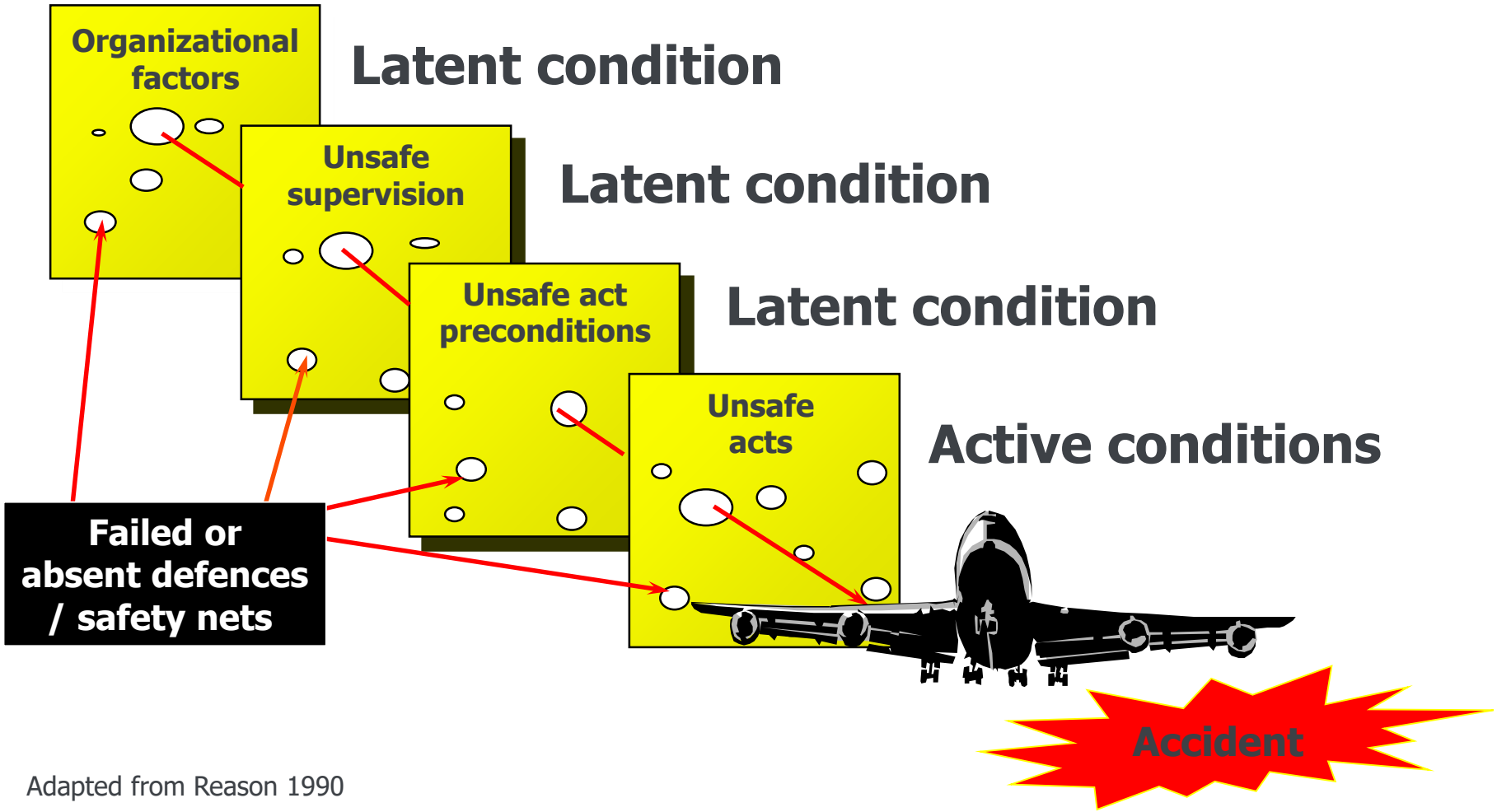
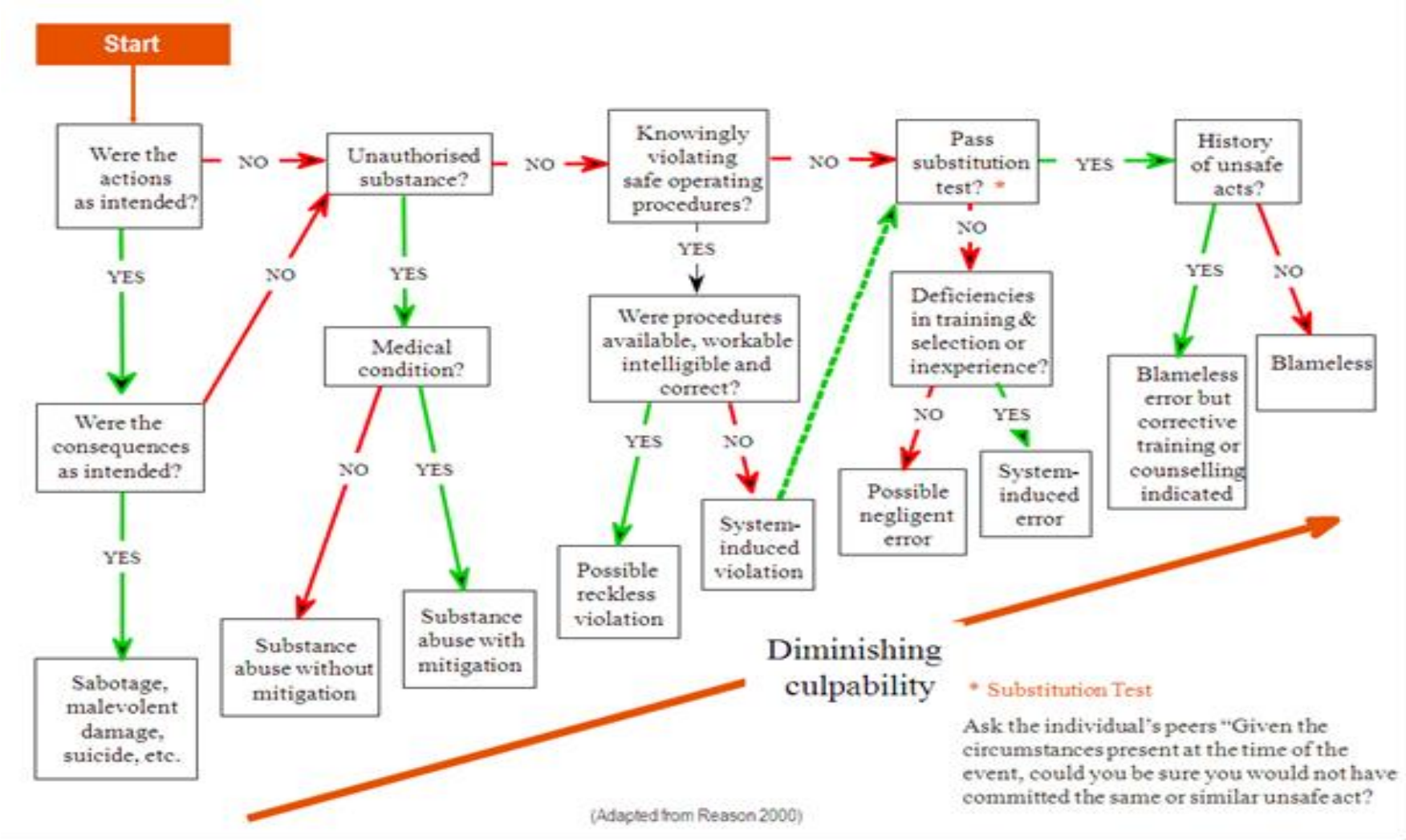
Reason's 'swiss cheese' model



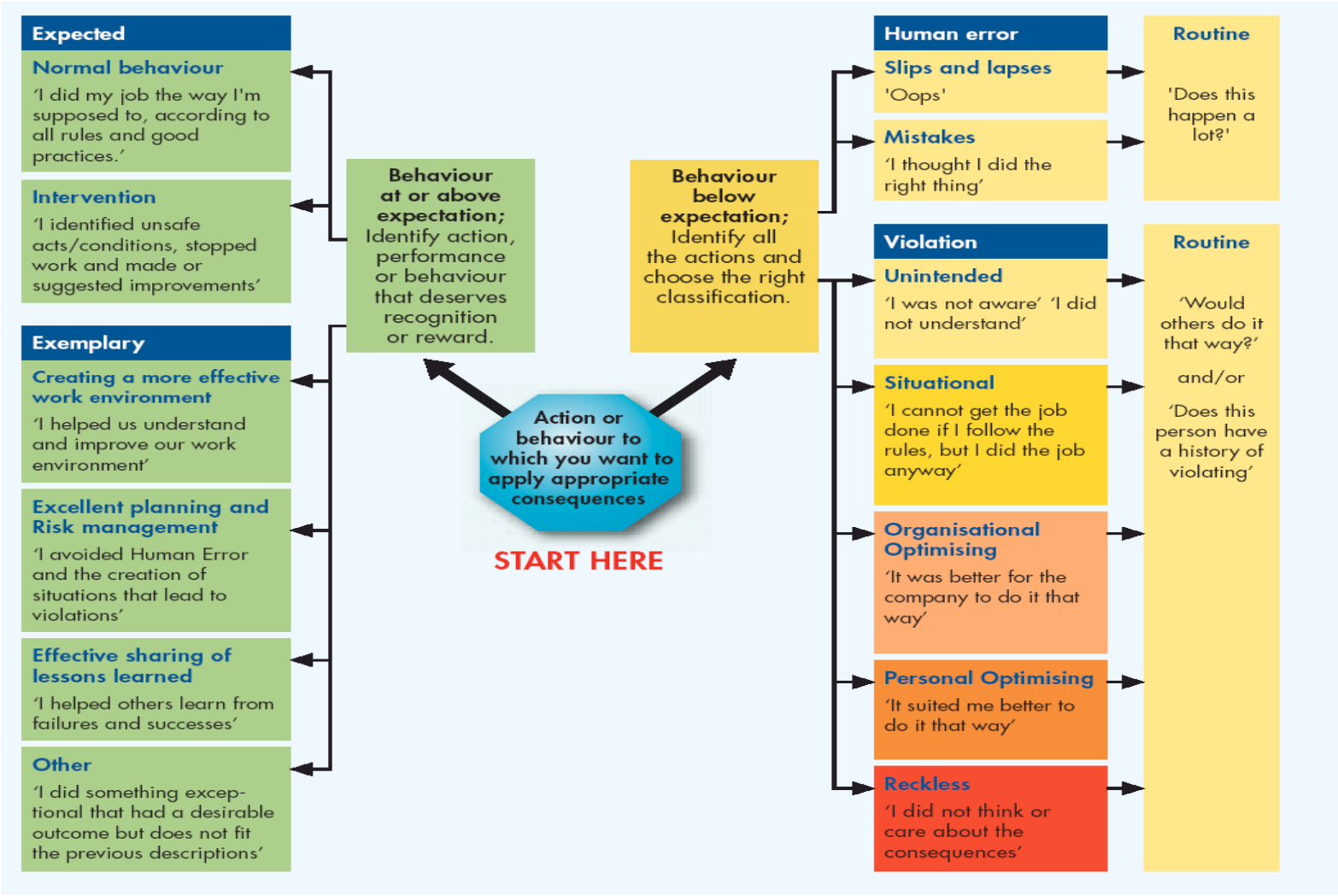
Adapted from Reason 1990

Safety culture and accountability



Incident decision tree

Hudson 2008



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The substitution test is so important

Given the same circumstances and criteria would a person with the same training, competency and experience have done exactly the same thing or made the same decision

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Learning process

- For learning to happen there is usually a consequence to an action
- People learn from mistakes and violations
- It can be as simple as telling the person they performed a violation
- There does not need to be punitive action

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Analysis of reporting data

- Cause – What a person did or did not do error/slip/lapse/violation (active)
- Contributing factors – human factor or organisational (latent)
- Corrective and preventative action
- Closeout details – reporting to the customer
- Lesson's learnt

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Accountability at the active failure

- During investigation we must;
  - Determine the cause at the active failure
  - Define all of the latent organisational and systemic issues

- It is key to
  - Make recommendations for preventative and corrective action
  - Hold people accountable for what they did or did not do
    - Whether they be managers in organisational issues
    - Or operators in the active failure

In summary

- Holding people to account is not apportioning blame
- But if they are not held to account then they don't learn and
- The incident will most likely recur

Holding people to account is an essential part of the learning culture and the overall safety culture

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Questions?

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Referenced documents

- Patrick Hudson SPE Leiden University, Margot Vuijk Dockwise BV, Robin Bryden Shell International EPS-HSE, Dominika Biela Leiden University, Charles Cowley Shell International 2000 A New Model for a Just and Fair Culture
- Reason, James (2000-03-18). Human Error Models and Management
- Reason, James (1990-04-12). "The Contribution of Latent Human Failures to the Breakdown of Complex Systems