

# Trust Culture: creating an environment for safety and learning



**Presentation to PACDEFF 2018**

# Flight plan



Just & Fair Culture



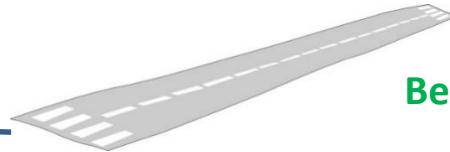
Trust Culture



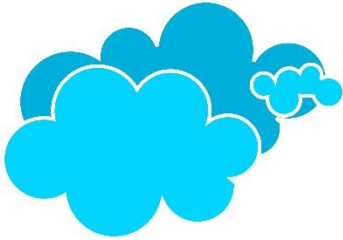
Challenges



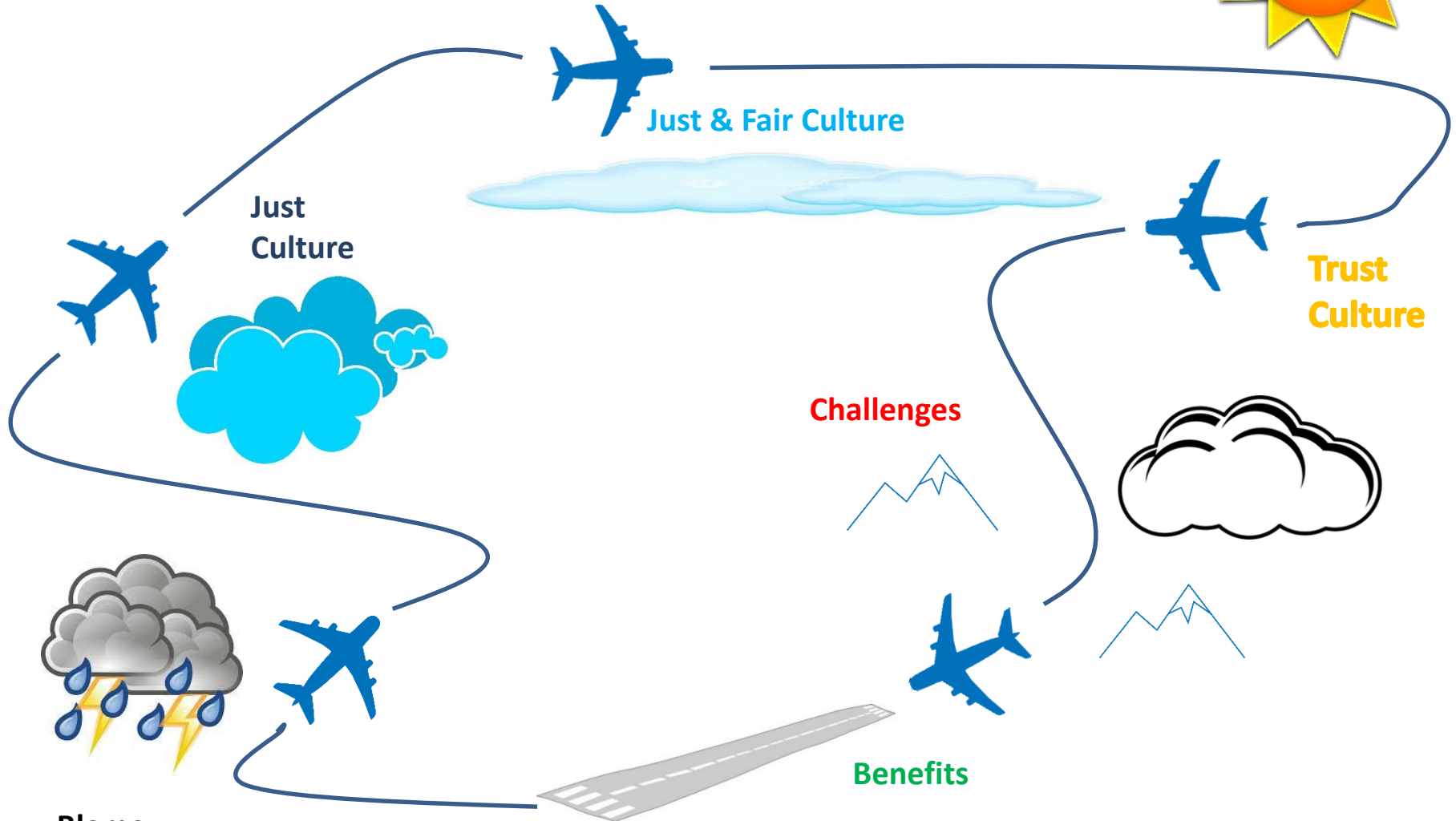
Benefits



Just Culture



Blame Culture



# Blame Culture

## Hapag-Lloyd Flight 3378

- Response – Captain left airline soon after incident; later convicted of ‘dangerous interference in air traffic’
- Report – 14 recommendations for improvements in systems, documents, procedures, and training



Vienna International Airport, 12 July 2000

# Unjust culture

## Air transport operator [de-identified example]

- *“My roster changes constantly, I can’t plan my life, and it seems to be worse after I raised concerns about the way the operation is managed.”*
- *[Manager] watches the flight tracking like a hawk. If the route is clouded and we need to go around, we are always asked about our decisions.*
- *“It’s a distraction constantly worrying about what the managers will say about your decisions. You end up second guessing yourself.”*
- *“My hours were cut after expressing safety concerns to [Manager.]”.*
- *“I am reluctant to put in observation reports even after writing them up.”*
- *“An unsafe culture has developed due to operational pressures”*



# Trust in the workplace

Global survey of professionals in eight countries finds that less than half have a 'great deal of trust' in their employers, bosses or colleagues<sup>1</sup>

49%

<sup>1</sup>EY survey conducted 2016

# Effects of an 'unjust culture'



- Employees unlikely to report
- Information source dries-up
- Unsafe practices driven underground
- Reputational damage – whistleblowing
- Regulatory compliance failure
- Unaware of organisation's risks – no mitigation
- Serious Incident or Accident?

# Just Culture

“Promoting a *just culture* is based on treating people compassionately, and fairly, when errors do occur. This requires creating a culture where management is willing to go beyond the first story, to understand the deeper and more complicated second story through the narrative of the operator”

**Janice R. McCall and Shawn Pruchnicki (2017)**

# WestJet Flight 2652

Princess Juliana International Airport, Sint Maarten (TNCM), 07 March 2017



# Company response

- Didn't rush to judge crew's actions
- Conducted an investigation
- Safety communication to crews about possible challenges and threats at TNCM
- Provision of a flight safety briefing during ground school
- New RNP instrument approach procedure with vertical guidance designed for airport/runway and submitted to SMCAA for approval

**Result: threat awareness, learning, improved procedures, enhanced *safety* and *trust***

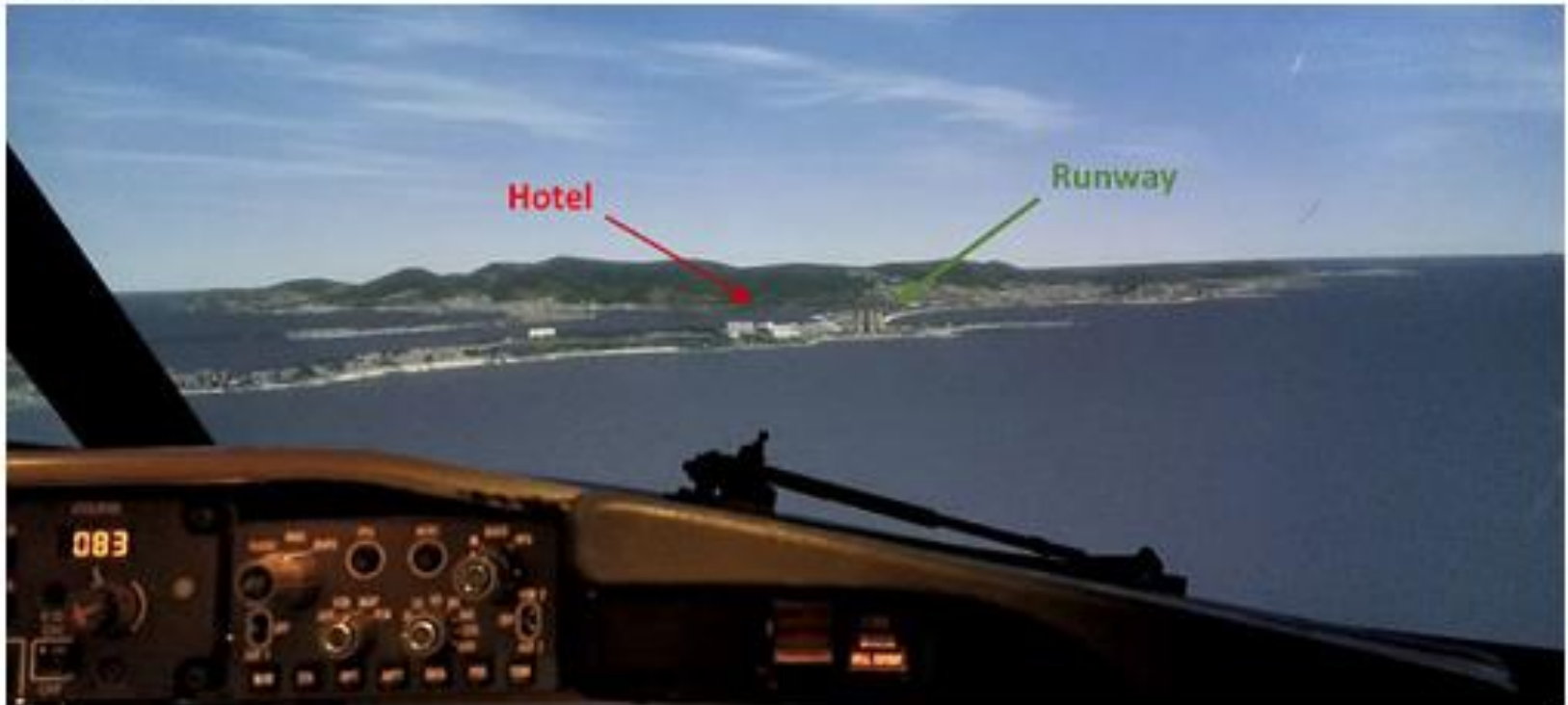
# TSB Investigation

**Figure 3.** Visual references as seen in a flight simulator at approximately 500 feet AGL in poor visibility



# TSB Investigation

**Figure 5.** Approach to Runway 10 at TNCM on a clear day, viewed in a flight simulator



# Investigation report

- Significant changes to visibility not reported to crew
- PAPI lights were set to low intensity despite deteriorating visibility
- Limited visual references led to crew misidentifying runway
- The increase in visual workload led to narrowed attention focus and inadequate altitude (vertical path) monitoring
- Delayed response to first EGPWS alert due to procedure differences between operator/OEM and EGPWS manufacturer

# Just culture in New Zealand

- **CAA Regulatory Operating Model**
  - Consistent messaging from the Director
  - Application of these principles in practice
- **Civil Aviation Act Review** (initiated 2014)
  - Investigating the barriers to full reporting of accidents and incidents
  - Assessing options to create an environment for free and open disclosure of information
- **Civil Aviation Bill** (expected 2019)
  - CAA proposes the inclusion of just culture principles in legislation, including defining how reported safety information can be used

# Just Culture - regulator

## Just Culture and Reporting

Many employers in aviation try to follow 'Just Culture' principles, and it is an issue often discussed. But how does the Civil Aviation Authority apply Just Culture principles? The Director, Graeme Harris, explains the regulator's approach and gives an assurance.

**S**o what, exactly, are Just Culture principles in the view of the CAA?

"They recognise the difference between human error," says Director of Civil Aviation Graeme Harris, "at-risk behaviour, and recklessness, and treat them differently."

"If an incident has resulted from human error, it's pointless to punish the person involved. It's human to make mistakes, we all do it. So the CAA's approach is to support the person, learn from the information provided, improve the system if we can, and move on."

"A single at-risk action is up the line a bit from a pure mistake. But it's not unusual, for a range of reasons, for people to drift from compliance. The normal response to a single at-risk action is coaching, and examining the system that allowed that at-risk action to occur."

"Just Culture principles balance individual and system accountability."

The Director is frank about why he is talking about Just Culture at this time.

"We want to increase reporting. The recent risk profile of the Part 125 sector, Air Operations - Helicopters and Small Aeroplanes, has highlighted that a number of operators and pilots are not reporting occurrences because they're worried about the CAA's response to those reports."

The Director says when participants don't report, the results are two-fold, neither of them good.

"If someone fails to report an occurrence, everyone else in the industry is denied the benefit of learning from it, and acting on the lesson."

"For the CAA to build a picture of flying conditions, and where most risk lies, and to do something positive about that, we need to hear from those who deal every day with the complex conditions of aviation in New Zealand."

"The second thing that happens as a result of non-reporting, is that it exposes those involved to increased risk of enforcement action if the CAA does learn about the event."



Graeme is aware there's an 'urban myth' behind much of the failure to self-report: that reporting an occurrence means the person involved will likely end up in court.

"The stats, however, don't bear that out. Over the last five years, the CAA has received about 32,500 reports and complaints, from the public, from industry, from CAA personnel. In that time there have been just 79 prosecutions."

"I don't believe there is any rational basis for a pilot, for instance, to worry about sanction if they report an incident they caused."

*"If somebody fully, frankly, and in a timely fashion, reports their involvement in an incident, the CAA will apply Just Culture principles when it looks at what contributed to that event."*

"I cannot recall any prosecution taken over an incident during the last five years, where the CAA learned about it only through a report by the person involved."

"If anyone knows from personal experience of such a case, I invite them to email me."

To try to chip away at the urban myth, and improve reporting, Graeme is offering an assurance.

"If somebody fully, frankly, and in a timely fashion, reports their involvement in an incident, the CAA will apply Just Culture principles when it looks at what contributed to that event."

"We will not apply those principles, however, where there's no self-reporting and we learn about the incident from some other source."

Graeme says there's a good reason why self-reporting of incidents, and non-reporting, are treated so differently by the CAA.

"Frankly, it's carrot and stick. We want to improve the reporting, we otherwise wouldn't be waste of. So we undertake to apply Just Culture principles only to self-reporting."

With regard to repeated at-risk actions, or recklessness, Graeme says everyone would understand why they might be more likely to attract a penalty.

There is also another type of occurrence where Just Culture principles may not apply - an accident where harm results.

Graeme illustrates why, using the following scenario:

"A car drives through a red traffic light due to human error. There's no conflicting traffic and the car proceeds safely on its way. A second driver does exactly the same thing once again due to human error, but this time a van carrying the local pre-school group goes through the conflicting green light and is 'blown' by the first car. The car driver survives but four toddlers are killed and a number seriously injured. You're the local road traffic safety authority and you learn about the two events. What action do you take with respect to each of the two drivers? Is it the same, or is it different?"

Graeme explains that in a pure Just Culture environment, the drivers would be treated the same. They would be counselled, and the traffic safety authority would look for system fixes to prevent a recurrence.

"But in countries like New Zealand, the legal framework doesn't support such an approach. There's a limit to which regulators can commit to ignoring the consequences of an action, even one caused by human error."

"People dying or being seriously injured does drive regulator responses. That's why whenever a regulator announces with fanfare that they are hencforth applying Just Culture in all their dealings, you really do need to look for the fine print."

"But I've tried to be clear and honest about the limited scope of Just Culture as applied to occurrence reporting, so there is no fine print for aviation participants to worry about."

The easiest way to report an occurrence is online, [www.caa.govt.nz/report](http://www.caa.govt.nz/report), or use the *How and Now* app.

Look up Part 1 of the Civil Aviation Rules to read definitions of an accident, serious incident, and incident.

The *How to Report Occurrences* booklet is available free by emailing [info@caa.govt.nz](mailto:info@caa.govt.nz).

# Just and Fair Culture

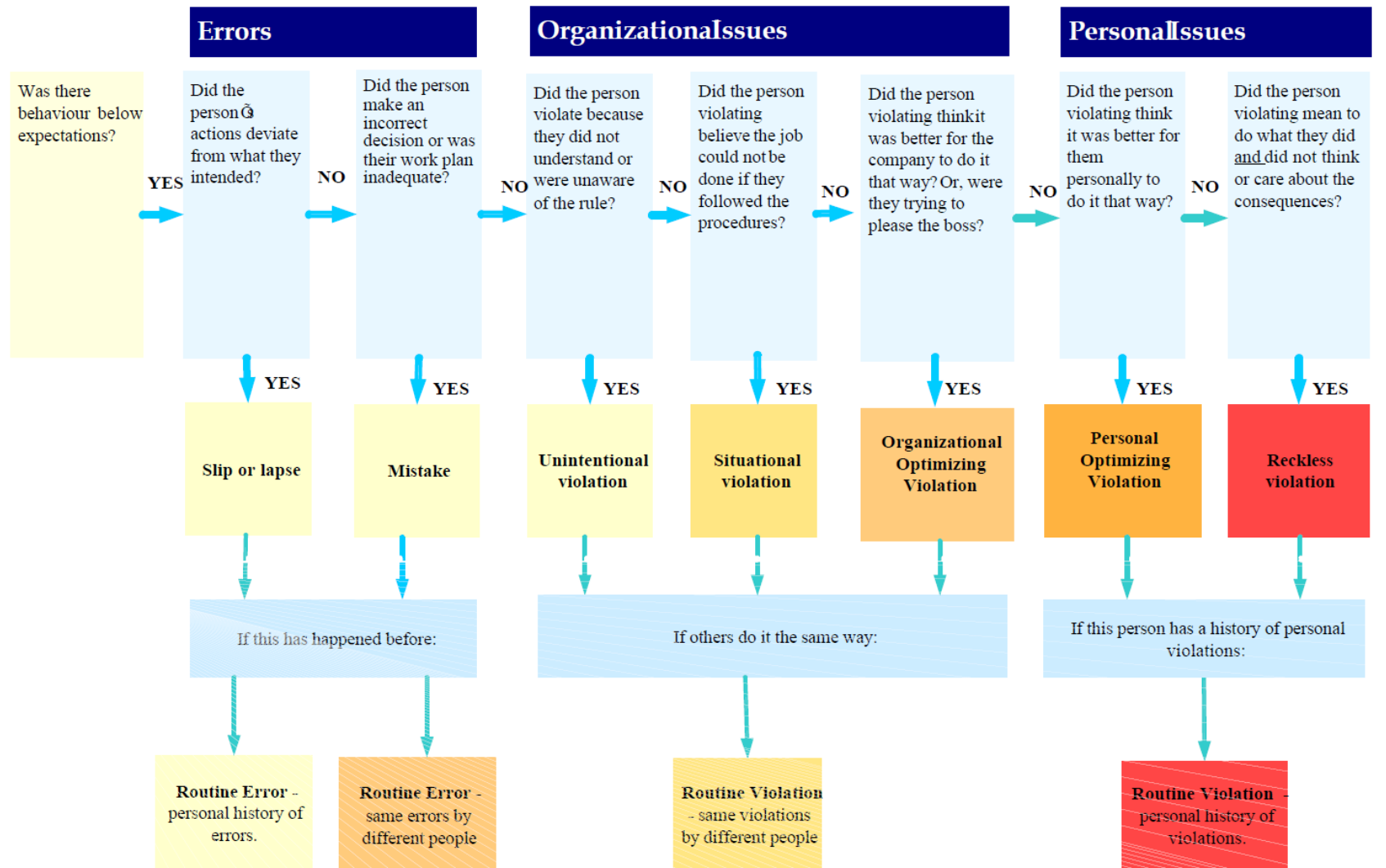
- **Just Culture models**
  - Assume individual guilt unless proven otherwise
  - Do not take into account the role of the manager
- **Just and Fair Culture model**
  - Builds on Just Culture model(s)
  - Descriptions of both good and poor behaviours
  - Integrates human error and non-compliance
  - Based on understanding of the ‘why’
  - Applies to front-line personnel and managers



# Just and Fair Model

Human Error and Violation Decision Flow Chart

Reward Formal Coaching Discipline





# Just and Fair Model



# Just and Fair Model – excerpt

Behaviour	Description of Behaviour	Consequences for the Individual	Consequences for the Managers of the individual
<b>Human Error</b>	Human error is a part of life that can rarely be eliminated entirely. Disciplinary actions in line with local practices and guidelines are usually not appropriate when slips, lapses or mistakes have been made, but many things can be done to prevent their (re-)occurrence.		
<b>Slips and Lapses</b>	Actions that did not proceed as planned e.g. something was done twice, the wrong way or a step is forgotten.	Coaching on how to spot errors, what influences the occurrence of slips and lapses and the importance of reporting them to aid detection of trends and underlying causes.	Coaching in Error Management.
<b>Mistake</b>	Mistakes are actions that proceed as planned but do not achieve their desired end. (Incorrect decision or inadequate plan).	Competence development/ coaching	Coaching in Error Management and Competence Management.
<b>Routine Error</b> <i>Same errors by different people</i>	It is not the first time that this type of error or mistake has happened.	Whole team to receive coaching on how to spot errors, what influences the occurrence of slips and lapses and the importance of reporting them to aid detection of trends and underlying causes.	Coaching in Error Management and Competence Management. Performance appraisal affected for not addressing clear problems in own area.
<b>Routine Error</b> <i>A personal history of errors – when the same errors are not made by others in similar situations</i>	It is <b>not</b> the first time that this type of error or mistake has been made by this person. Other people in similar situations do not make this error.	Assessment of fitness to work (abilities and suitability for this type of job). If appropriate, competence development and coaching, if not consider assigning alternative more appropriate type of work.	Coaching on Fitness To Work.
<b>Unintended Violation</b>	A rule or procedure violated because people were not aware of the rule or did not understand it.	Competence development/ coaching	Coaching on how to ensure procedures are correct, available, and understood.
<b>Situational Violation</b>	A job cannot be done if the rules are followed. Instead of stopping the job it is done anyway and the rule is violated.	Coaching on the need to speak-up when rules cannot be followed and to stop the job until it can be done safely.  Mild disciplinary action in line with local practices and guidelines.	Coaching on Managing Rule Breaking. If this type of situation has occurred before performance appraisal is affected for not demonstrating commitment to rule compliance.
<b>Organisational Optimising violation</b> <i>Optimising for company benefit</i>	The person committing the violation thought it was better for the company to do it that way. The violation was committed to improve performance or to please the supervisor.	Coaching on the need to speak-up when rules cannot be followed and to stop the job until it can be done safely.  Mild disciplinary action in line with local practices and guidelines.	Performance appraisal is affected Coaching on Managing Rule Breaking.  If this type of violation has occurred before there should be formal discipline for reckless supervision in creating a culture that encourages this behaviour.

# Trust Culture



# Just vs. Trust

## Just Culture:

- Systemised form of decision-making. People are forgiven for making genuine errors and mistakes, and are held to account for behaviours and actions which deliberately create risk or cause harm.

## Trust Culture:

- An organisational environment where all employees are: (1) encouraged to **respect and value** the ideas of others until there is a clear and compelling reason not to; (2) **empowered** to contribute towards a shared purpose; and (3) willing to embrace **personal responsibility** and accountability for their own actions.

# Description

- **Common vision & values**
  - Visible (and aligned) leadership
  - Explain the what and why
- **Care**
  - Genuine concern for others' wellbeing
  - Contribute to others' growth and development
- **Communication**
  - Communication and actions are transparent
  - Share information, including errors/mistakes
- **Commitment**
  - Walk the talk
  - Follow-through on plans and promises
- **Connection**
  - Collaborative / team behavior
  - Empowerment, enablement



# Challenges



- Manager time for people / leadership
- Conflicting goals (e.g. self-interest)
- Uncertainty / change
- Misinformation / other agendas
- Short-sighted view of ‘human error’
- Discipline inappropriately applied
- Actions  $\neq$  words
- Cognitive biases
  - Outcome bias
  - Fundamental attribution error

# The 'criminalisation of error' concept

- **Threat to Just/Trust Culture**

- Fact vs. fear?
- Need to differentiate between accident/harm events and incidents?
- Consequence events → public interest/expectations
- Reluctance [by some] to accept that accountability for deliberate/willful action which creates risk or harm is a key element of Just/Trust Culture

- **Treatment**

- Alignment between State/regulator and industry participants
- Accident response – should consider context for individual action (e.g. environment, procedures, training/competency assessment, management involvement/inaction)
- Outcome focus – reporting, learning, prevention, system safety



# Benefits of a trust culture

- Increase in amount and richness of reporting
- Better decisions (diverse input, respectful challenge)
- Employee engagement and satisfaction
- Empathy; 'team' behaviours
- Safety information used to learn and improve
- Proactive management of risk
- Reduction or elimination of harm events
- Resilience
- Business benefits (e.g. quality of work, reputation)





# Final thoughts

- Restrictions to the rate and quality of safety reporting is one of the greatest challenges to aviation safety.
- While trust is fundamentally an individual belief or choice, it can be fostered within organisations through credible leadership, reliability, and people-centred engagement.
- Trust leads to an environment in which **learning** actively drives improvements and questioning is openly encouraged.
- Strong link between a trust culture and organisational performance, including **safety** performance.
- *“The best way to find out if you can trust somebody is to trust them.” — Ernest Hemingway.*

# Keeping people safe

