

A CASE STUDY

And a Merry Xmas to You

This case study is not based on an actual event but is made up from experiences I have had, that for this study, have been amplified. No one should think that such a scenario could not happen

Look at the chain of events as they build up and look at some ways we can prevent it from happening.

Note how the organization contributed to the error

***“We must learn from the mistakes of others
because we will never live long enough
to make them all ourselves”***

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**This case study is part of the video “And a Merry Christmas to You”
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And a Merry Christmas to You

It was Christmas Eve and the corporation's maintenance department was shutting down for the Christmas holidays. Joe was looking forward to this Christmas because his parents were coming to spend it with him and the children were old enough to enjoy the full excitement of present opening. It was going to be like old times.

As he locked up his tools, he was asked by the Director of Maintenance (DOM) if he would mind staying back a few minutes to clear a snag on 402 when it arrived. It was needed for a personal flight with the boss and his family, early the next morning, and Joe was the company's best AME. "D__", thought Joe, "*but OK, I guess a few minutes won't hurt.*"

As the hangar emptied Joe felt the anger welling up inside him. "*Why always me?*" Dispatch wished him a Merry Christmas when he finally went up to find out why 402 was late and he found it difficult to respond in kind. Two hours later, Joe finally got 402 into the hangar: "*About the same time everyone is sitting down to dinner without me*" he thought. "*Small problem my A__! The only way to properly fix this snag is to replace the governor. D__! The special tools are locked away: Can't anything go right? Double D__! that last stud broke off and now I've got to pull the whole thing off again. I'll bet they're opening up their presents by now. There, the d__ thing is in and all I have to do is run it up. Look at that, its snowing and there's only me to get this thing out of the hangar. To h__ with it! I'll just sign the logbooks and just maybe, someone will still be up when I get home.*"

They weren't and at 0630 the next morning the bedside phone rang in Joe's ear. The morning shift had loaded the plane with the boss and his family and he was not amused when the right engine covered the aircraft with oil on startup. The oil line to the governor had not been tightened up. "My G__" thought Joe, "*How could that have happened?*"

Post script:

On his first day back to work, Joe was fired for his carelessness because as the Director of Maintenance said: "In this company,

Safety is our number one concern".

In the CHAIN OF EVENTS

A link is

*Any event, that is a contributing factor,
and which if broken or removed,
might prevent the occurrence.*



*If we can break the chain
the occurrence likely doesn't happen*



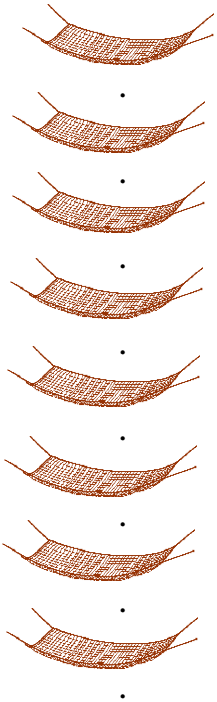
Safety Nets

What can we put in place to help ensure the error or one like it never occurs in the future?
Remember that 70% of all errors have a management responsibility.

- A Safety Net is a Regulation, Policy, Practice or Procedure which, if in place might break a link or prevent a link in the chain of events
- The regulatory body controls the regulations
- The company controls the policies
- The individual controls the practice or procedures.

Watch out for the “*Motherhoods*”; those responses that look good but are safety nets ONLY if there is a practical means of accomplishing it.

For example: *Introduce better communication*. Sure, the how you do that is the safety net. *Better, more, improved and increased* likely indicate a “Motherhood.”



A Safety net is often the last chance to stop an error from becoming an accident.