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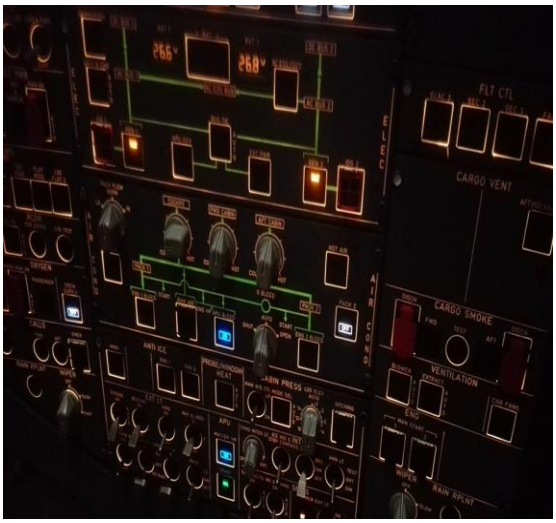
"Barbarians: Ideas cannot be killed!"

Miguel Ángel Álvarez (Javier Portales)
Film "Fifth National Year". 1961

How Feasible is Safety in my Organization?

- We need to talk about the SMS in Layman's terms -

Aircraft hydraulic power lost when landing was just the first hilltop for this airline that week. We were talking in a smooth mood. No air could be grasped whatsoever with both of us at the airport lounge in this afternoon. It is the same feeling as when my old man took me to the airport for the first time when I was just a kid. All these people on tarmac, all those passengers escorted by airline staff members, all these vehicles braking two times before stopping next to the airplane, all these badges for everyone. Inheritance is a shouted word that could explain why I am trying still to understand the passion and dedication I saw from my Dad for more than forty years as an aircraft engineer. I came back to actual times in some eye-opener surge, and I am three months now before this new incident of the hydraulic power lost upon landing. **Did you let ATC know about it?** I asked. **No, Sergio. Did you enter this into the aircraft logbook? No, Sergio. We managed all this stuff internally!**



I knew it was going to become tough dealing with these procedure violations, but as I was talking I could not help staring at his face. No expression. He was painting his masterpiece in a focused and dedicated manner. I noticed myself it was fair reading Boeing Aeromagazine's "Creating a More Effective Safety Culture" by Maggie J. Ma and William L. Rankin, that said: **"A Just Culture emphasizes shared accountability between the organization and its employees. In the Just Culture, an individual employee is not held accountable for system failures over which he or she has no control, but it does not tolerate conscious disregard of rules, reckless behavior, or gross misconduct."**

French fries and sausages came to our table and, as I was trying to process and to enter fair information to my report, I made my mind up. This airline's operational context could not be as rich in documents as me actually taking part in this interview. The chat was worth. No need to "lean" it. Mixture was just fine!

So, my questions had to address key issues on management of this airline against ICAO's structure of the SMS. **"Kindly let me know about your safety policy and objectives. Have you heard about it? Could you tell me in your words what do you understand from the policy and safety objectives of your company?"** He tried to make a word, I am emphasizing in the fact he tried hard to find a rational statement. Not even two sentences in a row. I tried to bring confidence to the meeting, so more bottles of sparkling water came by. **What about Risk Management?** I asked once again. **Have you ever heard or seen the hazard register or discussed it? Well, you know, our Safety Manager sends safety alerts or newsletters through whatsapp after incidents or accidents occur. The next day after, he shows up with a sheet of paper wherein we have to sign acknowledging receipt of the document. And that's it! But do you guys discuss these incidents and/or accidents with the Safety Manager? Well, Sergio, I am flying two years for this company and that what you are asking never happened.**

It was clear I found cues of latent conditions to be dealt with, but believe me, this is not new. We continued talking and no safety assurance activities were neither made. Training was delivered after operational shifts ended. So, they have to stay at the office for training sessions after flying or maintainng the airplanes. What could be told after this? I made the safety report in SMS Layman's terms.

a) In a management system, like the SMS, activities must be made in a systemic manner, including interaction and coordination. All of these must be linked to the policies and objectives set by the company.

b) The safety vision and perspective must be shared both by the employer and the employees. Responsibilities must be designed and disseminated to all people involved. It does not matter how much expertise is bearing some employee. Everyone must be informed about his/her responsibilities. Accountability must take part in this safety equation. This is a valuable asset for the confidence of the system. Organizations must hire accountable personnel. These accountable people need to use expertise, regulations and awareness of the consequences of their acts, including ethics, to fight the battles, wherein hazards are trying to prevail.

c) Risk management and management of change deal both with risks. Organizations must detect hazards (using SWOT analysis is worth). That is the first step in Risk Management. All of us need to understand this. Then, it is important to analyse the consequences of such hazard. But it should be more important to notice consequences do not "unleash the hell" in a standalone manner. They need a trigger. Once this is analysed taking into account probability and severity, we are able to set a value for that risk. What happens if such value is higher than acceptable? Mitigation comes into place; no doubt about it! Where is the limit for this? Mitigation measures must be closed in a responsible manner. Safety Committees must be active here. When does this take place? Obviously, before the incidents or accidents occur! All the available artillery is always fighting against hazards. They appear more often and insidious than you think, and personnel must be aware of this. A good communicational program is worth for this reason.

d) But what happens after the incident or accident occurred? An investigation must be made. What would be my advise? If your organization was not able to detect such an accident, first thing to do is looking backwards at your defenses, and ask yourself whether they were designed, developed and working as a system customized to your organizational policies and objectives. As long as defenses such as regulations and standards, training or equipment are alive in your organization, which means producing data and sketching the actual cultural behavior or performance lines, you will be able to shield an operation with

the risks you managed; i.e. to be deemed as a proactive organization, or as a system-driven business.

e) We cannot forget the operation. It is set up by regulations, standards, documentation and people. Once operational staff is trained and aware the operation and the relevant requirements are not mines to actual activities, but milestones, both for frontline personnel and the administrators, safety shall be obtained. It does not work the other way around. Setting safety as priority just in documents and fancy speeches ends up in the organization failing to operate safely. What would be my advise? I would rather say do not mislead yourself, your customers and shareholders by saying safety is top priority in your company, when you are not complying with regulations, you are not managing risks, and you are not running your business in a systemic process-based approach. Taking into account its dynamic nature, safety cannot be automatically attained by just proclaiming it in policies, standards and manuals. Safety is not an advertisement. Safety is not just a documented objective. Safety is the endeavor. Safety is the end product of complying with regulations, managing risks, learning from accidents and incidents, understanding the consequences of the ethics, and communicating news to the operators.

The airline received my safety report with the recommendations. **The audit we agreed, later, Sergio**, he knocked me. After a short while, other incidents happened. **Are you planning to keep calling me everytime your airplanes are involved in accidents?** I asked. Just a smile as a reply. For all the accidents and incidents that happened, recommendations were made, but in this case the SMS was useless, Risk Management could not be accounted for in the airline along with lack of latent condition detection and awareness. What were the preventive measures?.Just having an on-call Safety Investigator, waiting for the safety improvement report, and hoping no accident occurs again. But they keep on happening, based on the company's safety culture. Regarding this, I found this quote again by Maggie J. Ma and William L. Rankin: **"About 80 to 90 percent of actions leading to safety events are caused by system issues. Focus on correcting system issues instead of blaming individuals."**

That day I remembered I walked all the way to this CEO's office and told him **"you also need to perform continuous research on SMS, so you will be able to understand and optimize the use of management tools."** Safety shall be not feasible if organizations do not even understand what's the SMS. It is a matter of perspective and overview. Cake will not be enough for everyone no matter how small or big it is if you are not skilled to cut properly the slices!