Just Culture – from aspiration to reality

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Background to this work

• The fragility of a Just Culture - inconsistency of Just Policy application is a common *killer* of a safety culture

• Our experience of the real-world application of extant culpability models taught us that there is a pressing need for a:
  – workable, straightforward toolset
  – toolset which can be repeatedly and credibly applied by non-HF specialists
  – toolset that does not require extensive training
  – tool that minimises variability, ensures consistency and stands the test of perishable training

• Outcome – The **FAIR™** system (*Flowchart Analysis of Investigation Results*)

• **FAIR™** is free of charge
The basis of FAIR™

• The ‘best practice’ elements of the two main academic (Reason/Hudson) ‘in-use’ models
**Prof. James Reason - Culpability Model’**

*Further developed by QANTAS Airlines and Baines Simmons Limited*

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**Substitution Test**
- Question to peers: “Given the circumstances, is it possible that you could have made the same or a similar error”
- If answer "yes" then blame inappropriate.
- The best people can make the worst mistakes.

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**Flowchart Description**
- **Were the actions as intended?**
  - No → Unauthorized substance? (Yes → Medical condition? (Yes → Substance abuse with mitigation; No → Substance abuse without mitigation))
  - Yes → **Unauthorized substance?** (Yes → Medical condition? (Yes → Substance abuse with mitigation; No → Substance abuse without mitigation))

- **Were procedures available, workable, intelligible and correct?**
  - Yes → Evidence of reckless, optimising or negligent behaviour
  - No → Situational Violation - Under pressure to get job done
  - System Induced violation

- **Were the consequences as intended?**
  - Yes → **System Induced violation**
  - No → Deficiencies in training & selection or inexperience

- **Pass substitution test**
  - Pass → History of unsafe acts (Yes → Blameless error; No → Blameless error but corrective training or counselling indicated)

- **Diminishing culpability**
  - Substitution Test: "Given the circumstances, is it possible that you could have made the same or a similar error"
Were *safe* operating procedures knowingly ignored / rules broken?

In the circumstances of the event, could the task have been done in accordance with *safe* operating procedures?

Were the consequences as intended?

Did the actions benefit the individual?

Did the actions benefit the organization?

Was the situation outside normal operating procedures?

Apply routine and substitution test at each outcome to determine most appropriate intervention actions.

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Flowchart Analysis of Investigation Results (FAIR™)

**Unintended Action**

**Unintended Consequence**

- Error (slips and lapses)
- Skill-based
- Memory or attentional failure

**Intended Action**

**Intended Consequence**

- Unintentional rule-breaking
- Mistake
- Rule-based
- Knowing rule-breaking
- Situational
- Organisational optimising
- Knowledge-based
- Exceptional

**Increasing culpability**

1 - **Substitution test:** Would someone else in the same situation have done the same thing? (if not, what is it about individual?)

2 - **Routine test:** Does this happen often to a) the individual or b) the organisation?

3 - **Proportional punishment test:** What safety value will punishment have?

4 - **Intervention:** What needs to happen to reduce likelihood of recurrence at a) an individual level and b) an organisational level?

**Manage through** improving performance influencing factors (PIFs) – person, task, situation, environment

**Manage through** appropriate disciplinary action

**Sabotage**

**Reckless behaviour**

**Gross negligence**

**Personal optimising**
Managing The Three Behaviours

**Normal Error**
Manage through changes in the immediate 'system':
- Processes
- Procedures
- Training
- Design
- Environment
- Move or manage the person

**At-Risk Behaviour**
Manage through:
- Understanding our at-risk behaviours
- Removing incentives for at-risk behaviours
- Creating incentives for healthy behaviour
- Increasing situational awareness

**Intentional Risk-Taking**
Manage through:
- Disciplinary action
Where does FAIR reside in your Error Management System?

Unwanted event/error or near miss

Precautionary action?

Carry out 'Root Cause Investigation' (using tools such as MEDA, HFIT, PEAT, REDA) using trained investigators

Investigation Output - Event Review Team (ERT) convened

Further 'unsafe act' information required

*FAIR system

See next page

No Further action regarding person

Instigate disciplinary process

Non-Judgemental

Decision

Judgemental

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(developed) Substitution Testing

- This must be carried out by the Event Review Team (ERT) on at least three of the person’s peers.

- The substitution test is designed to ascertain whether, in the circumstances, it is possible that another similarly skilled, trained and experienced individual would have done anything different.

- These peers must not be members of the ERT, investigation or any other committee that could bring in a pre-existing knowledge or bias that would be directly associated with the event/near-miss circumstances.

- If answer no then it is most likely a system problem, not necessarily an individual’s problem, and blame is not appropriate. It proves that the best people can make the worst mistakes.

- Ask other peers this question – “Could you have made the same or similar error under similar circumstances?”

- Peers must consider the event/near-miss contributing factors i.e. (maintenance) system failures, and circumstances beyond the individual’s control as determined through the related investigation.

- If the peer group indicates a positive response (yes) the person is probably blameless.

- A review of their previous decision history is in order. If they have a previous history of poor decision-making, counseling may be in order depending on event/near-miss factors.
What is a Just Culture?

A Set of Beliefs
- A recognition that professionals will make mistakes
- A recognition that even professionals will develop unhealthy norms
- A fierce intolerance for reckless conduct
- An expectation that hazards and errors will be reported
- Accountability for choosing to take risk
- Expectation that system safety will improve

A Set of Duties
- To raise your hand and say “I’ve made a mistake”
- To raise your hand when you see risk
- To resist the growth of at-risk behaviour
- To participate in generating learning from our every-day bad experiences
- To absolutely avoid reckless conduct

Inspiration: David Marx
Does a Just Culture deliver?

- Some interesting lessons regarding the application of the Just Culture
Internal Reporting

FURBYs Raised from Nov 07

- Horizontal axis: Weeks
- Vertical axis: FURBYs
- Graph shows the increase in FURBYs raised over 43 weeks from November 07.
The MAS Programme

2005 2006 2007 2008

- Senior Mgt HF Training
- HF Programme
- MEDA Training
- Continuation Training
- Safety Review Board
- Safety Action Groups
- SMS Training

Reactive “Systems”
Proactive “Culture”

MEMS Report 700 +
MEDA Investigations 200 +
Initial HF Trained 2800 +
Regeneration outcomes

Annual Occurrence Reports Raised

2006 2007 2008
A Journey to the Bottom of the Error Iceberg – MEMS Implementation 2005 – 2008

Low risk items including non event items/near miss

QANTAS Maintenance Error Management System
A Journey to the Bottom of the Error Iceberg – MEMS Implementation 2005 – 2008

- Reasons for Increased Reporting
  - Increased belief that Just Culture Principles will be followed
  - Changing belief in reporting making a difference
  - Better understanding of reporting via HF training
  - No Punitive actions outside of Just Policy
  - Much easier to report via online reporting system
  - Good MEDA Investigations and results
Measures to protect Just Culture

• only one committee member to be technically knowledgeable
• only one investigator to be technically *knowledgeable*
• only one investigator to be *local*
• confidentiality maintained
• Investigators have limited participation in decision making process
• no secrets – published procedure promoted from the top down
Measures to protect Just Culture

Train the Management Team (an example curriculum)

• An Introduction to Human Error
• Managing Error
• Managing At-Risk Behavior
• Managing Reckless Behavior
• Developing a reporting culture
• The Investigation Process
• Just Culture and its link to safety
• How to do just culture
• Making Smart System Changes
The reality of being Just

• As we move into the brave world of SMS, the actions that an organization takes for or against its people after an event occurs will continue to be the single biggest determiner of its success (in terms of managing safety proactively)

• Its the doing that's the undoing...
It’s the doing that can be the undoing

Three airlines drop self-reporting safety program

By Alan Levin, USA TODAY

Three large airlines have abandoned a safety program credited with helping to lower accident rates, prompting criticism of the airlines and unions by safety advocates and government regulators.

American Airlines, Delta Air Lines and Comair have dropped programs that encourage pilots to come forward and report their own mistakes without fear of being punished. Known as the Aviation Safety Action Program (ASAP), the program has helped airlines and regulators uncover scores of potentially dangerous situations and make fixes before they caused crashes.

ASAP depends on a consensus among pilot unions, airlines and the Federal Aviation Administration (FAA), any of which can halt the agreement by refusing to participate.

Several leading safety experts and the FAA’s acting chief criticized the companies and unions in recent days, accusing the two sides of letting politics and bargaining get in the way of safety.

Union leaders have charged that airlines have gone back on their word and unfairly punished pilots who voluntarily disclosed problems.

US Airways Pilots Halt Voluntary Data-Sharing Program

By ANDY PASZTOR

LOS ANGELES – In the latest setback for pilot-airline cooperation on safety initiatives, US Airways became the third mainline U.S. airline to discontinue voluntary programs for reporting operational incidents.

Following similar disputes affecting Delta Air Lines Inc. and AMR Corp.’s American Airlines, the collapse of the US Airways program underscores the difficulties of pursuing voluntary data-sharing in the face of the airline industry’s rancorous labor-management relations. The move not only does away with a powerful tool for the airline and its pilots to spot all types of budding safety hazards, it also could slow the spread of such voluntary incident-reporting systems at some foreign carriers, safety experts say.

The US Airways program, which had been active for more than 10 years, ran into trouble over pilot complaints that the company was seeking to use voluntary reports to punish individual
Summary

• Being fair is a management accountability (be tough)

• Managing consistency is the real challenge, or being just most of the time – irrespective of output failure consequence

• Formally record how you responded - for performance review by seniors and independents

• The regulator should care too
Conclusion

- The FAIR™ tool – a workable, and straightforward toolset which can be repeatedly and credibly applied by non-HF specialists, without the need for extensive training

  So that our people tell us about safety

- Interested in trialling/using FAIR™?
- please leave your business card, or contact us through our website
- In return we would value your feedback as to its usability