BY ROBERT L. SUMWALT

Do You Have a Safety Culture?

A major responsibility of management is to establish and maintain a safety culture. It must start at the top and permeate the entire organization. If the leaders do not truly believe in safety, then why would others in the organization be expected to embrace it?

Do you have a safety culture in your organization?

Think carefully before answering. For those who immediately answer that they do, Dr. James Reason has some words to keep us on our toes: "[I]f you are convinced that your organization has a good safety culture, you are almost certainly mistaken — A safety culture is something that is strived for but rarely attained — [T]he process is more important than the product."

What is safety culture? I define safety culture simply as doing the right thing, even when no one is watching.

The U.S. National Transportation Safety Board (NTSB) has long believed in the importance of such a culture. After questioning an organization's safety focus in a number of accidents, NTSB in 1997 hosted the Symposium on Corporate Culture and Transportation Safety. Jim Hall, chairman of NTSB at the time, said: "We've found through 30 years of accident investigation that sometimes the most common link is the attitude of corporate leadership toward safety. The safest carriers have more effectively committed themselves to controlling the risks that may arise from mechanical or organizational failures, environmental conditions and human error."

Although that symposium was a decade ago, we continue to see accidents in which an operator's safety culture is questioned.

The safety board recently investigated an accident involving a regional jet nighttime positioning flight. The pilots had no passengers and decided, as they told air traffic control, they would "have a little fun." Post accident analysis reveals that the crew performed a number of unauthorized actions, including intentionally causing the stall warning system to activate on three occasions, imposing dangerous sideloads on the aircraft's tail structure by intentionally mishandling the rudder, allowing the first officer to occupy the captain's seat while the captain sat in the first officer's seat and a series of other deviations from standard operating procedures (SOPs).

Once level at flight level 410, the crew allowed airspeed to bleed off, leading to a stall and loss of control. The high-altitude upset disrupted airflow through the engines, and both flamed out. Unfortunately, the crew was unable to restart either engine and they paid for this behavior with their lives.

These were not rogue pilots. In fact, both were generally described as being good pilots. One first officer described the captain as "the best stick-and-rudder pilot" he had ever flown with. Another pilot who flew with the captain a week before the accident said that the captain operated in a standard manner with no deviations from SOPs.

Clearly, however, on the accident flight they were not doing the right

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things when no one was watching. Why did this crew think that they could do what they did?

Dr. Reason states that a safety culture consists of an "informed culture," a "reporting culture" and a "just culture." During the board meeting for this accident, I asked questions concerning two of these elements — informed and reporting cultures.

"In my view, a safety culture depends critically upon first negotiating where the line should be drawn between unacceptable behavior and blameless acts."

In an informed culture, an organization collects and analyzes the data to stay informed of its safety health. Examples of such programs are internal and external audits, flight operational quality assurance (FOQA), line operations safety audits (LOSA) and confidential incident reporting systems such as Aviation Safety Action Programs (ASAP).

Interestingly, at the time of the accident, the airline had no effective programs to collect and analyze safety data; it did not have a FOQA or ASAP program; and it had never conducted a LOSA.

Remarkably, when asked how they ensured that crews adhered to SOPs during positioning flights, the company's chief pilot stated, "Same way I do any flight being conducted to SOP. We look at the reports. We look at the numbers, you know: Did they leave on time, did they not leave on time, and if anyone is on the jump seat doing a check. That's the only way I know if any flight I have is being conducted per SOP."

In other words, we don't know.

Reporting cultures are receptive to employee safety-problem reports. The employees know they will not be punished or ridiculed for their reports. The Flight Safety Foundation Icarus Committee stated several years ago that if you expect employees to provide safety information, then you must have a printed policy signed by the CEO that assures employees that the organization will not initiate disciplinary proceedings against an employee who, in good faith, discloses a hazard or safety incident due to conduct that was unintentional. Employees must be confident that confidentiality will be maintained.

The airline involved in the previously mentioned accident had a safety hotline crewmembers could use to report safety concerns. However, investigators discovered that no one used the hotline.

In other words, whatever we have is not working.

One board member at the hearing stated, "Based on what you've told me today, I would say that … [the airline] lacked at least two elements of a successful safety culture — an informed culture and a reporting culture."

I believe the absence of these elements, while not *causing* the accident, may have *enabled* the accident. It enabled a culture in which crewmembers felt they could do whatever they wanted when no one was watching.

A just culture is essential but it is often misunderstood. In a just culture, employees are confident that while they will be held accountable for their actions, they will be treated fairly. They also know that those who act recklessly or deliberately take unjustifiable risks will be punished.

Dr. Reason emphasizes that we must not confuse "just culture" with "no-blame culture" (*FSD*, 3/05, p. 2). He explains that a "no-blame" culture does not address how to deal with "individuals who willfully (and often repeatedly) engaged in dangerous behaviors that … increase the risk of a bad outcome. Secondly, [no-blame culture does] not properly address the crucial business of distinguishing between culpable and nonculpable unsafe acts.

"In my view, a safety culture depends critically upon first negotiating where the line should be drawn between unacceptable behavior and blameless acts," he says.

The three elements of a safety culture are like gears, turning together to propel an organization towards a safety culture. If one or more are missing, the intended movement doesn't happen.

So, again, the question arises: Do you have a safety culture? Perhaps a more telling question is: Do you have these elements, and are they effective?

Be careful how you answer that one. ●