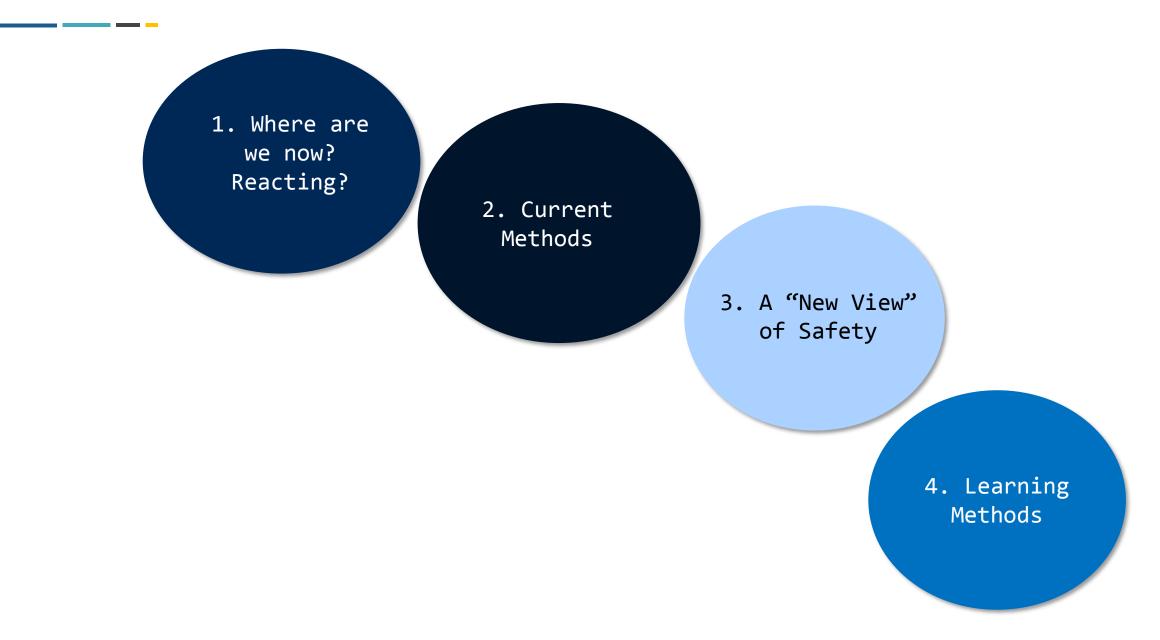


S O U T H P A C aerospace





FROM REACTING TO LEARNING...THE NEXT STEP IN AVIATION SAFETY

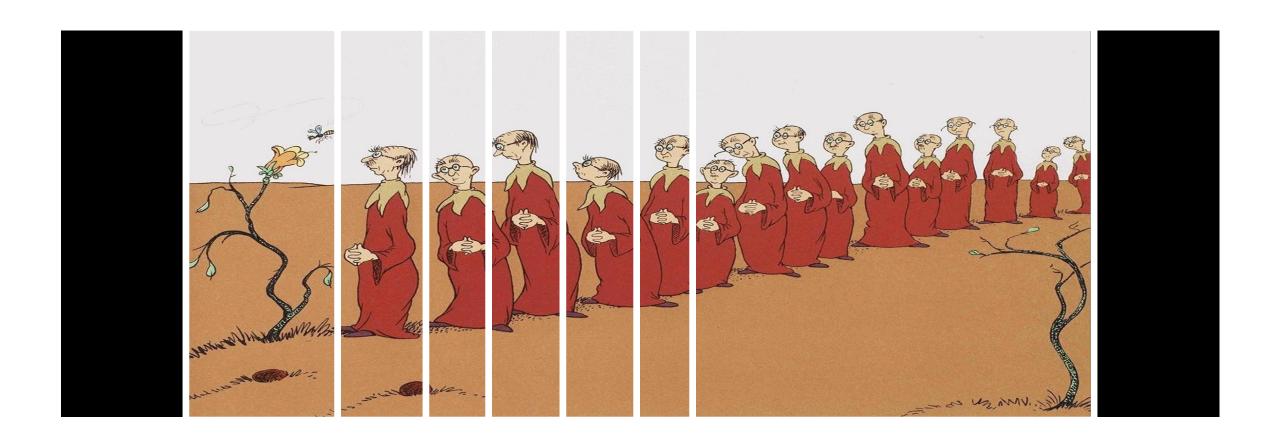


CONTEMPORARY SAFETY?



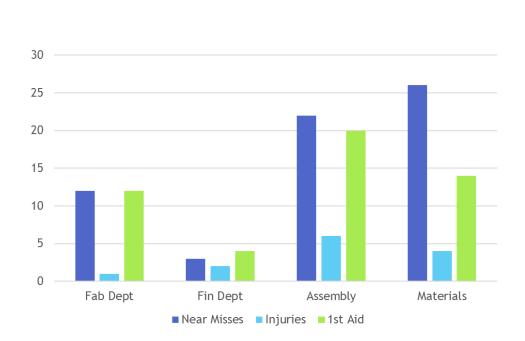


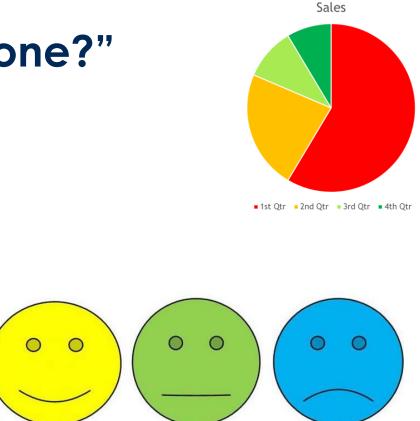
COMPLIANCE MONITORING



DASHBOARD SAFETY – CRAZY METRICS & RIGID RULES

You've heard it said, "what gets measured, gets done?"





International Standards and Recommended Practices



Annex 13 to the Convention on International Civil Aviation

Aircraft Accident and Incident Investigation

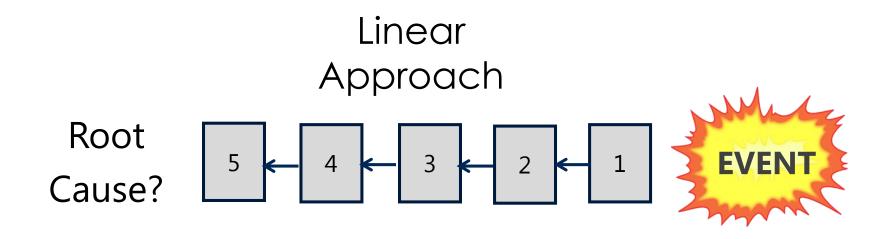
COMMON 'CAUSES' AND FIXES

CAUSES	FIXES
Operator did not follow procedure	Remind all operators to follow procedures
Did not know about procedures	Issue a "read and sign"
Inadequate procedures	Write another procedure
Operators still not following procedures	Blame the operator – Blame, Shame, Retrain
Operators STILL not following procedures	Fire the operator, "they're a bad apple"

CAPTAIN HINDSIGHT



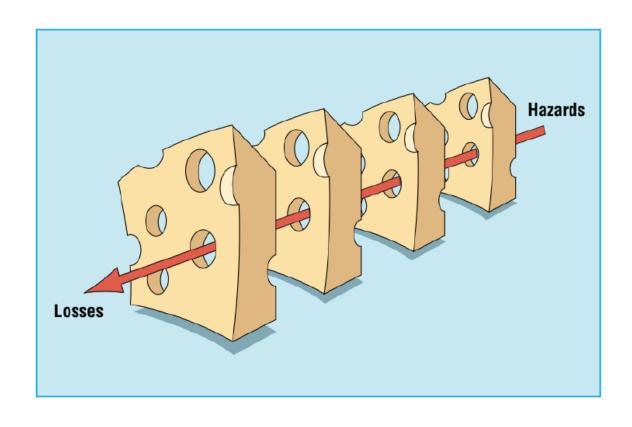
LOOKING FOR ROOT CAUSE OR CAUSES...

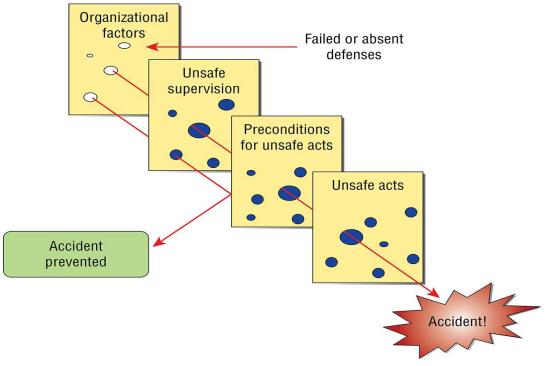


The problem is, the failure probably was not linear . . .

... and there almost **NEVER** is one root cause.

THE DOMINANT ACCIDENT MODEL





THE SWISS CHEESE FALLACY



The SCM **does not** provide a detailed accident model or a detailed theory of how the multitude of functions and entities in a complex socio-technical system interact and depend on each other.

REASON ET AL., 2006

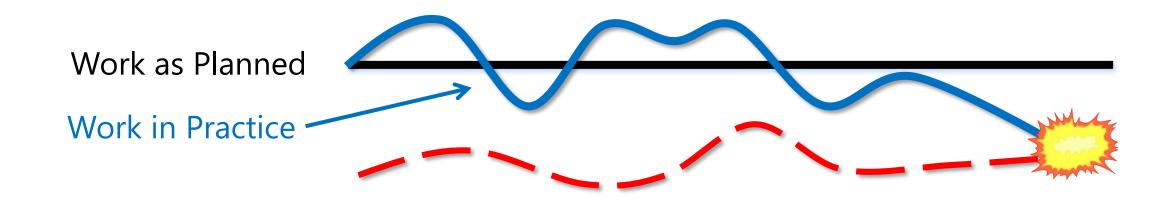
THE SWISS CHEESE FALLACY



the SCM has an indisputable value as a means of communication, as a heuristic **explanatory** device.

REASON ET AL., 2006

WORK AS PLANNED vs WORK IN PRACTICE



"Workers are Masters of Complex Adaptive Behaviour"

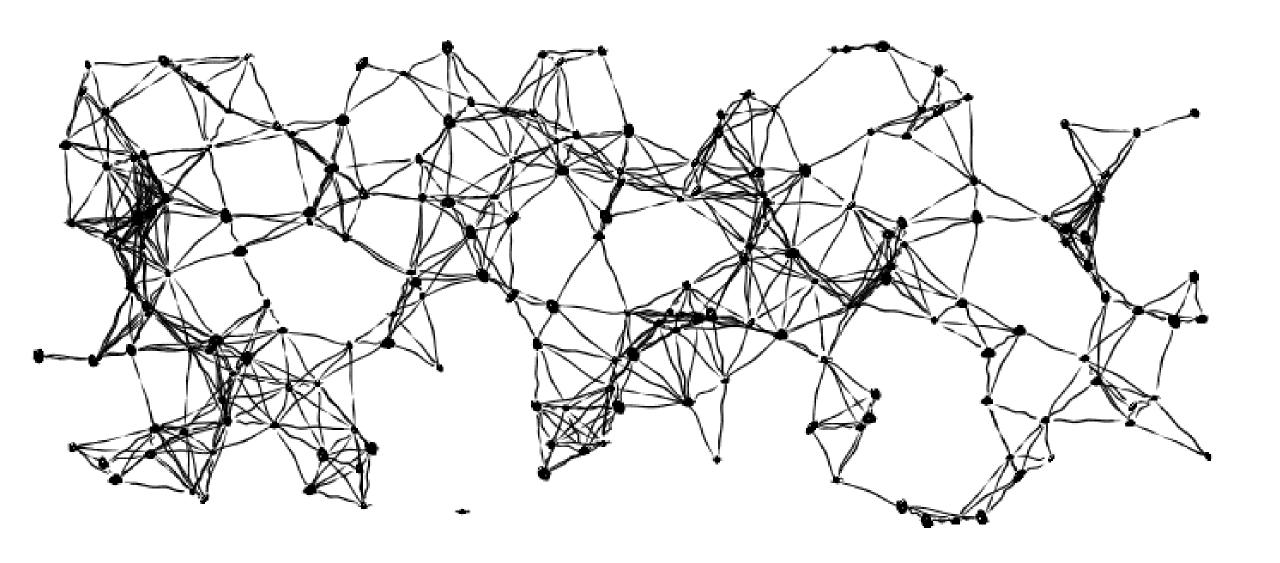
"masters of the blue line"

A 'MESSY' STORY

tradeoffs

```
weak signals
 production pressure
unclear signals
                  incomplete procedures
  fear of reporting
                    near misses latent conditions
                                                      errors
                   local factors HAZARDS & RISKS flawed processes
system strengths
                                                                           data
                                   design shortcomings system weaknesses
                        surprises
  resource constraints
                   goal conflict
past successes
                                   normal variability
                       change in plans
  poor communication
personal factors
                  adaption
```

COMPLEX VS LINEAR





Workers
Are Masters of
Complex Adaptive
Behavior... (Conklin)

NORMAL ACCIDENTS?

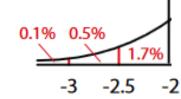
66

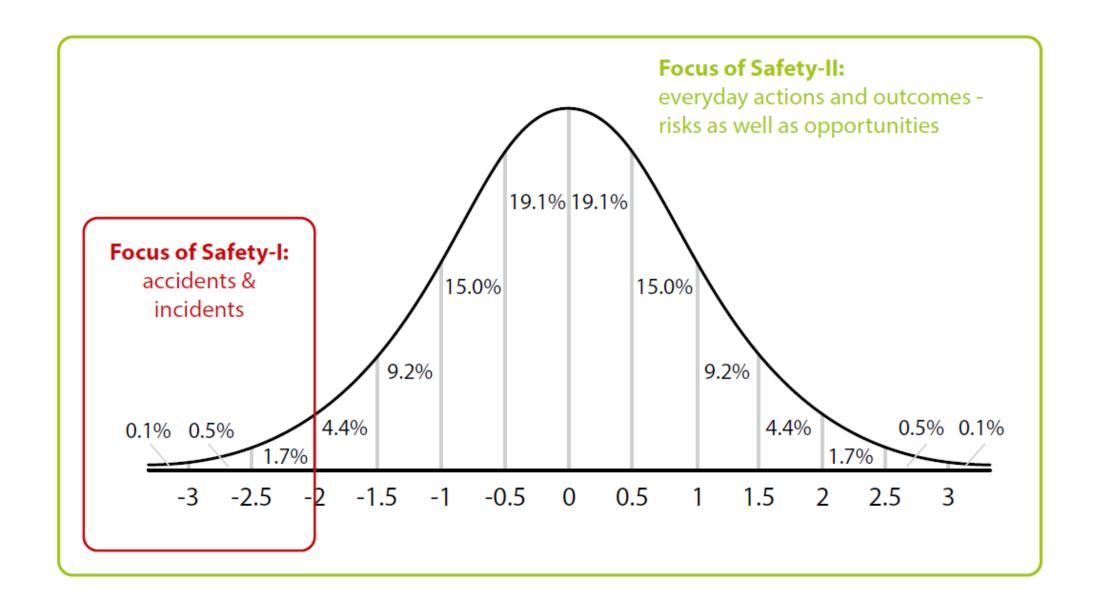
Safety focus: accidents & disasters

In our passion to understand and create an orderly universe we explain the unusual event by invoking the usual and proclaiming it to be different, when of course it is not.

Instead, it is the **obscure**, **accidental**, **and even random concatenation of normal disorders**that produces a great even that we assume must have had great causes.

The equivalence principle...





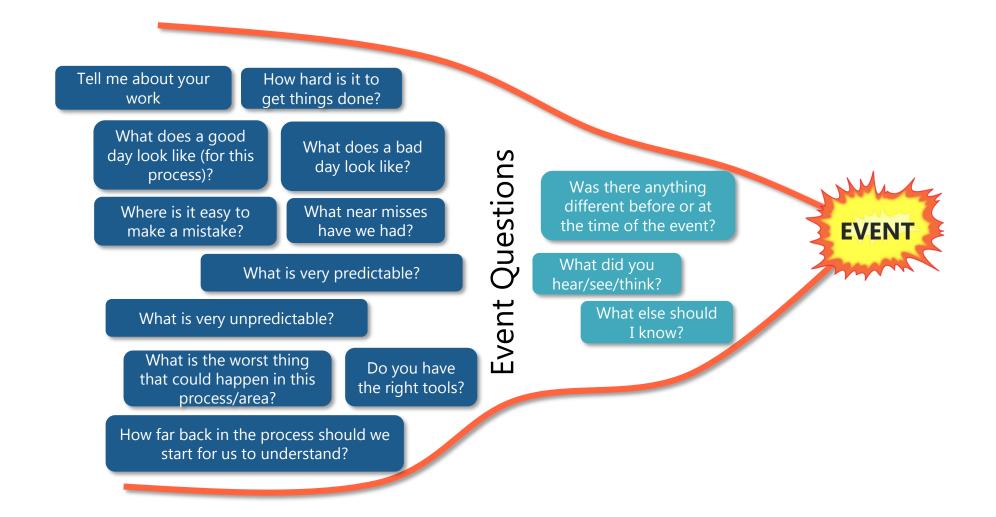
UNDERSTANDING

if we want better answers...



...we have to ask better questions!

EXAMPLE QUESTIONS



THE HOP PRINCIPLES

error is normal

blame fixes nothing

systems drive behaviour

learning is vital

response matters





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THANKYOU!