Safety Management Systems
- An Independent Perspective

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The safety management challenge

- Systematic and proactive data on current hazards?
- High-fidelity, data-intensive identification of hazards?
- Continuous collection and analysis of daily operational data?
Aren't we already doing it?

Output failure (occurrence) → Report (?) → Investigation? → Data analysis? → Intervention?

Revised system/process → People engagement → Proactive reporting hazards/1-3rd age → Investigation (trained/local)

Safety assurance → Socio/technical intervention → Data analysis 80/20 → Predictive (risk-based) hazard management → High-value input dataset

People-centric, high fidelity data
The challenge

- A strategic approach requires a clear model of good!
Difficult to buy into something we don’t agree on or have a model of?

What will be the biggest challenge in developing your SMS?

- Front-line buy-in i.e., necessary cultural change: 33%
- Management support: 34%
- Unclear regulatory requirements: 13%
- Conflict with commercial priorities: 4%
- Financial budgets: 16%
The challenge

Having a clear model of what good looks like or Point-B

- So that everyone can buy into the task
- We can’t start if we don’t know where we are now – Point-A
- We can provision for the transition to Point-B
- We can review progress at anytime – on course?
- Without this we won’t know if we've made it?
Navigating the SMS cloud

Phase 1 - Understanding, underdeveloped, initiating

Phase 2 - Build, emerging competence

Phase 3 - Informed, operationally sound

Phase 4 - Proactive, learning, towards excellence

Phase 5 - Predictive, world-class

Safety Management System Maturity

Learning culture

Informed culture

Reporting culture

Just culture

Powering RAF safety performance
So what might good look like?

**Leadership**
- Strategic

**Compliance**
- Regulations
- Leading Practice
- Enablers

**Culture**
- Best Practice
- Performance
- Enablers

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**‘Active’ ... Safety Leadership**
- SMS Safety Vision, Strategy, Policy, Objectives, Beliefs & Principles
- SMS Implementation Goals & Maturity Development Roadmap
- Safety Roles, Accountabilities, Responsibilities and Delegation
- SMS Safety Performance, Measurement & Reporting

**‘Intelligent’ ... Regulatory Adoption**
- Systems
- Resource
- Processes
- Competence
- Safety Policy & Objectives
- Safety Risk Management
- Safety Assurance
- Safety Promotion

**‘Positive’ ... Safety Culture**
- Safety Leadership
- Just Culture
- Human Factors & Fatigue Risk Management
- Human Performance Management
- Hazard & Risk Management
- Safety Assurance
- Safety Competence
- Safety Communication
- Error Management
- Reporting & Investigation
- Safety Engagement
- Resilience & Emergency Response

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Powering RAF safety performance
You need to make decisions
The essence of SMS for leaders

- Making decisions without knowledge creates risk in itself

- Your role in this?
The essence of SMS for leaders

- With the correct culture we can become knowledgeable

- Your role in this?
The essence of SMS for leaders

- For the correct culture to flourish we need to be trusted

- Your role in this?
The essence of SMS for leaders

- With this we can make risk-based decisions

- Your role in this?
Is safety management cultural?

Press Release re: Koito Industries

Koito admits falsifying seat test results

Koito Industries, which makes passenger seats for some of the biggest names in the industry, admitted on 8 February that it had falsified test results for seats and made design modifications that weren’t approved by regulators. Koito now plans to fix 150,000 seats in about 1,000 aircraft.

At a news conference in Tokyo, President Takashi Kakegawa said executives – even those with no connection to the seat-making division – were aware of the practice, which dated back to 2003. “The entire organisation was involved,” Kakegawa told reporters.
The organisational cultural motivator

- “I can only speak for myself but I was shocked by the Texas City explosion.”

- “It seemed so out of character with what I believed was BP’s prevailing safety culture.”

- “Please learn from our mistakes.”

John Mogford - BP Senior Group VP Safety and Operations
“Human behaviour is the key to SMS success”.

Human Factors and Safety Culture

- SMS is more than a system
- It needs the right organisational culture
- Enables open reporting
- The key component of an SMS is the people
- Understanding human behaviour and organisational factors is the key to SMS success.
- Human Factors should be an integral part of a Safety Management System

Simon Roberts - SMS Programme Manager at the UK Civil Aviation Authority
Culture is a basic issue in all these accidents

- Our culture determines what we regard as important
- Our culture determines what we see as normal and acceptable
- Culture acts as a multiplier on all safety elements
  - Facility
  - Process
  - People
Safety Culture?

Flexible Culture

Just Culture

Reporting Culture

Learning Culture

Informed culture

a safety culture

Powering RAF safety performance
Conclusions

- Whilst a systems approach is absolutely necessary - effective safety management is largely cultural

- Proactive hazard identification (risk management) cannot happen without people engagement

- Possessing a consensus of what good safety management looks like is vital
  - without this - where you are going, how you are doing, have you arrived?

- Hazard rather than event/occurrence centric

- Safety (hazard) reporting becomes part of the organisation’s DNA (Duty holder Nav. Aid)