



NTSB National Transportation Safety Board

Aviation Lesson Learned:

Presentation to: DOE Nuclear
Executive Leadership Training

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**Better
Collaboration
Can Help
Improve Safety**

The Contrast

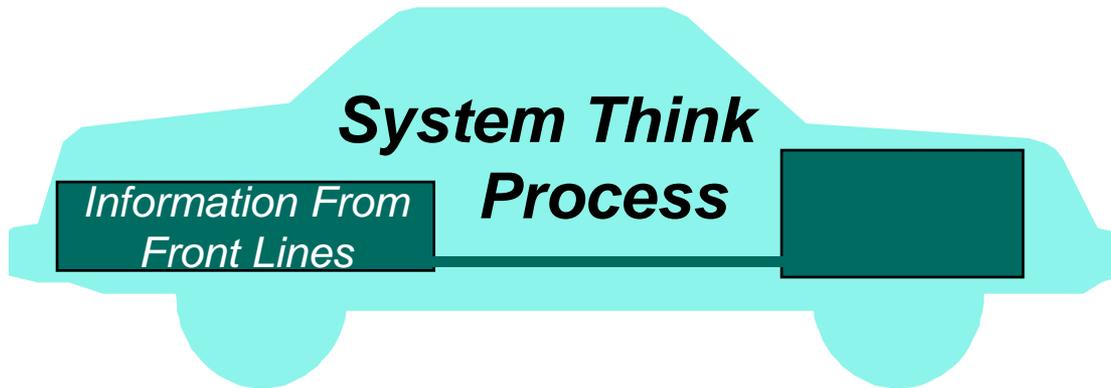
- **Conventional Wisdom:**

Improvements that reduce risk usually
also reduce productivity

- **Lesson Learned from Proactive Aviation Safety Information Programs:**

Risk can be reduced in a way that also results in
immediate productivity improvements

Process Plus Fuel Creates A Win-Win



Outline

- **The Context**
- **Importance of “System Think”**
- **Importance of Better Information**
- **Safety Benefits**
- **Productivity Benefits**
- **Aviation Successes and Failures**
- **The Role of Leadership**

The Context: Increasing Complexity

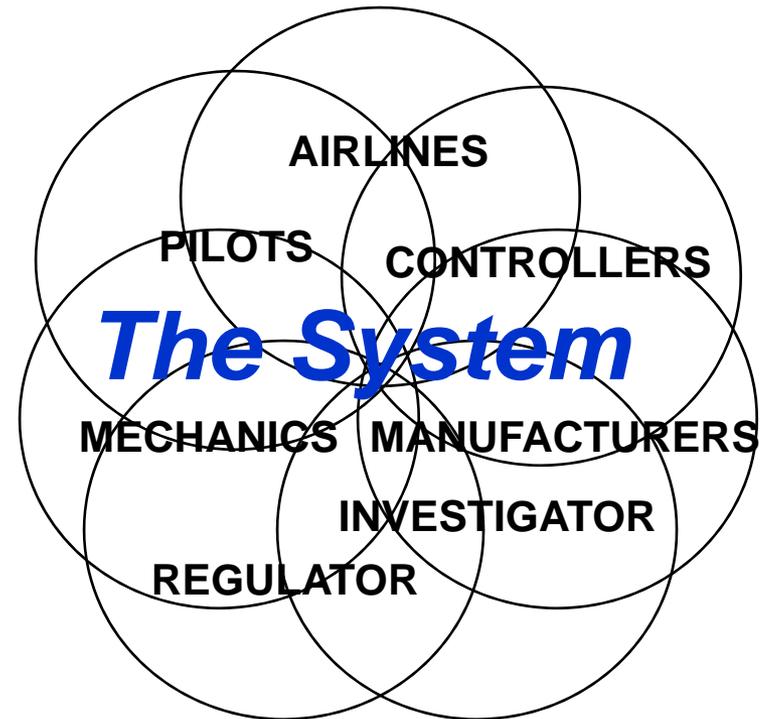
- **More System**

 - *Interdependencies*

 - Large, complex, interactive system
 - Often tightly coupled
 - Hi-tech components
 - Continuous innovation
 - Ongoing evolution

- **Safety Issues Are More Likely to Involve**

 - *Interactions Between Parts of the System*



Effects of Increasing Complexity:

More “Human Error” Because

- **System More Likely to be Error Prone**
- **Operators More Likely to Encounter Unanticipated Situations**
- **Operators More Likely to Encounter Situations in Which “By the Book” May Not Be Optimal (“workarounds”)**

The Result:

Front-Line Staff Who Are

- Highly Trained
- Competent
- Experienced,
- Trying to Do the Right Thing, and
- Proud of Doing It Well

... Yet They Still Commit

**Inadvertent
Human Errors**

When Things Go Wrong

How It Is Now . . .

You are highly trained
and

If you did as trained, you
would not make mistakes

so

You weren't careful
enough

So

You should be

PUNISHED!

How It Should Be . .

You are human
and

Humans make mistakes
so

Let's *also* explore why
the system allowed, or
failed to accommodate,
your mistake

and

Let's **IMPROVE THE
SYSTEM!**

Fix the Person or the System?

Is the **Person**
Clumsy?

Or Is the
Problem . . .

The ***Step???***



Enhance Understanding of Person/System Interactions By:

- Collecting,**
- Analyzing, and**
- Sharing**

Information

Objectives:

Make the System

***(a) Less
Error Prone***

and

***(b) More
Error Tolerant***

The Health Care Industry

To Err Is Human:

Building a Safer Health System

“The focus must shift from blaming individuals for past errors to a focus on preventing future errors by designing safety into the system.”

Institute of Medicine, Committee on Quality of Health Care in America, 1999

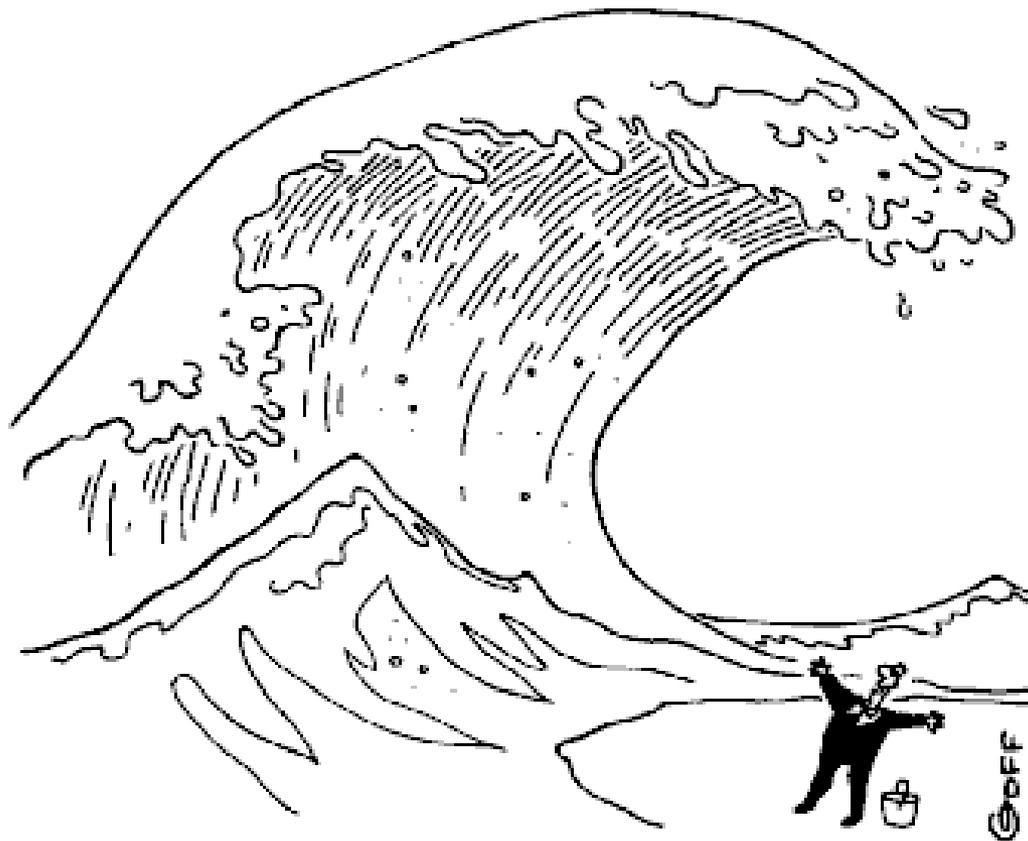
**Major Source of Information:
Hands-On “Front-Line” Employees**

**“We Knew About
That Problem”**

***(and we knew it might hurt
someone sooner or later)***

Information Overload

© 1996 Ted Goff



"EUREKA! MORE INFORMATION!"

From Data to Information

Tools and processes to convert large quantities of data into useful information

Data Sources

Info from front line staff and other sources

DATA



Analysts

USEFUL

INFORMATION

Smart Decisions

- Identify issues
- **PRIORITIZE!!!**
- Develop solutions
- Evaluate interventions

Tools



Processes

Aviation Success Story

65% Decrease in Fatal Accident Rate,
1997 - 2007

largely because of
System Think

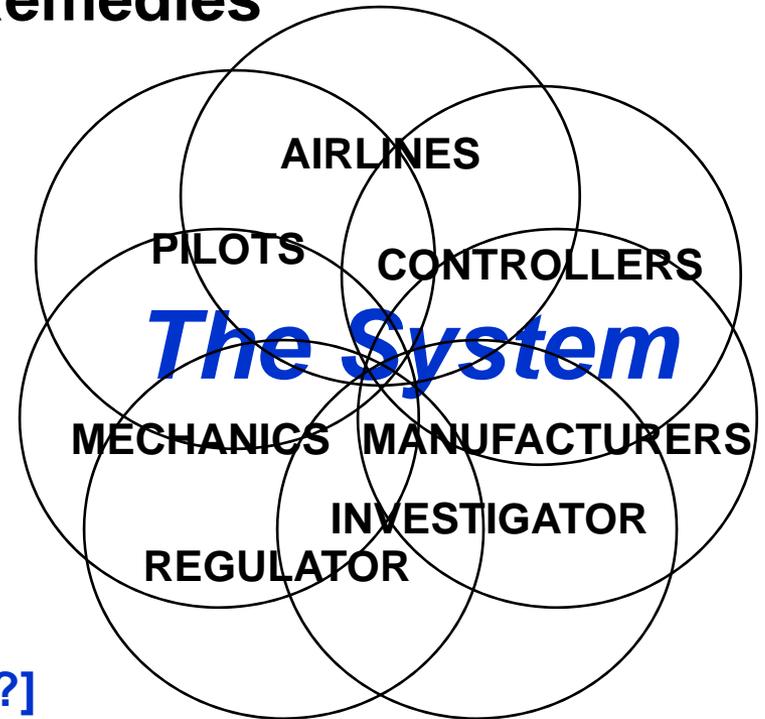
fueled by
***Proactive Safety
Information Programs***

P.S. Aviation was already considered **VERY SAFE** in 1997!!

Aviation “System Think” Success

Engage All Participants In Identifying Problems and Developing and Evaluating Remedies

- Airlines
- Manufacturers
 - *With the systemwide effort*
 - *With their own end users*
- Air Traffic Organizations
- Labor
 - *Pilots*
 - *Mechanics*
 - *Air traffic controllers*
- Regulator(s) **[Query: Investigator(s)?]**



Major Paradigm Shift

- **Old: The regulator identifies a problem, develops solutions**
 - Industry skeptical of regulator’s understanding of the problem
 - Industry fights regulator’s solution and/or implements it begrudgingly
- **New: Collaborative “System Think”**
 - Industry involved in indentifying problem
 - Industry “buy-in” re solution because everyone had input, everyone’s interests considered
 - Prompt and willing implementation
 - Solution probably more effective and efficient
 - Unintended consequences much less likely

Challenges of Collaboration

- Requires all to be willing, in their enlightened self-interest, to leave their “comfort zone” and think of the System
- Not a democracy
 - Regulator must regulate
- Regulator probably not welcome
- Labor/Management issues between some participants
- Participants are potential co-defendants

TRUST

Applicability of Collaborative Approach:

- **Entire Industry**
- **Company (Some or All)**
- **Type of Activity**
- **Facility**
- **Team**

Manufacturer “System Think” Success

Aircraft Manufacturers are Increasingly Seeking Input, Throughout the Design Process, From

- ***Pilots*** (***User*** Friendly)
- ***Mechanics*** (***Maintenance*** Friendly)
- ***Air Traffic Services*** (***System*** Friendly)

Process Plus Fuel Can Produce An Amazing Win-Win



Not Only Improved Safety, But Improved Productivity, Too

- **Ground Proximity Warning System**
 - *S: Reduced warning system complacency*
 - *P: Reduced unnecessary missed approaches, saved workload, time, and fuel*
- **Flap Overspeed**
 - *S: No more potentially compromised airplanes*
 - *P: Significantly reduced need to take airplanes off line for **VERY EXPENSIVE (!!) disassembly, inspection, repair, and reassembly***

But Then . . .

Why Are We

So Jaded in The Belief That

Improving Safety

Will Probably

Hurt The Bottom Line??

Costly Result\$ Of Safety Improvements Poorly Done

Safety *Poorly* Done

1. Punish/re-train operator
 - *Poor workforce morale*
 - *Poor labor-management relations*
 - *Labor reluctant to tell management what's wrong*
 - *Retraining/learning curve of new employee if "perpetrator" moved/fired*
 - *Adverse impacts of equipment design ignored, problem may recur because manufacturers are not involved in improvement process*
 - *Adverse impacts of procedures ignored, problem may recur because procedure originators (management and/or regulator) are not involved in improvement process*

Safety *Well* Done

Look beyond operator,
also consider system
issues

Costly Result\$ Of Safety Poorly Done (con't)

Safety *Poorly* Done

2. Management decides remedies unilaterally

- *Problem may not be fixed*
- *Remedy may not be most effective, may generate other problems*
- *Remedy may not be most cost effective, may reduce productivity*
- *Reluctance to develop/implement remedies due to past remedy failures*
- *Remedies less likely to address multiple problems*

3. Remedies based upon instinct, gut feeling

- *Same costly results as No. 2, above*

Safety *Well* Done

Apply “System Think,” *with workers*, to identify and solve problems

Remedies based upon evidence (including info from front-line workers)

Costly Result\$

Of Safety Poorly Done (con't)

Safety *Poorly* Done

4. Implementation is last step

- *No measure of how well remedy worked (until next mishap)*
- *No measure of unintended consequences (until something else goes wrong)*

Safety *Well* Done

Evaluation after implementation

Conclusion: Is Safety Good Business?

- *Safety implemented poorly can be **very costly (and ineffective)***
- *Safety implemented well, in addition to improving safety more effectively, can also **create benefits greater than the costs***

The Role of Leadership

- Demonstrate Safety Commitment . . .

But Acknowledge That Mistakes Will Happen

- Include “Us” (e.g., System) Issues,
Not Just “You” (e.g., Training) Issues

- Make Safety a Middle Management Metric

- Engage Labor Early

- Include the ***System*** --

Manufacturers, Operators, Regulator(s), and Others

- Encourage and Facilitate Reporting

- Provide ***Feedback***

- Provide Adequate ***Resources***

- ***Follow Through*** With Action

Thank You!!!



Questions?