

A near miss or deeper concerns?

The other day I was grabbed by a headline that read; aviation wrestles with decades-old problems which led me to recall issues discovered as a result of the Nimrod accident¹ in 2006; the enquiry “...uncovered matters which are as surprising as they are disturbing” and further concluded “There has been a yawning gap between the *appearance and reality* of safety”. A recently published report into an aviation near miss, that took place in 2018, serves as another reminder of what we face each day; some would say, on this occasion, we dodged a bullet.

This latest report revealed little in the way of surprises and showed the fairly typical case of an organisation, fuelled by social dynamics and enterprise influences, slowly drifting to a place where a negative outcome was highly likely. The broader aspects contributory to this event, I feel, did not receive the same level of scrutiny afforded to the Maintenance facility [an EASA Part 145² approved organisation] and we can only hope that if we are to truly see aviation as one system going forwards, this will need to be reflected in future analysis.

We can all pour over the findings of this particular report, read what wasn't done at an operational and tactical level then simply refer to the recommendations; in this case, unsurprisingly they read like a copy of EASA Part 145 with the added point of the need for an effective SMS. I say unsurprisingly as the mantra like “need an effective SMS” and continued scrutiny of well-rehearsed drift from standards has become customary and here we are again. It is worth reiterating, the random yet rare nature of negative events, shaped by multiple factors, context and complexity are not reserved for ‘bad’ organisations just as the absence of a negative event is not necessarily deserving of a ‘good’ organisation. We know this, it's not new, so does that therefore, in this age of data and analysis, beg a different set of questions to be asked?

Flight Global published an interesting article³, in relation to the event, containing a quote that I feel sums up where we are and I share it with you now; in response to the finding that the organisation did not have a fully implemented Safety Management System [SMS] it stated that it is “not legally required to do so” further adding that work had started on implementation [since the event] and cannot be deemed to have had any impact on the incident. Let's be clear, the view point regarding the need for a SMS is not limited to the organisations involved and as such, I wish to soften the focus on the details of this particular event.

Having assisted organisations who are ‘waiting for the regulation’ many of those face the very same issues highlighted in the accident report and yet appear to see SMS as something else that will solve their issues which is both curious and a cause for concern. Given the vast overlap between aviation SMS and in the case of the UK, the Health and Safety at Work act [4], a robust argument exists that a majority of the regulatory obligations for safety already exist with latter being well established. Yet more significantly, if the lever of a specific regulation is needed, EASA Part 145, in this case, is one of the most mature, stable and upto date regulations within the European regulatory space. Updated in 2006 and with much of the work of the JAAHFWG [5] making its way into the requirements, it became the leading light with respect to modern day safety management. Many of the elements required by ‘SMS’ including human performance, attitudes and culture are baked into EASA Part 145; they are inherent in the very fabric of the rule which itself sits underneath a higher requirement for *all* EASA approved organisations to have a management system and demonstrate continuous improvement. I would go so far to say that EASA Part 145 already obliges you to adopt those elements required to satisfy SMS or to put it another way, effectively manage those aspects that are essential to aviation safety and it has done so for over 14 years.

Yet the JAAHFWG report is hardly known about, rarely spoken of and the *intent* of EASA Part 145 is rarely satisfied consistently; operations continue and all too often, as this event demonstrates, the organisation starts to drift. The warning signs [the *smaller* reminders] can be easily hidden and, with a belief that the often audited organisation is in a good place, a harsh lesson becomes more likely. If you wish to use safety risk language, hazards were not being addressed, safety risk was going up and no one was shouting about it. Yet no regulation of any sort can cater for the willingness to adopt such measures; these are the ethical and cultural aspects that have to come from within.

Hey look, it's not easy and many pressures exist, are likely to remain for some time or get even worse. We are deep into this SMS era yet we appear to be suffering the very same problems we did prior; problems that SMS should be addressing so we have to acknowledge the challenge⁷. Organisations need support from all aspects of the aviation system to make this work and contribute to business success. This event however goes much deeper than the maintenance error and the contribution from both the Flight Operation organisation and its associated CAMO⁶. More broadly, there are questions regarding oversight, robust understanding of existing obligations and, interpretation of what constitutes an SMS along with clarity of objectives⁷.

Yet, it does feel that we are at a crossroads; if SMS is to deliver, not only against the objectives, but against the promised benefits to the broader enterprise then we must find the courage to pose different questions, more strategic in nature and we must be prepared to be intensely curious and get behind the issues we have faced for years as they don't appear to be going away in a hurry.

References

1. The Nimrod review. <https://www.gov.uk/government/publications/the-nimrod-review>
2. EASA part 145. The regulatory requirements for aircraft maintenance; since 2006, contains a majority of the elements required by 'SMS'. Shaped by the JAA Human Factors working group; meet the *intent* of Part 145 consistently and you significantly satisfy your reasonably practicable obligations and reduce the chance of harm to the flight operation; thereby meeting objective of safety risk management.
3. <https://www.flightglobal.com/safety/maintenance-firm-clashes-with-inquiry-over-severe-e190-loss-of-control-incident/139033.article>
4. Health and Safety at Work etc Act 1974. The primary piece of legislation covering occupational health and safety in Great Britain. It's sometimes referred to as HSWA, the HSW Act, the 1974 Act or HASAWA. It sets out the general duties which employers have towards employees and members of the public, employees have to themselves and to each other and certain self-employed have towards themselves and others. Similar overlaps exist in countries with established occupational health obligations eg New Zealand AC100-1 and Health and Safety at Work Act.
5. JAAHFWG. Joint Aviation Human Factors Working Group. Created to develop a series of initiatives, including the taking into consideration of Human Factors in Operations, Certification and Maintenance.
6. CAMO. Continuing Airworthiness Management Organisation. EASA Part CAMO contains the requirements to be met by an organisation to manage the continuing airworthiness of an aircraft and its components.
7. Additional reading. <https://www.linkedin.com/pulse/safety-risk-management-missing-biggest-all-neil-richardson>