21st European Airline Training Symposium

8-9 November 2023

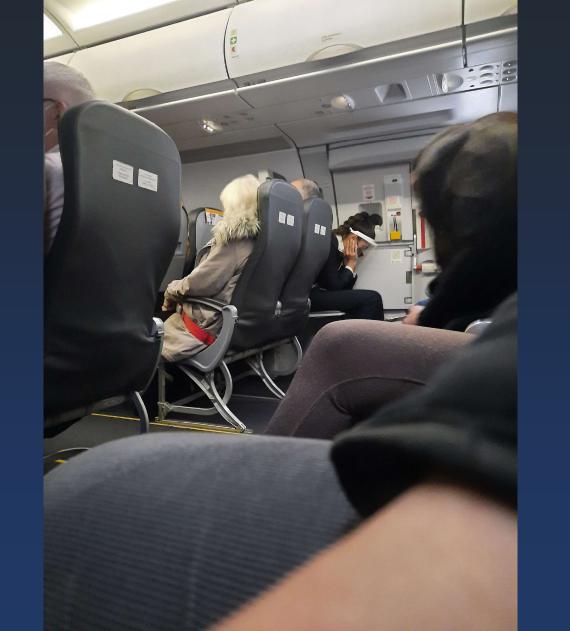
Estoril Congress Centre, Cascais, Portugal

Transforming Recurrent Training by Gathering Safety Intelligence for your SMS

Cengiz Turkoglu

Safety & Accident Investigation Centre







"I've never learned anything from anyone who agreed with me"

PLEASE DO CHALLENGE MY ARGUMENTS

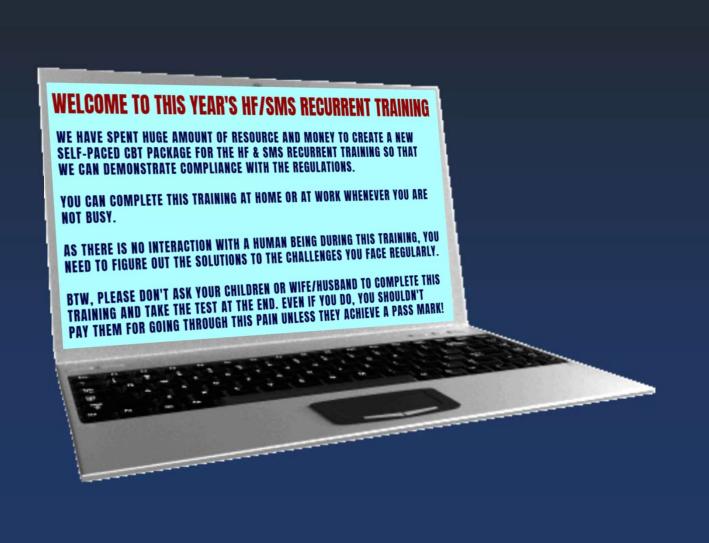
MY PERSONAL OBSERVATION ABOUT THE CURRENT STATE OF THE COMMERCIAL AIR TRANSPORT INDUSTRY

DESPITE SOME FANTASTIC TRAINING PROGRAMMES DEVELOPED OVER THE YEARS AND DECADES AND STILL CURRENTLY DELIVERED TODAY,

NOWADAYS <u>SOME</u> ORGANISATIONS SEEM TO HAVE CONTRACTED A

DEADLY DISEASE!

"SELF-PASED ONLINE/CBT FOR CRM/SMS TRAINING"



WELCOME TO THIS YEAR'S HF/SMS RECURRENT TRAINING

WE HAVE SPENT HUGE AMOUNT OF RESOURCE AND MONEY TO CREATE A NEW SELF-PACED CBT PACKAGE FOR THE HF & SMS RECURRENT TRAINING SO THAT WE CAN DEMONSTRATE COMPLIANCE WITH THE REGULATIONS.

YOU CAN COMPLETE THIS TRAINING AT HOME OR AT WORK WHENEVER YOU ARE NOT BUSY.

AS THERE IS NO INTERACTION WITH A HUMAN BEING DURING THIS TRAINING, YOU NEED TO FIGURE OUT THE SOLUTIONS TO THE CHALLENGES YOU FACE REGULARLY.

BTW, PLEASE DON'T ASK YOUR CHILDREN OR WIFE/HUSBAND TO COMPLETE THIS TRAINING AND TAKE THE TEST AT THE END. EVEN IF YOU DO, YOU SHOULDN'T PAY THEM FOR GOING THROUGH THIS PAIN UNLESS THEY ACHIEVE A PASS MARK!

ONE SIMPLE IDEA TO ADDRESS THREE CHALLENGES



YOU, TRAINERS CAN MAKE A REAL IMPACT!



three separate safety issues one potential solution

HAZARDS / RISKS / SAFETY ISSUES

→ **REMINDER - Hazard:** A condition or an object with the potential to cause or contribute to an aircraft incident or accident. (ICAO Annex 19)

HAZARDS	CONTRIBUTING FACTORS	POTENTIAL ROOT CAUSES
Under-reporting	Lack of fear (Just Culture) Ease of reporting Nothing happens, why should I bother? Lack of time, when am I going to report?	Organisational Culture Peer pressure Leadership's attitude
Limited / Lack of monitoring culture (weak signals) in an organisation	Too much driven by compliance To much focus on significant events	Inevitable pressure to maintain approvals Risk perception (Risk Homeostasis)
Ineffective recurrent training due to minimal or lack of interaction (i.e. computer based training becoming norm)	Achieve compliance (following syllabus)	Training seen as a non-productive activity rather than opportunity to capture feedback from employees

THREE KEY CHALLENGES

Limited
Utility of
Safety
Culture
Surveys

Limited interaction in training

"Weak Signal Detection'
'Learning from All Operations'

A
PROPOSITION
TO ADDRESS
ALL THREE
CHALLENGES

CONTINUOUS MONITORING OF SAFETY/RISK CULTURE IN THE ORGANISATION

- CONTINUALLY CAPTURE 'LIVED EXPERIENCES' OF FRONTLINE OPERATORS DURING RECURRENT TRAINING SESSIONS
- ENABLE THE PARTICIPANTS TO ANALYSE THEIR OWN STORIES (CRUCIALLY IMPORTANT!) AND USE THE ORGANISATIONAL RISK BEHAVIOUR FRAMEWORK
- FEED THAT SAFETY INTELLIGENCE TO SMS TO ACHIEVE ORGANISATIONAL LEARNING

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TRANSFORM YOUR RECURRENT TRAINING SESSIONS TO MONITOR YOUR SAFETY/RISK CULTURE & ENABLE ORGANISATIONAL LEARNING



2017 2nd RISK CULTURE SURVEY IN CAT INDUSTRY

2018 DEVELOPMENT OF ORGANISATIONAL RISK BEHAVIOUR FRAMEWORK

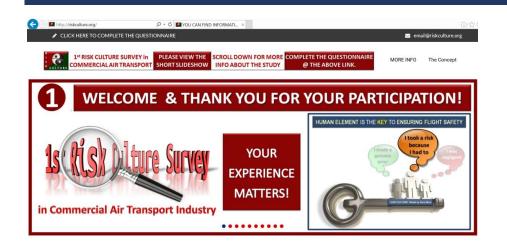
2021 COLLABORATIVE STUDY (BALPA, CRANFIELD, COGNITIVE EDGE) VALIDATION OF FRAMEWORK

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2021 COLLABORATIVE STUDY (BALPA, CRANFIELD, COGNITIVE EDGE) VALIDATION OF FRAMEWORK

INDUSTRY-WIDE SURVEYS IN 2016 & 2017



www.riskculture.org email@riskculture.org

FOCUS ON TWO FUNDAMENTAL QUESTIONS

- & SUB-QUESTIONS

 1. Risk Decision Making
- A scenario & decision on most significant 'accepted/acceptable risk'
- 2. Factors encouraging / discouraging people to take such safety risks.

Individual vs Organisational

A scenario & decision on most significant 'unacceptable/rejected risk'

OPERATIONAL TARGETS & RISK TAKING

2016

Operational targets (such as 'on-time performance', 'availability', 'technical dispatch reliability'), can encourage pilots, engineers and their managers to take **SIGNIFICANT** risks potentially impacting on flight safety.

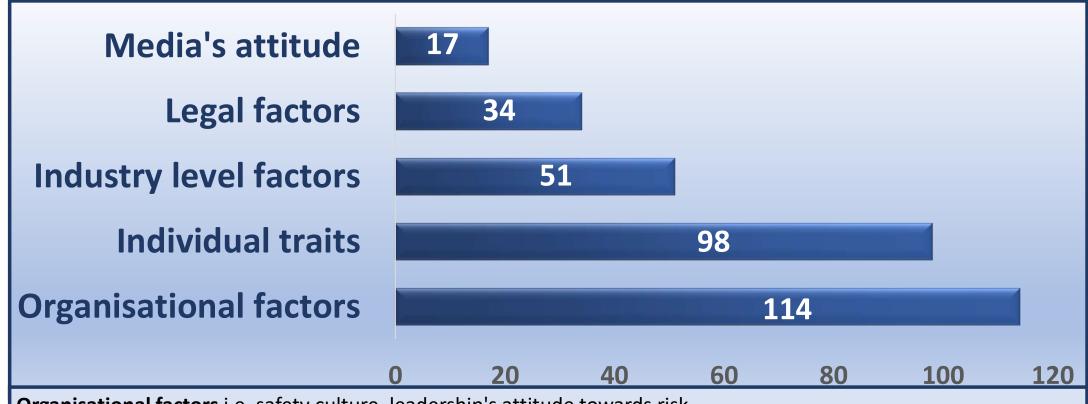
2017

Operational targets (such as 'on-time performance', 'availability', 'technical dispatch reliability'), can encourage "EXCESSIVE' / 'UNNECESSARY' risk taking behaviour impacting on flight safety.

You may not necessarily agree with this statement. For example, some people argue that nowadays, particularly professionals (pilots & engineers/technicians) in large organisations do not have much discretion any more and considering the strict rules and regulations, they really cannot take any risks. However the counter argument is that there will always be circumstances that a pilot or engineer/technician must use judgement based on his/her technical knowledge and perception of risk before making a decision such as releasing or accepting an aircraft to service.

	2016 (n=165)		2017 (n=123)	
Strongly Disagree / Disagree	30	18%	16	13%
Neither Agree Nor Disagree	33	20%	20	16%
Strongly Agree / Agree	102	62 %	87	71%

FACTORS ENCOURAGING RISK TAKING



Organisational factors i.e. safety culture, leadership's attitude towards risk Individual traits i.e. 'can do' attitude or 'thrill seeking'

Industry level factors i.e. policies, growth in the industry, competition

Legal factors i.e. litigation, unrealistic expectations about passenger rights legislation

Media's attitude i.e. victimisation of individuals who make mistakes

2016 1st RISK CULTURE SURVEY IN CAT INDUSTRY
2017 2nd RISK CULTURE SURVEY IN CAT INDUSTRY

2018 DEVELOPMENT OF ORGANISATIONAL RISK BEHAVIOUR FRAMEWORK

2021 COLLABORATIVE STUDY (BALPA, CRANFIELD, COGNITIVE EDGE) VALIDATION OF FRAMEWORK

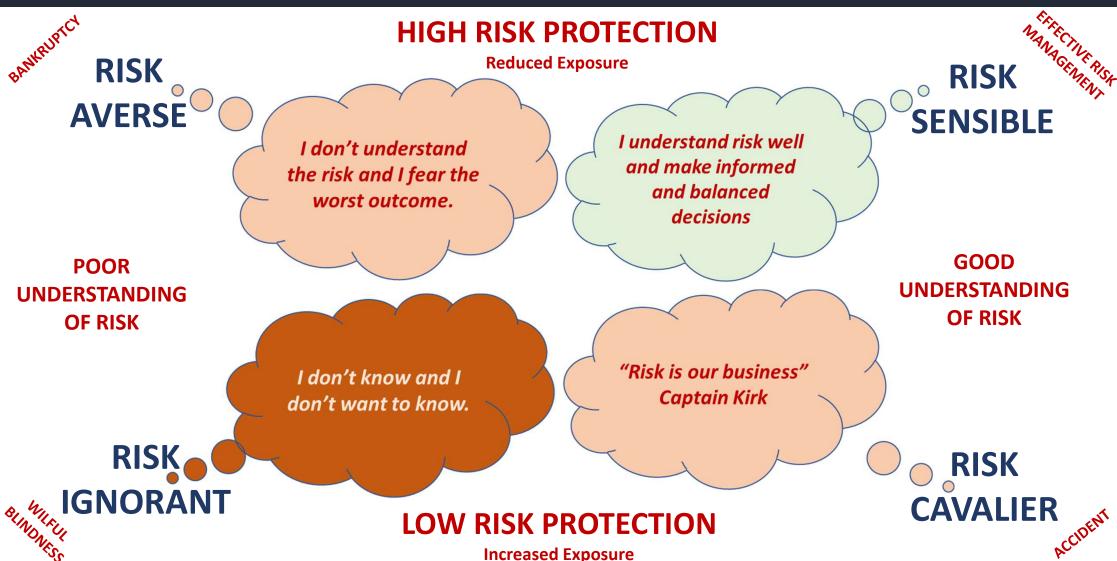
2016 • 1st RISK CULTURE SURVEY IN CAT INDUSTRY
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2018 DEVELOPMENT OF ORGANISATIONAL RISK BEHAVIOUR FRAMEWORK

2021 COLLABORATIVE STUDY (BALPA, CRANFIELD, COGNITIVE EDGE) VALIDATION OF FRAMEWORK

TYPOLOGY OF ORGANISATIONAL RISK BEHAVIOUR

Based on the concept of "Four States of Man" coined by Hon. Lord Justice Charles Haddon-Cave



THE AIM IS NOT TO LABEL ANY INDIVIDUAL, DEPARTMENT, PROFESSIONAL GROUP OR THE ENTIRE ORGANISATION BASED ON THIS FRAMEWORK

THE AIM IS TO IDENTIFY OPERATIONAL RISK DECISIONS AND BY DIALOGUE TO CREATE A COMMON UNDERSTANDING OF RISK AND MOVE TOWARDS A 'RISK SENSIBLE' POSITION.

2016 • 1st RISK CULTURE SURVEY IN CAT INDUSTRY
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11 November 2023

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2021 COLLABORATIVE STUDY (BALPA, CRANFIELD, COGNITIVE EDGE) VALIDATION OF FRAMEWORK

11 November 2023 36



A Collaborative Study





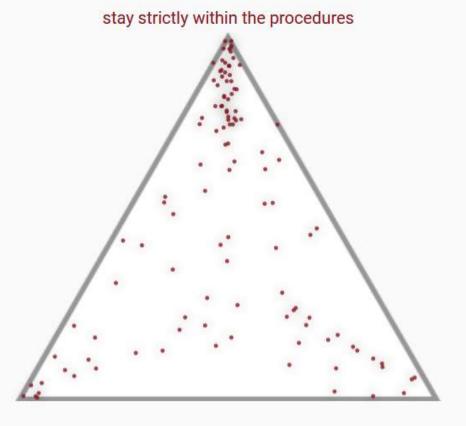




FIRST SHARE YOUR 'LIVED EXPERIENCE' THEN ANALYSE YOUR OWN STORY BY ANSWERING UNIQUE QUESTIONS

Results of the 'Making Sense of Aviation' Study

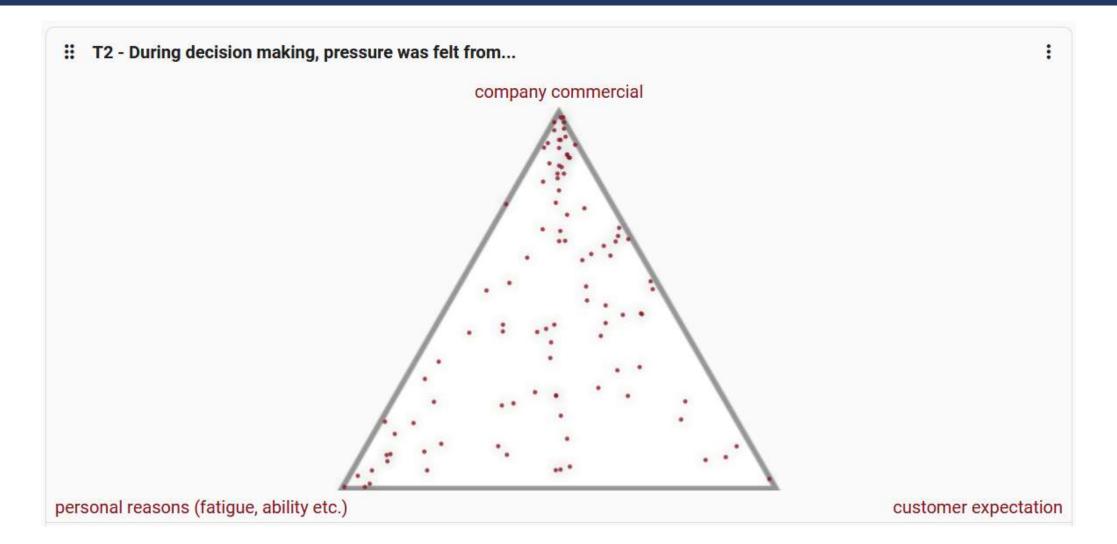
T3 - In this situation we chose to...



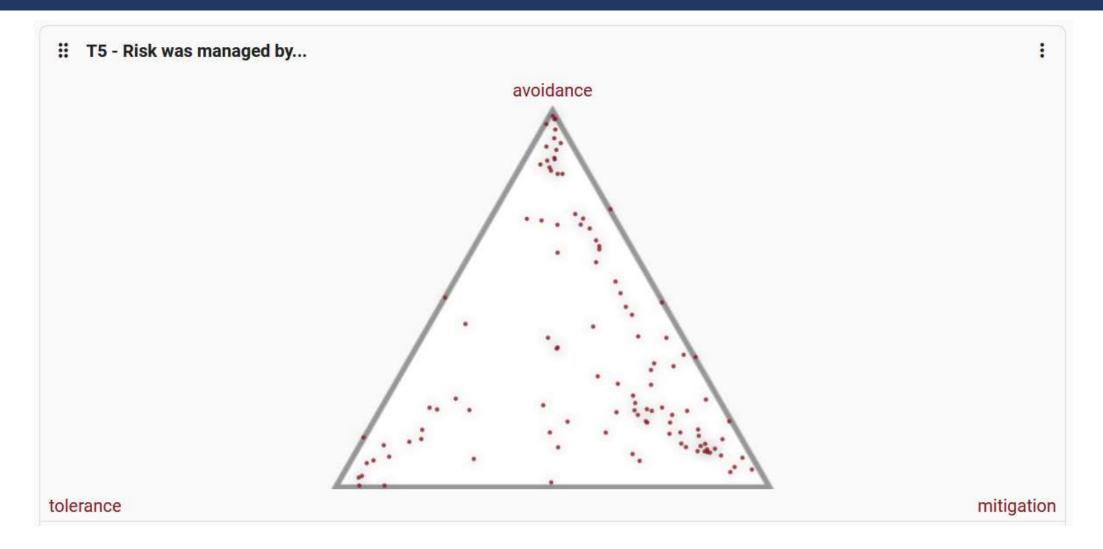
deviate slightly from procedures

use a novel solution

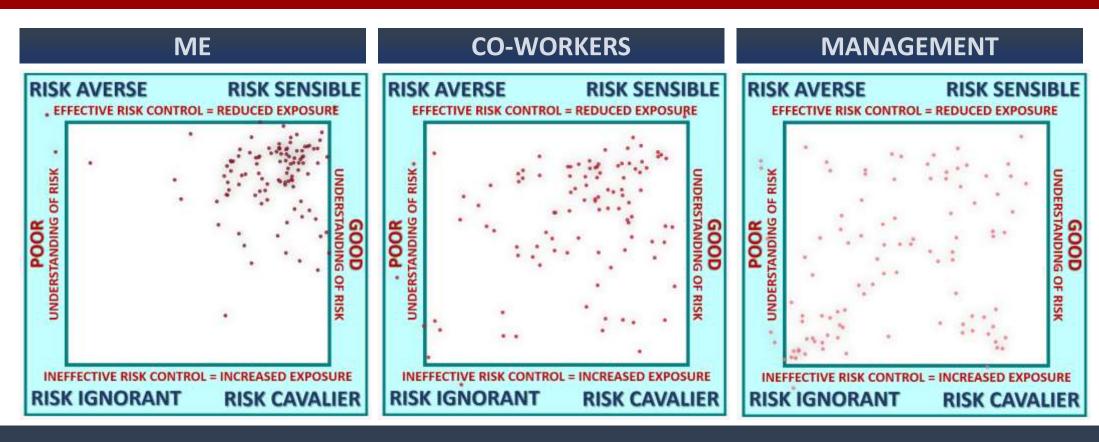
Results of the 'Making Sense of Aviation' Study



Results of the 'Making Sense of Aviation' Study



RISK AS ANALYSED/ASSESSED vs RISK AS MANAGED/TOLERATED



Data was collected between May 2021 and Jan 2022 as part of a collaborative study between BALPA, Cognitive Edge and Cranfield University.

A total of 125 pilots responded and shared their operational experiences about complex scenarios they faced during the pandemic.



www.pollev.com/eats2023

RESPONSES GIVEN BY THE PARTICIPANTS DURING THE PRESENTATION



retention shortage complacency incidents knowledge staffcustomer abnormal balancing hours leading sopbattery turbulence lack focus leading risk culture fatigue nruly standards service pressuretime fire paxcabinnon awareness in experienced lithium (otp) crazy paxcabinnon awareness in experienced company disruptive passengers high year recruitment behaviour passenger adherence situational inexperience maintaining round training

Unruly pax Shortage of crew leading to fatigue

Unruly pax Situational awareness

Inexperienced Crew Turbulence

Fatigue Risk

Abnormal passenger behaviour Lithium fire Lack of knowledge year round Turbulence Crazy flying hours:) Unruly Pax

Retention

Complacency

Non-adherence to sop

Disruptive passengers

Company culture

Disruptive passenger incidents and balancing training with time

Cabin battery fire

Inexperience

Recruitment

Unruly

Unruly passengers

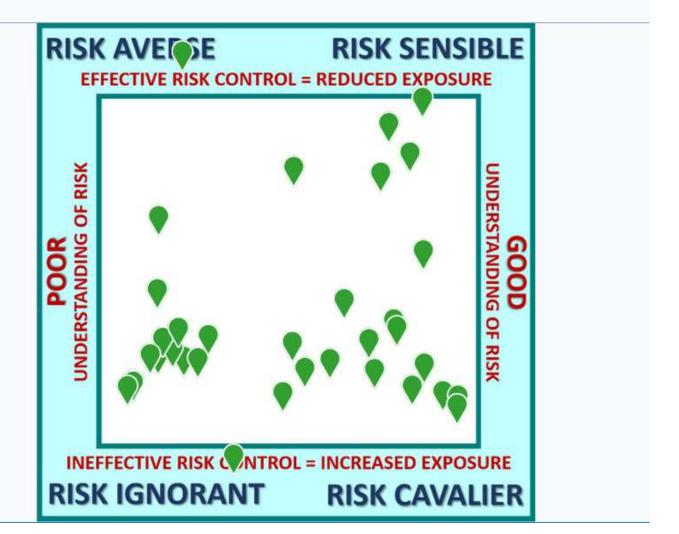
Lack of staff

The pressure of on time performance (OTP) and high customer service standards versus focus on maintaining safety standards

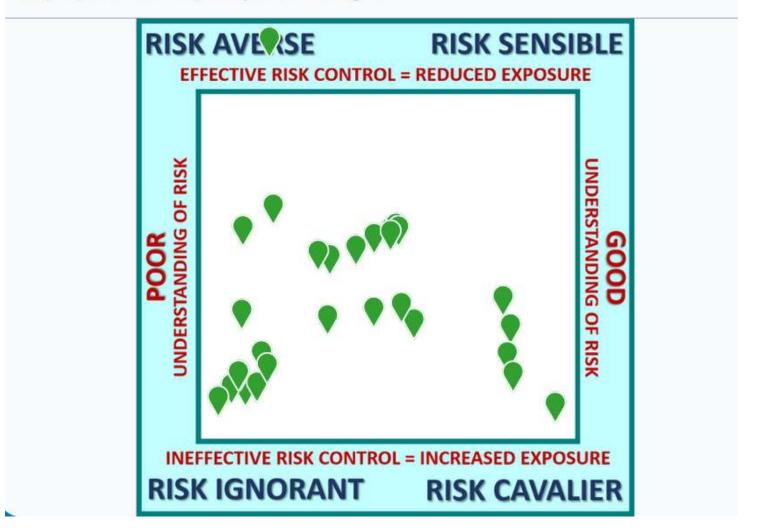
Unruly passengers

Turbulence

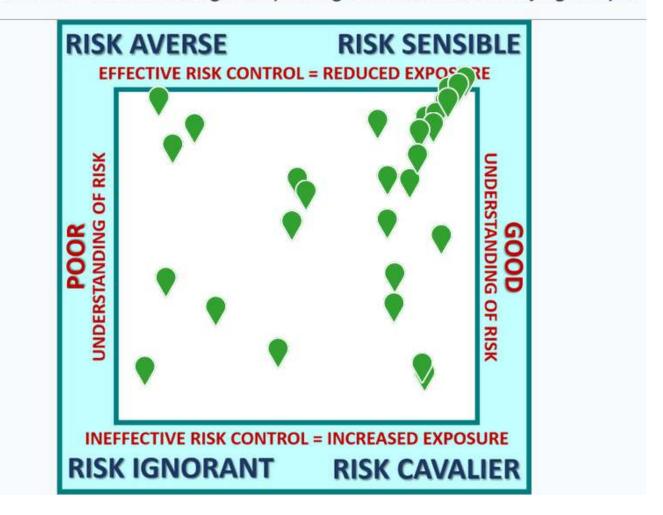
Starting pushback/taxiing before all passengers are seated and fastened their seatbelts.



A member of crew woke up having only slept 2 hours, but could not report unfit. So they reported for duty and joined the flight.



During taxiing, cabin was secured and the flight deck was notified. The aircraft started take-off roll and a passenger got up and tried to reach the overhead bin. The cabin crew tried to intervene and get the passenge to sit instead of notifying cockpit.

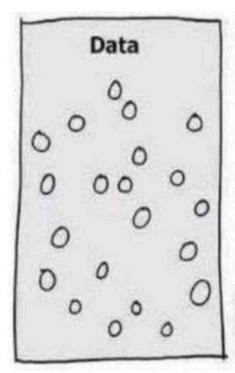


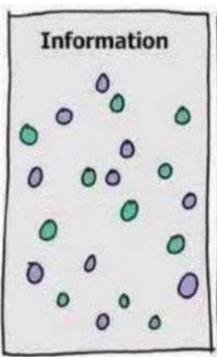
KEY TAKEAWAYS

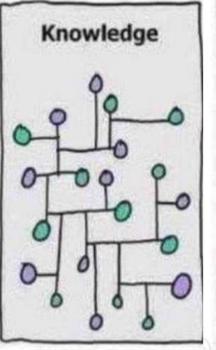
DETECTING WEAK SIGNALS IN A COMPLEX SOCIOTECHNICAL ECO SYSTEM IS IMPORTANT

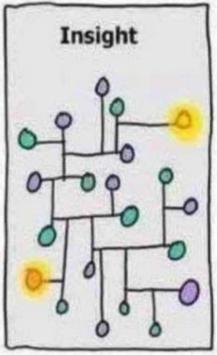
TRANSFORMING SAFETY DATA INTO SAFETY WISDOM

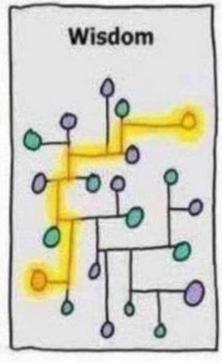
OUR AIM SHOULD BE TO ACHIEVE WISDOM











WE NEED TO AVOID ANALYSIS PARALYSIS

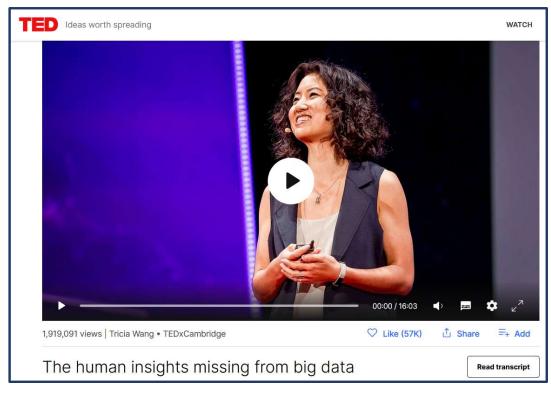
BIG DATA vs THICK DATA vs RICH DATA

If You Torture the Data Long Enough, It Will Confess to Anything

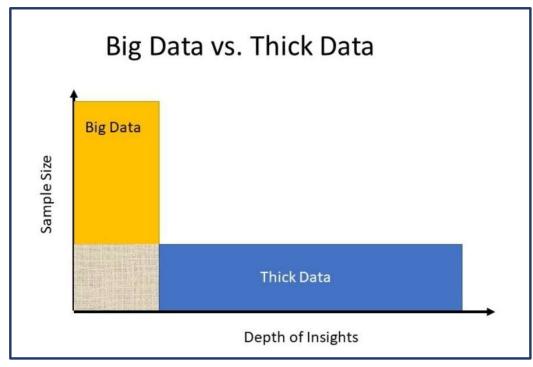
Ronald Coase? Irving John Good? Charles D. Hendrix? Robert W. Flower? Bulent Gultekin? Anonymous?

Source: https://quoteinvestigator.com/2021/01/18/confess/

BIG DATA NEEDS THICK DATA - ETHNOGRAPHY



https://www.ted.com/talks/tricia_wang_the_human_insights_missing_from_big_data?language=en



https://www.linkedin.com/pulse/thick-data-vs-big-ahmed-banafa/



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Weak Signals Approach to ANSP Safety Performance

Introduction

"Creating foresight", "anticipating future threats" and "how to be prepared for possible future surprises" are fundamental issues in managing today's complex socio-technical systems. Traditional safety approaches use after-the-event data to evaluate the organisation's safety level. This is based on the theoretical understanding that safety is seen as the absence of unwanted consequences. Consequently, managing safety is seen as the avoidance or elimination of negative outcomes. This safety approach follows the credo of improving safety by learning from errors and mishaps. Organisations with this understanding may learn from past events, but hardly pro-actively anticipate future threats.

In the current complex socio-technical systems, traditional theories of safety that follow a structural view and focus only on the negative limit the understanding of the interactive complexity and dynamics are inherent in such systems. Only finding and counting human errors, failures or breakdowns is no appropriate way to get a better insight of how today 's systems work and possibly fail. A better understanding of the interactions and couplings of system components is necessary.

The following presentation illustrates the traditional approach of managing safety.

Article Information Category: Organisation and Human Performance Content source: SKYbrary Content control: SKYbrary SKYbrary SKYbrary

2014





2021



Patterns in How People Think and Work

Importance of Patterns Discovery for Understanding Complex Adaptive Systems

2022



Unearthing Weak Signals for safer and more efficient socio-technical systems

The Structured Exploration of Complex Adaptations (SECA) method



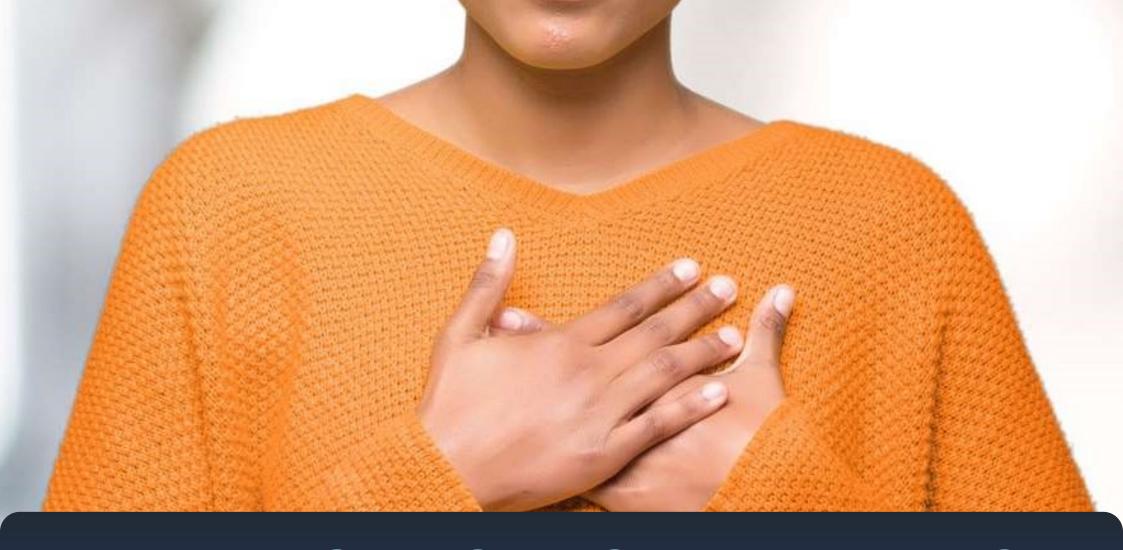
DO YOU HAVE **A STORY** TO TELL ABOUT **EXCESSIVE OR** UNNECESSARY RISK TAKING



PLEASE DO GET IN TOUCH I AM HERE TO LISTEN



www.riskculture.org email@riskculture.org



THANK YOU FOR YOUR ATTENTION