Example of decision-making and processing of occurrence reports and events in an organisation – CASE GREEN

Page 1 contains an example of a ground handling organisation and an event that led to the occurrence report filed by the flight crew and the ground handling organisation's loading personnel and the processing of the event by the ground handling organisation as described below. Both the organisations and the event and related examples are fictitious. However, they represent realistic situations and operations models. **CASE GREEN** is an example of **CONFIDENTIAL** and **SOLUTION-ORIENTED** processing in the spirit of **JUST CULTURE** and **GOOD SAFETY CULTURE**. The organisation **GENUINELY RECOGNISES ITS ROLE** in the problem-solving process and utilises the experience as an SMS source in its risk management and safety management. The authors of the occurrence report are given **PROPER FEEDBACK** about the progress of the process. Risk management measures targeting an individual are **JUSTIFIED IN A GENUINE AND HONEST MANNER** (e.g. possible additional training).

Page 2 describes how the processing of the case progresses and defines the decision-making points at different organisational levels. Page 1 contains further information for the decision-making points on page 2. The chart on page 2 is derived from Patrick Hudson's decision-making chart *(GAIN working group - Roadmap to a Just Culture - Enhancing the Safety Environment, 1997).* The chart was modified on the basis of authorisation given by *Global Aviation Information Network* in the document in question *("Derived from a document for which permission to reprint was given by the Global Aviation Information Network")*. The chart focuses on utilising safety information produced by personnel in the organisation's safety management (SMS processing).

CASE: LOADING ERROR

INFORMATION ABOUT THE ORGANISATION: Flight Helsinki-Malmi (HEM) – Stockholm Bromma (BMA) – Oslo Fornebu (FBU).

INCIDENT D DESCRIPTION BASED ON THE OCCURRENCE REPORT PREPARED BY THE FLIGHT CREW AND BMA'S GROUND HANDLING PERSONNEL PROVIDED BY THE AIRLINE: The pilots suspect the centre of gravity is incorrect during take-off and notify their own company's personnel after take-off, who look into how the aircraft was loaded. The aircraft was trimmed according to the values given but the nose of the aircraft became lighter too early at the rotation stage.

Planned loading: FBU (freight 1,000 kg and 40 bags/560 kg) in front hold number 1 and BMA (mail 300 kg and 50 bags/700 kg) in rear hold number 3. There was moderate crosswind during landing in Bromma. The pilot noticed that the aircraft's behaviour was abnormal.

After landing, the ground handling company noticed that the Oslo load had not been loaded at Helsinki-Malmi and the Bromma goods had been incorrectly placed in hold number 4. The flight was operated in bulk configuration, i.e. without containers. It was detected that the aircraft's actual centre of gravity was outside the permitted CG envelope.

BACKGROUND INFORMATION THAT IS NOT EVIDENT FROM THE OCCURRENCE REPORTS: The company's accountable **management has defined** boundary conditions, i.e. processes, guidelines and resources, for loading. These conditions **state that the loading process must be supervised** and **the final load must be inspected**. Due to a rush at Helsinki-Malmi, the aircraft was loaded only by one loader and loading supervisor. The loader had been working for two (2) months. The loading supervisor was ordered to monitor the arrival of an important cargo flight. This flight had arrived ahead of schedule. The BMA/FBU flight had been scheduled to depart at a specific time, which is why the supervisor instructed the loader to load the aircraft while they were monitoring the cargo flight.

When the loading supervisor returned 30 minutes later, the loader said that he had loaded everything. At the same time, the CLC centre was pressing them to provide load information in order to release the load sheet. The supervisor did not bother to check the hold but believed the loader had acted as expected.

BACKGROUND INFORMATION ON CASE PROCESSING, CASE GREEN**:**

8A: The management decides that the incident could not have been predicted. The incident occurred partially due to haste but the persons involved also neglected certain measures citing their lack of time. The management aims to involve all parties concerned in the process to ensure that everyone's opinions are heard.

8B: The party responsible for the processing (Safety Manager) launches a thorough investigation and responds to the findings reported. They interview the loader, loading supervisor and shift supervisor immediately after the incident and ask them to provide written statements of the event. All this is done during the same work shift.

8C: Personnel is allowed to participate in the process to determine corrective measures.

8D: Due to the loading mistake, the loader is given further training, emphasising the importance of compliance with instructions. In future, the company will ensure that new employees complete an on-the-job training period during which they do not have to make decisions independently. The airline understands that the ground handling company is not responsible for catching up with the schedule on the airline's behalf by changing its own working practices.

8E: After the investigation, the company applied measures according to the SMS process in order to prevent similar incidents from occurring in the future. The processing stages were recorded (SMS), communication was improved, the amount of training was increased to the extent necessary, and the practical implementation of the changes was monitored. Aircraft loading is a process that should not be tied to a timetable. The idea that things happen in a specific order and take a certain amount of time is stressed to the employee. The aircraft departs when it is ready.

The decision-making chart is an example of the principles of processing aviation occurrences within an organisation – Just Culture as part of safety management

The chart below focuses on utilising safety information produced by personnel in the organisation's safety management. The chart is derived from Patrick Hudson's decision-making chart (GAIN working group - Roadmap to a Just Culture - Enhancing the Safety Environment, 1997). The chart was modified on the basis of authorisation given by Global Aviation Information Network. Reading instructions: Start from the yellow box. Choose the situation that suits the case in question. Then go over the column below it. In this case, stop at the first box and continue down because the persons involved followed the valid instructions.

Incident analysis (people = employees involved in the incident)	Compliance with instructions and procedures	Unintentional deviation from instructions and operations models / possible cause: lack of situational awareness or judgement	Routine violation of instructions and procedures	Situational violation of instructions and procedures	Optimising in the (imagined) interests of the organisation	Personal optimising	Reckless personal optimisation	Exceptional violation
Nature of person's actions in the incident	1. Did they follow all procedures and instructions?	Did they think they were following the procedures and instructions?	People thought everyone in the organisation would do what they did.	People thought following the procedures would not get the job done.	People thought it was better for the company to do the job that way.	People thought it was better for themselves to do the job that way.	People did the job their own way because they don't care about the organisation's procedures.	People didn't realise that their course of action was abnormal.
	YES	NO / YES	NO / YES	NO / YES	NO / YES	NO / YES	NO / YES	NO / YES
Management – need for further measures	A. Take active steps to identify why the procedures were not suitable for the situation in question.	Think why people thought they were doing nothing wrong.	Take active steps to identify why the procedures are not followed, incl. adequacy of procedures.	Be active and learn why the procedures were not applicable in this case.	Set boundary conditions. Evaluate procedures. This may be a real target for improvement.	Set limits and boundary conditions for acceptable actions.	How was the person in question hired?	A. The management determines that the incident was not predictable and wants to conduct a thorough investigation.
Supervisors and other key SMS personnel – need for further measures	B. Thank the employee for bringing up the occurrence information. Assess whether the procedures and instructions are suitable.	Analyse the incident as part of risk management	Analyse the incident as part of risk management	Determine the grounds for changing the procedures. Assess the scope of the issue.	Think why the situation wasn't recognised before, incl. preventive risk management measures. Identify the potential for improvement.	Understand that some people can act like this. Assess the scope of the phenomenon from the perspective of risk management.	Were there any prior signs of similar behaviour?	B. The Safety Manager launches a thorough investigation and applies the necessary measures.
Employees involved in the incident	C. You can have piece of mind and learn from the occurrence.	Report your own non-compliance with the instructions or standard methods.	Help the organisation analyse whether the current procedures should be adjusted.	The party responsible must be informed of the potential need to change the instructions or procedures.	Tell the persons responsible for development about your ideas for new procedures. Make sure you are competent enough.	Think about your own attitude and readiness to follow the procedures.	Reason to consider is the person suitable for this industry	C. Participated actively in correcting the issue
Need for a reprimand or disciplinary measures	D. No need	No need	Active training on the importance and development of procedures and instructions at all organisational levels	Feedback about neglected/poorly carried out tasks in the organisation.	Remind the organisation that partial optimisation doesn't necessarily serve all interests.	Need to discuss the motive for optimisation with the person. Possible administrative measures are decided afterwards.	Assessment of administrative measures to be taken	D. Active training on the importance and development of procedures and instructions at all organisational levels.
Guidance, more training and information (safety promotion)	E. Thank the employee. Utilise the occurrence and the lessons learned as an example for the others.	Process owners must evaluate the functionality and quality of procedures and instructions.	Process owners must evaluate the function-nality of procedures and instructions. If functional, compliance must be ensured.	Direct the persons in charge to inform personnel about existing and new procedures and tell them to observe them and report needs for changes.	Direct the persons in charge to inform personnel about existing and new procedures and tell them to observe them and report needs for changes.	Instruct and oblige persons in charge to communicate about the common ground rules.	Instruct and oblige people in charge to react in similar situations.	E. The lessons learned were utilised and the functionality of SMS was checked