

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

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 organisation and the event and related examples are fictitious. However, they represent realistic situations and operations models. **CASE GREY** is an example of the processing of an event in which **THE ORGANISATION DOES NOT RECOGNISE ITS LIABILITY TO FIND A SOLUTION** and the root cause analysis is **SUPERFICIAL**, i.e. the actual **ISSUE IS NOT SOLVED**, and the corrective measures taken to "close" the case are "cheap and easy." The only feedback given to the authors of the occurrence report is an automatic response.

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 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 GREY:

8A: The management considered the case to be a so-called black swan event that could not have been predicted.

8B: The Safety Manager did not see any need for investigating the case further because the situation was beyond anyone's control. The Safety Manager also thought the SMS system was functional and the instruction was sufficient.

8C: The employees were not allowed to participate in the investigation process, but they were told to be careful during loading via email.

8D: The organisation did not deem it necessary to take further action because the occurrence was an isolated incident. The wrong course of action leading to the incident was not identified.

8E: A copy of an email message reminding employees to consult their supervisor in cases of doubt was posted on the break room noticeboard.

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.

