

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

Page 1 contains an example of an AOC organisation and an event that led to the occurrence report filed by the flight crew and the processing of the event by the organisation. Both the organisation 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: EFRO A32S foreign AOC, 30/9/20XX

INFORMATION ABOUT THE ORGANISATION: The company is financially sound with no need for economy measures. The flight crew has not been pressured to save in de-icing/ice prevention, for example. The company's home country does not have winter conditions, and the company flies rarely to destinations where winter conditions must be considered. Rovaniemi (EFRO) is a new destination for the company. The destination had been added to the company's destination selection on a tight schedule one month prior to the incident. The company was in a hurry to operate in the autumn and winter season. The Winter Operations Manual (WOM) is pending for final approval with an entry into force on 1 October. The de-icing agreement is still waiting for the Accountable Manager's (AM) approval.

INCIDENT DESCRIPTION BASED ON THE FLIGHT CREW'S OCCURRENCE REPORT: The country of departure X had sunny, autumnal weather. Flight planning was done as usual. ARR EFRO 0300Z CAVOK BECMG SN -> 0420Z in METAR -RASN -> 0520Z SN TM/DP difference less than 3. There was CAVOK during approach. There was a four-hour turnaround on the ground, during which the crew was provided with updated time-specific weather information. There were several aircraft on the apron. It started to snow during the turnaround. The pilots noticed that the aircraft next to them was being washed. They concluded that this was done because the aircraft was staying the night. The pilots discussed the need for de-icing but thought that the warm fuel would defrost the wing. During DEP, the weather was T00/DM01 BKN/OVC, and the front had already passed the airport. The departure and take-off went normally. When the cabin seat belt light had been turned off, a pilot from another company who was travelling home asked the cabin crew to convey the following message to the cockpit: "The wings were covered by a thick layer of snow during take-off. Why wasn't the aircraft de-iced?". The pilots discussed the situation and decided to file an occurrence report.

BACKGROUND INFORMATION THAT IS NOT EVIDENT FROM THE OCCURRENCE REPORT: The summer holiday season was ending in the country of departure X. The pilots had recently returned from vacation: the captain two weeks and the co-pilot three weeks ago. Both pilots were flying to Rovaniemi for the first time. Other than that, the pilots were quite experienced (CPT 4,000 h, FO 2,500 h) and had piloted A32S for a long time. The crew CRM was at a good level, and the team did the flight planning and made all decisions together. The pilots' annual refresher day had been scheduled for 15 October, i.e. two weeks from the time of incident. When the company introduced Rovaniemi as a new destination, winter operations had been added to the agenda of the refresher day.

Incident-related background information: during flight planning, the pilots had access to an SWC map showing the front passing by during the turnaround at EFRO. In addition, the TAF report forecasted BECMG -SN for the time of turnaround, which was not considered in flight planning. During the turnaround, there was dense snowfall, and wet snow was visible on the wings. The pilots thought that the warm fuel would defrost the wings but they neglected to consider the de-icing of the rudder, for example. At the time of departure, the air traffic controller did not have a visual line of sight to the aircraft by the pier. In addition, the air traffic controllers were changing shifts at the time of departure.

BACKGROUND INFORMATION ON CASE PROCESSING, CASE GREEN:

1A: The management learned about the incident, the conclusions made and the need for action via SMS. The management reviews and confirms the need for changes in the timing and scheduling of the MoC process.

1B: The parties responsible for the processing conduct a thorough investigation of the incident and react to the findings reported. The causes/contributory causes identified included the lack of a de-icing agreement and Winter Operations Manual (WOM, pending for final approval) and lack of training (to be provided on 15 October). The underlying factor was the time pressure in the MoC process related to the start of traffic to and from EFRO. If there was more time, the schedule issues could have been identified. The management was informed of the incident and the related conclusions and needs for changes. The organisation's processes will be improved as necessary.

1C: The pilots reported the incident and they were interviewed for further information and praised for reporting the incident. The pilots will be given more training during refresher days together with other personnel.

1D: The crew acted correctly and the causes behind the incident and the need for changes were identified to be at the organisational level.

1E: The incident will be presented as an anonymous example as part of winter operations training during the refresher course. The parties involved will be praised for reporting the incident and the lessons learned will be shared with the course participants.

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.

