



**NTSB** National Transportation Safety Board

## **Establishing and Maintaining Safety Culture**

**Robert L. Sumwalt  
Vice Chairman**

*Air Charter Safety Foundation  
February 19, 2008*

**Do you have a safety culture?**



## Do you have a Safety Culture?

- “... it is worth pointing out that if you are convinced that your organization has a good safety culture, you are almost certainly mistaken.”
- “... a safety culture is something that is striven for but rarely attained...”
- “...the process is more important than the product.”

- James Reason, “Managing the Risks of Organizational Accidents.”



## NTSB Perspective on Corporate Culture



Symposium on  
Corporate Culture  
and Transportation  
Safety

• April 1997

“We’ve found through 30 years of accident investigation that sometimes the most common link is the attitude of corporate leadership toward safety.”

- Honorable Jim Hall



## NTSB Perspective on Corporate Culture



Symposium on  
Corporate Culture  
and Transportation  
Safety

• April 1997

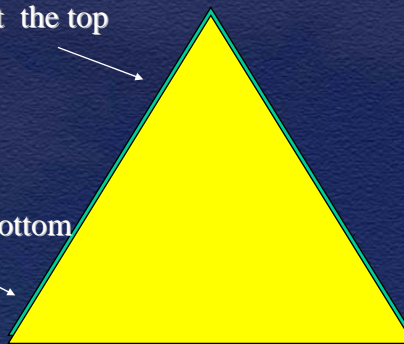
“The safest carriers have more effectively committed themselves to controlling the risks that may arise from mechanical or organizational failures, environmental conditions and human error.”

NTSB 

## Corporate Culture is:

Triggered at the top

Measured at the bottom



Corporate culture starts at the top of the organization and permeates the entire organization.

## Culture Defined

- Culture is a set of established beliefs, values, norms, attitudes and practices of an organization.



## “Culture” Simplified



“The way we do things here!”



## Safety Culture



- Employees do the right things, even when no one is watching.
  - Integrity
  - Core values

## Roadmap to Safety Culture

- Lautman-Gallimore Study
- James Reason

## Lautman-Gallimore Study



## Lautman-Gallimore Study

- Looked at the worldwide Boeing fleet for a 10 year period (1975-1984)
- 16 percent of the operators account for over 80 percent of the accidents.



## Lautman-Gallimore Findings: Best Practices

- Management emphasis on safety
  - Safety begins at top of organization
  - Safety permeates the entire operation



## Lautman-Gallimore Findings: Best Practices

### Standardization and discipline

- Management stresses need for these items
- Cockpit procedural compliance, callouts, and checklist usage are tightly controlled.





## Standardization



- Maneuvers Guide – contained key procedures for briefing and conducting instrument approaches
  - Pilots were expected to adhere to procedures in Maneuvers Guide
  - Maneuvers Guide was only issued to the chief pilot and instructors



## Standardization



- Company check airman: rated company's standardization as "6"
- Company pilot: "Fair to good"
- Lead ground instructor: "Fair"
  - Suspected that some pilots were following SOPs while others were not
  - Aware that some pilots used their own checklists, instead of company checklists
- Another pilot: never seen any standardized callouts documented in any company manual
  - To compensate, she used callouts she used at another company



## Lautman-Gallimore Findings: Best Practices

- Flight Operations quality control programs
  - conducted safety audits
  - confidential incident reporting systems



## Lautman-Gallimore Findings: Best Practices

- Training
  - Strong quality control program of training
  - Accomplished their own training so that positive control of standardization and discipline are maintained



## Lautman-Gallimore Findings: Best Practices

- Management emphasis
- Standardization and discipline
- Flight Ops quality control
- Training



## Professor James Reason



## The Organizational Aim:

To establish a safety culture where constructive criticism and safety observations are encouraged and acted upon in a positive way.



## Excellence

- “Without exception, the dominance and coherence of culture proved to be an essential quality of the excellent companies.”
- “In these [strong culture] companies, people way down the line know what they are supposed to do in most situations because the handful of guiding values is crystal clear.”

– T.J. Peters and R.H. Waterman, “In Search of Excellence: Lessons from America’s Best-Run Companies.”



## Components of Safety Culture

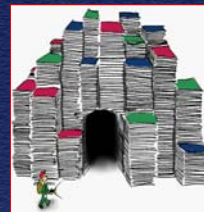
- Informed Culture
- Reporting Culture
- Learning Culture
- Just Culture

Source: James Reason, Ph.D.



## Informed Culture

- Informed culture – the organization collects and analyses “the right kind of data” to keep it informed of the safety health of the organization
  - Creates a safety information system that collects, analyzes and disseminates information on incidents and near-misses, as well as proactive safety checks.



NTSB 



**NTSB** National Transportation Safety Board

*Office of Aviation Safety*

## **Pinnacle Airlines Flight 3701 Jefferson City, Missouri**

October 14, 2004



inPhoto.com

## Reporting Culture

- Employees are open to report safety problems
  - They know they will not be punished or ridiculed for reporting
    - Non-reprisal policy signed by CEO
  - Confidentiality will be maintained or the data are de-identified
  - They know the information will be acted upon



### Non Reprisal Policy December 2005

SCANA Aviation Department is committed to the safest flight operation possible. Therefore, it is imperative that we have uninhibited good faith reporting of any hazard, occurrence or other information that in any way could enhance the safety and efficiency of our operations. It is each employee's responsibility to communicate any information that may affect the integrity of flight safety.

SCANA Aviation Department has developed a format for reporting information, hazards and safety concerns, whether in the air, on the ground or related to passenger or crew safety. [Reference is hereby made to "SCANA Flight Operations Manual," Section 7.11 Information, Safety and Hazard Reporting Procedure]

To promote a timely, uninhibited flow of information, this communication must be free of reprisal. SCANA will not use this reporting system to initiate disciplinary proceedings against an employee who discloses in good faith a hazard or occurrence involving flight safety which is the result of conduct which is inadvertent, unintentional or not deliberate.

We urge all employees to use this program to help this Department be a leader in providing our passengers and our employees with the highest level of flight safety.

\_\_\_\_\_  
William B. Timmerman  
Chief Executive Officer

\_\_\_\_\_  
Robert L. Sunwalt, III  
Manager – Aviation





**NTSB** National Transportation Safety Board  
*Office of Aviation Safety*

## **Pinnacle Airlines Flight 3701 Jefferson City, Missouri**

October 14, 2004



## **Learning Culture**

- In short, the organization is able to learn and change from its prior mistakes



## Learning Culture

“Learning disabilities are tragic in children,  
but they are fatal in organizations.”

- Peter Senge, “The Fifth Discipline: The Art and Practicing of the Learning Organization”



## “Just” Culture

- Basically, this means that employees realize they will be treated fairly
  - Not all errors and unsafe acts will be punished (if the error was unintentional)
  - Those who act recklessly or take deliberate and unjustifiable risks will be punished
- Substitution test





[www.flightsafety.org](http://www.flightsafety.org)



NTSB 

## Just Culture

- “An atmosphere of trust in which people are encouraged (even rewarded) for providing safety-related information, but in which they are also clear about where the line must be drawn between acceptable and unacceptable behavior. “

NTSB 

## Engineering a Just Culture

The term “no blame culture” flourished in the 1990s and still endures today.

Compared to the largely punitive cultures that it sought to replace, it was clearly a step in the right direction. It acknowledged that a large proportion of unsafe acts were “honest errors” (the kinds of slips, lapses and mistakes that even the best people can make) and were not truly blameworthy, nor was there much in the way of remedial or preventative benefit to be had by punishing their perpetrators. But the “no blame” concept had two serious weaknesses. First, it ignored — or, at least, failed to confront — those individuals who willfully (and often repeatedly) engaged in dangerous

behaviors that most observers would recognize as being likely to increase the risk of a bad outcome. Second, it did not properly address the crucial business of distinguishing between culpable and nonculpable unsafe acts.

In my view, a safety culture depends critically upon first negotiating where the line should be drawn between unacceptable behavior and blameless unsafe acts. There will always be a gray area between these two extremes where the issue has to be decided on a case-by-case basis. This is where the guidelines provided by “A Roadmap to a Just Culture” will be of great value. A number of aviation organizations have

embarked upon this process, and the general indications are that only around 10 percent of actions contributing to bad events are judged as culpable. In principle, at least, this means that the large majority of unsafe acts can be reported without fear of sanction. Once this crucial trust has been established, the organization begins to have a reporting culture, something that provides the system with an accessible memory, which, in turn, is the essential underpinning to a learning culture. There will, of course, be setbacks along the way. But engineering a just culture is the all-important early step; so much else depends upon it. ■

— James Reason



**Do you have a safety culture?**



“Safety culture is about having the will  
to do something – not the money.”

– The Honorable Debbie Hersman



**NTSB**