



National Transportation Safety Board

**Are your customers getting
what they expect?**

Robert L. Sumwalt, III

Different Expectations

- There is sometimes a “disconnect” between the expectations of the “customer” and what they are actually getting.



What do your customers want?

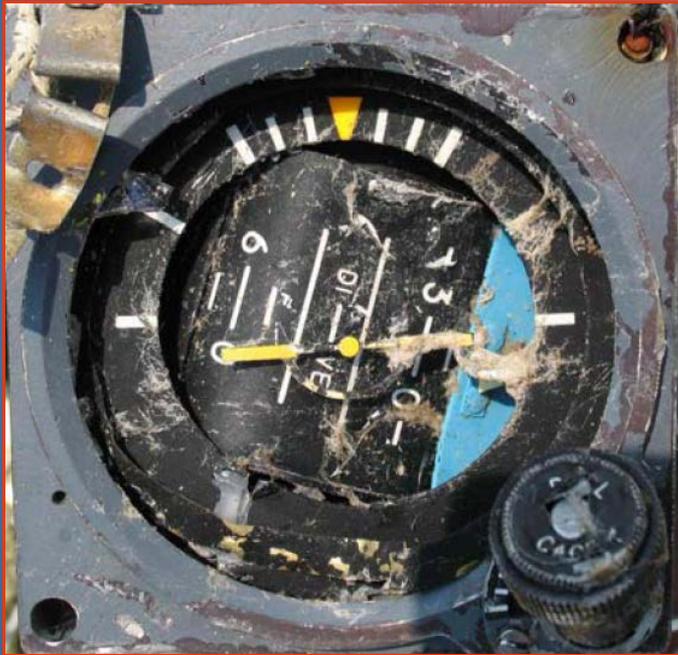
- **World class**
 - Top 3 - 5 percent of the industry
 - Organization thrives in seeking to be the very best
- **Best practices**
 - Adopts and implements procedures above and beyond regulatory requirements
- **Basic regulatory compliance**
 - Meets spirit of regulations, but no higher
- **Sub-standard performance**
 - non-adherence to regulations, cutting corners are the norm

Adopted from Pete Agur

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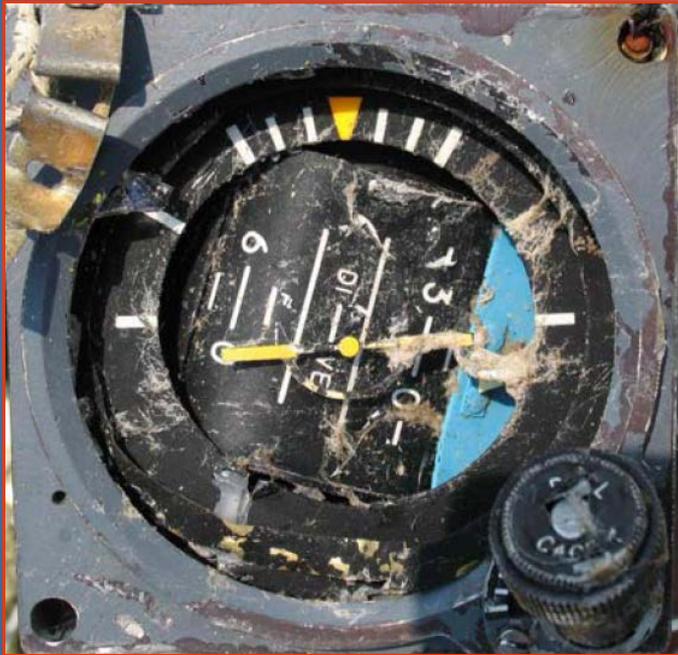
What is the attitude of your business aviation operation?



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June 4, 2007

6 Fatalities





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What the investigation found

Captain/chief pilot/check airman

- had prior certificate revocation
- routinely failed to comply with procedures and regulations
- falsified training records



NTSB Finding

- “The pilots’ lack of discipline, in-depth systems knowledge, and adherence to procedures contributed to their inability to cope with anomalies experienced during the accident flight.”



The customer

- Had contracted with this Part 135 operator for 19 years.
- Wanted safe transport for medical personnel, patients, and transport organs.



October 25, 2002



Is this what the customer expected?



- Company check airman: rated company's standardization as "6" (on 1-10 scale)
- 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



Manteo, NC October 1, 2010



“The pilot told NTSB investigators that the company advised him that they had no immediate need for an airplane and they did not intend to buy a replacement.”



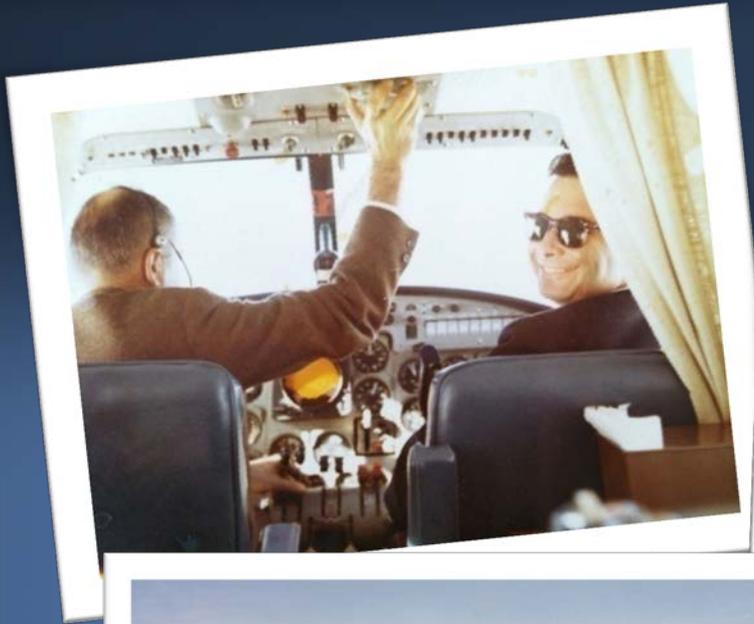
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“When asked about the flight department's standard operating procedures (SOPs), the chief pilot advised that they did not have any...”



“... the flight department had started out as just one pilot and one airplane, and that they now had five pilots and two airplanes...”

09 14 2007

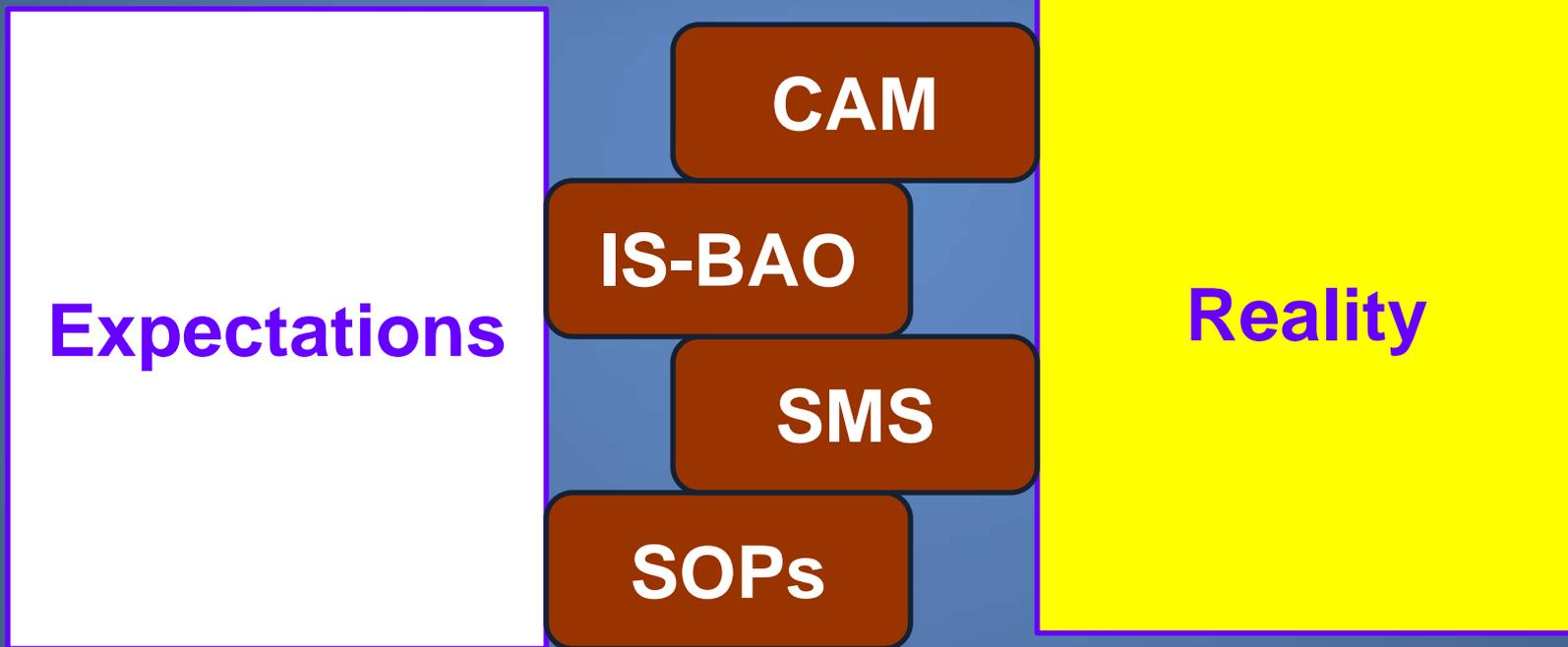


What do customers want?

- Flexibility
- Convenience
- Privacy
- Prestige
- Safety – is safety assumed??



Closing the Expectation Gap



To close the expectation gap requires:

R ealization

G uts

L eadership

C ommitment



What is Leadership?

“Leadership is about influence.
Nothing more. Nothing less.”

- John Maxwell



How leaders influence safety

“The safety behaviors and attitudes of individuals are influenced by their perceptions and expectations about safety in their work environment, and they pattern their safety behaviors to meet demonstrated priorities of organizational leaders, regardless of stated policies.”

- D. Zohar, as cited in NTSB accident report

Realization

Do you have a good safety culture?



Do you have a good 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.”



“Good can be Bad”

- With good safety performance, people/organizations can easily become complacent.
- Don't ever believe that a lack of accidents means you are “safe.”
- To counter this complacency, there must be a leadership obsession with continuous improvement.

- Courtesy of Jim Schultz



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Guts and Commitment

- 
1. Management Commitment and Emphasis
 2. Culture of Compliance
 3. Continuous Learning and Risk Awareness
 4. Just Culture & Trust



Roadmap to Safety Culture

Management commitment and emphasis on safety

- Safety begins at top of organization
- Safety permeates the entire operation



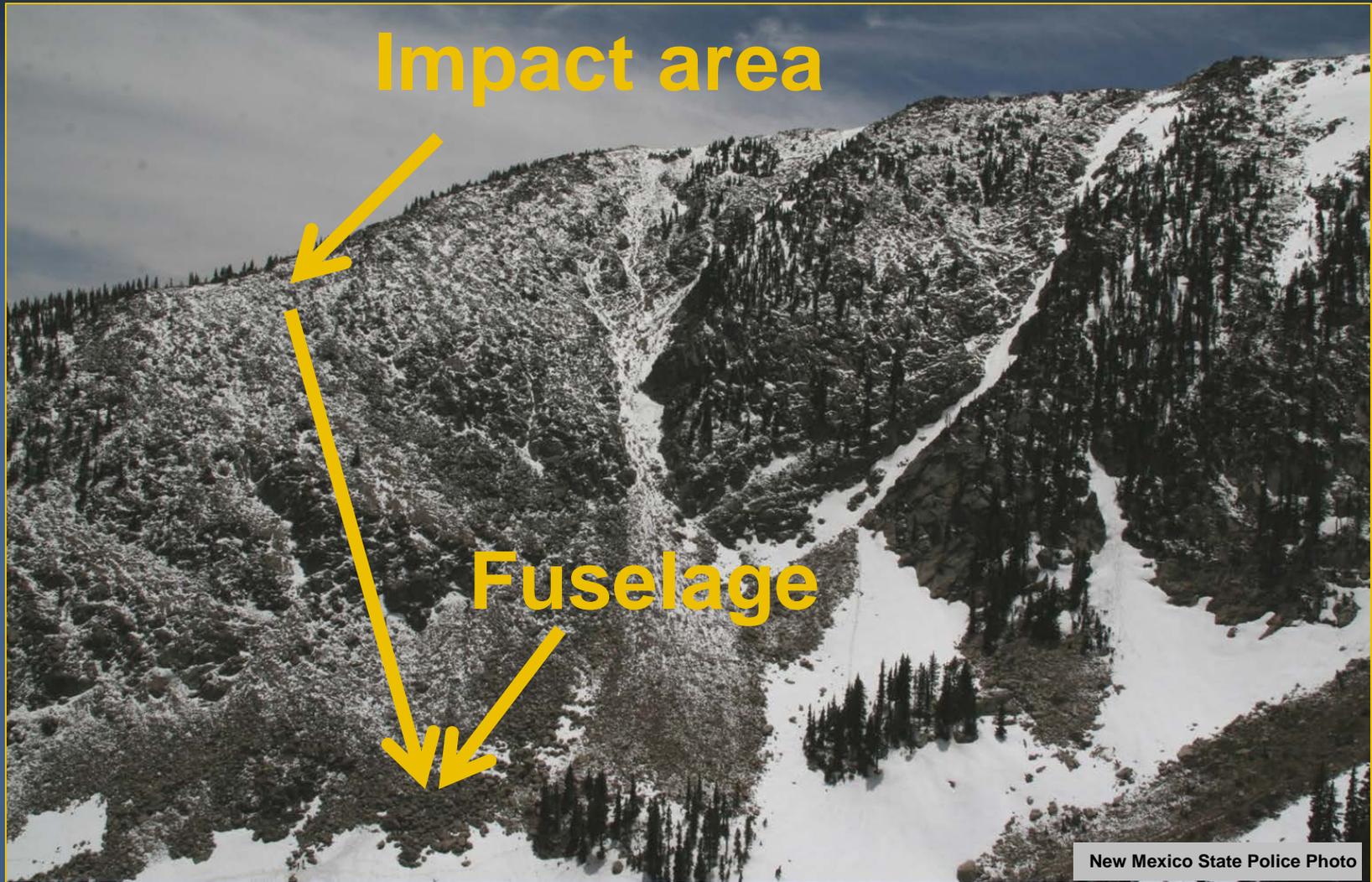
History of Flight



- June 9, 2009
- Agusta A-109E
- Search and rescue flight
- New Mexico State Police (NMSP)
- Near Santa Fe, New Mexico
- Pilot and passenger killed
 - spotter seriously injured

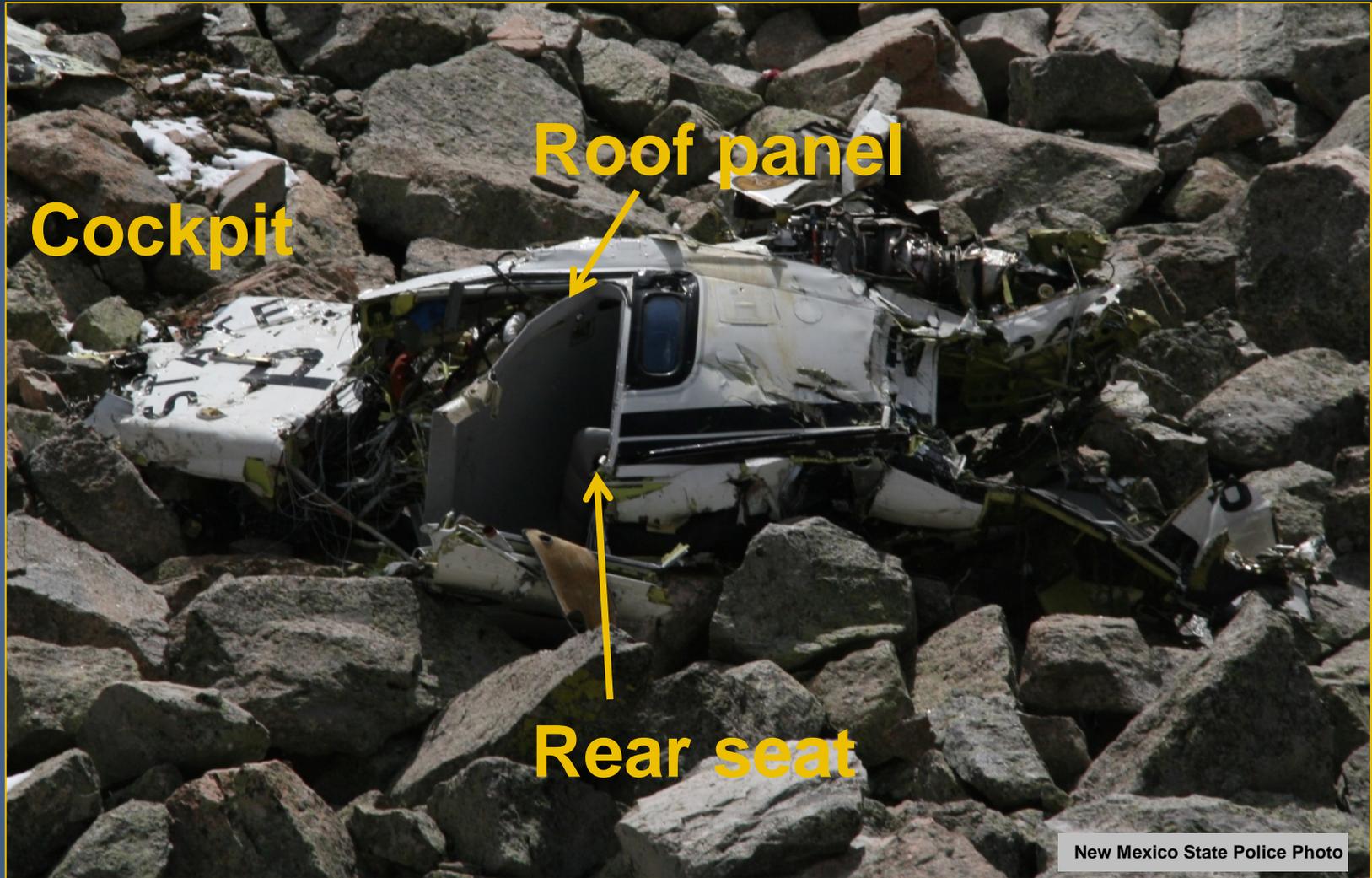


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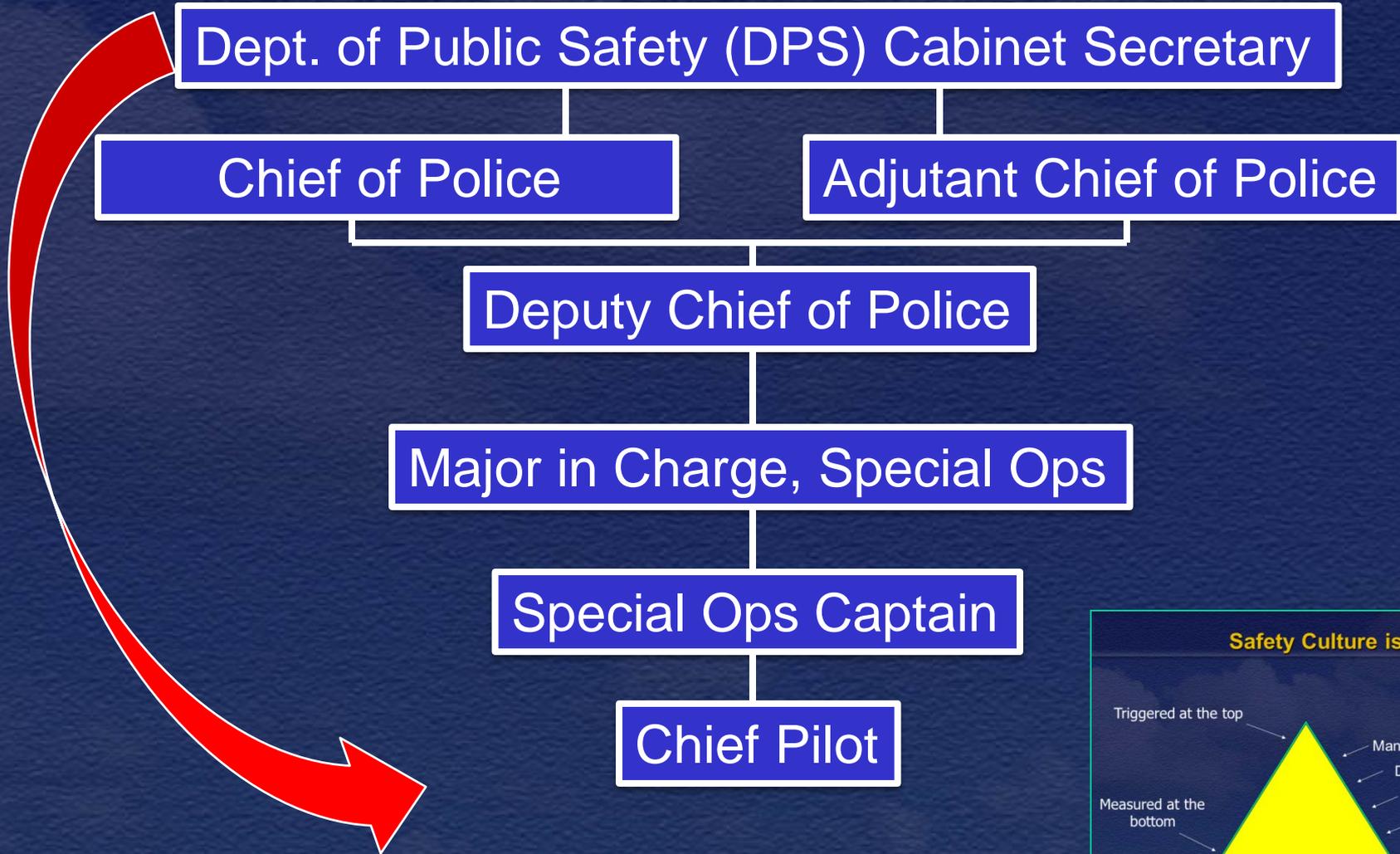
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Fuselage



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NMSP Reporting Structure



DPS Cabinet Secretary

- Had formerly been a NMSP chief pilot
- Liked to be involved with aviation section, but did not ensure it had an effective safety program
 - Wrote memo saying that accident pilot was authorized to operate the accident helicopter
- Took actions that were detrimental to safety
 - Dismissed former chief pilot for turning down missions
 - Demanded explanations whenever a pilot declined a flight
 - Complained vigorously when New Mexico National Guard pilots launched when NMSP declined
 - Would ask NMSP pilots to continue checking the weather when they had already declined mission due to weather



NTSB Finding

“... there was evidence of management actions that emphasized accepting all missions, without adequate regard for conditions, which was not consistent with a safety-focused organizational safety culture...”



Probable Cause:

- The pilot's decision to take off from a remote, mountainous landing site in dark (moonless) night, windy, instrument meteorological conditions.
- Contributing to the accident was an organizational culture that prioritized mission execution over aviation safety, and
- the pilot's fatigue, self-induced pressure to conduct the flight, and situational stress.



Guts and Commitment

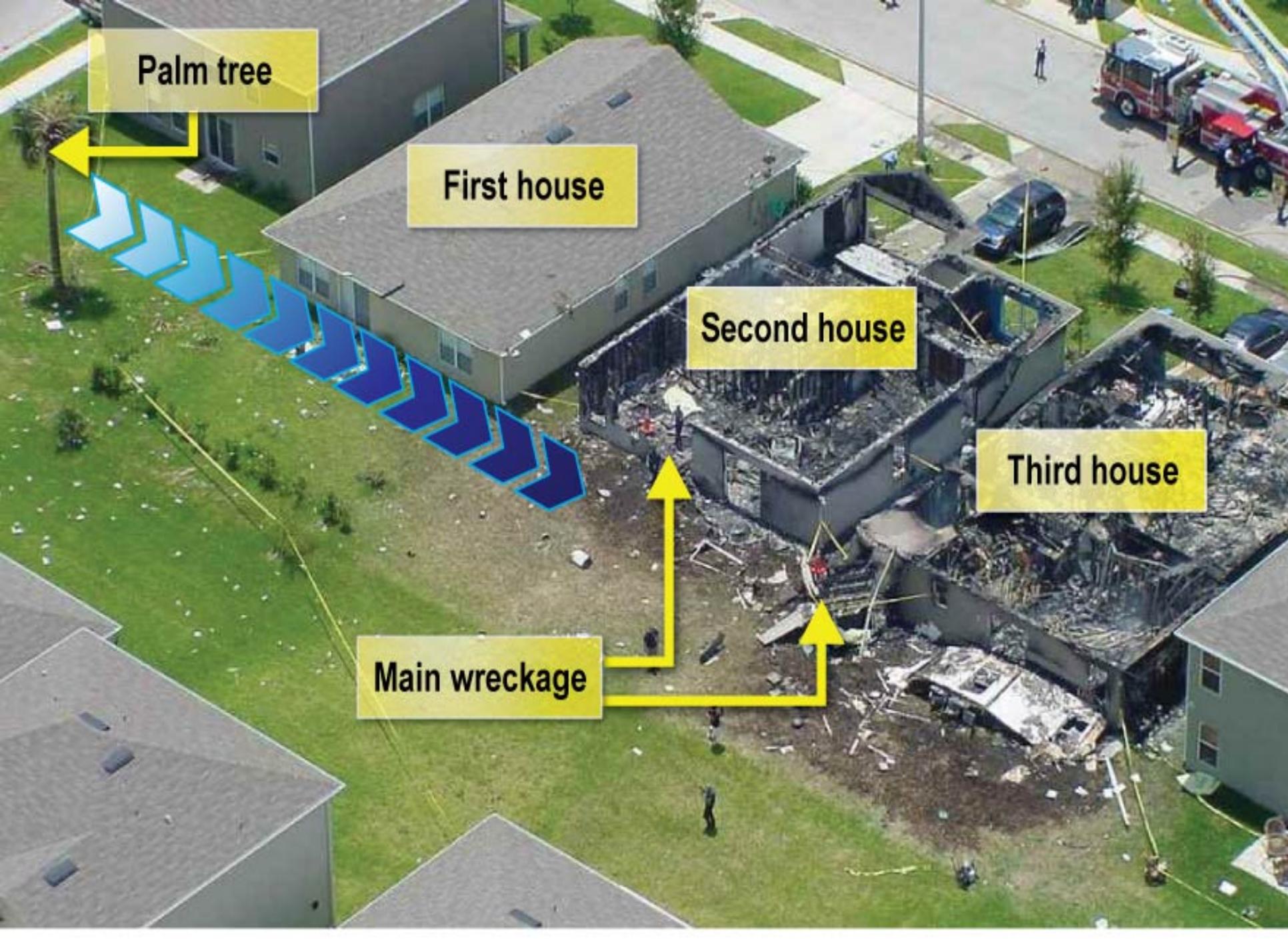
1. Management Commitment and Emphasis
-  2. Culture of Compliance
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July 10, 2007, Sanford, FL



- Cessna 310
- 5 fatalities



Palm tree

First house

Second house

Third house

Main wreckage



Declared Emergency

“Smoke in the cockpit.”

“Shutting off radios, elec.”





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Maintenance Discrepancy Entry

AIRCRAFT: N501N	DATE: 07-09-07	-ACTT	
MAINTENANCE WRITE-UP		-ACTL	
Entered By: ACT	Location: DAB	<input type="checkbox"/> Repaired	<input type="checkbox"/> Replaced
		<input type="checkbox"/> Released- Could Not Duplicate	<input type="checkbox"/> Loaner Installed
RADAR WENT BLANK DURING CRUISE FLIGHT. RECYCLED - NO RESPONSE... SMELL OF ELECTRICAL COMPONENTS BURNING		Corrective Action:	
TURNED OFF UNIT - PULLED RADAR C.B. - SMELL WENT AWAY. -			
RADAR INOP			

“SMELL OF ELECTRICAL COMPONENTS BURNING”

Probable Cause

- “...actions and decisions by [the organization’s] corporate aviation division’s management and maintenance personnel to allow the accident airplane to be released for flight with a known and unresolved discrepancy, and;
- “The accident pilots’ decision to operate the airplane with that known discrepancy, a discrepancy that likely resulted in an in-flight fire.”



Culture of Non-Compliance

- Aviation director could not readily locate SOP manual
- SOP manual viewed as a “training tool”
- Aircraft to only be used for company business
 - Accident flight was a personal flight
- PIC must possess ATP
 - PIC did not possess ATP
- Last 3 maintenance discrepancies had not been addressed



A Culture of Compliance

- Internal company policies, procedures, rules
- Ethical principles
- Company code of conduct
- Federal, state, and local laws and ordinances
- Industry best practices
- Financial guidelines and principles
- Etc.

**A commitment to doing things
right. Always.**



Avoid Selective Compliance



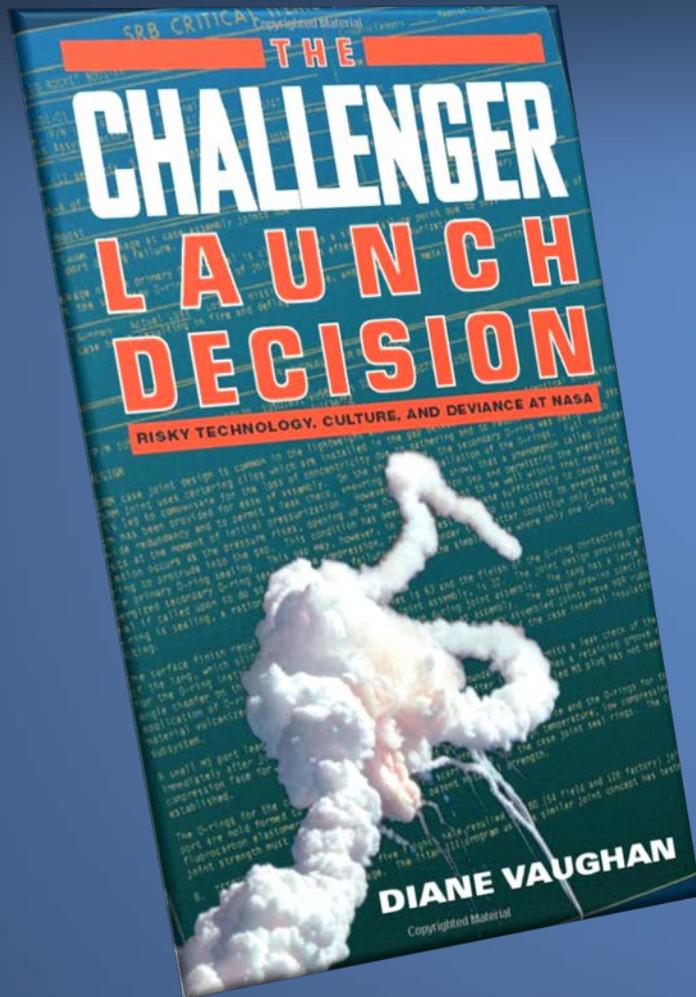
- “That is a stupid rule.”
- “I don’t have to comply with that one.”





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Avoid “Normalization of Deviance”



- Normalization of Deviance: When not following procedures and taking “short cuts” and becomes an accepted practice.



Guts and Commitment

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Continuous Learning and Risk Awareness

- Organizations with a healthy safety focus are constantly learning.
- They actively seek ways to improve safety.
- They learn from their mistakes and those of others.
- Information regarding prior incidents and accidents is shared openly and not suppressed.
- They are ever mindful of risks and are looking for ways to mitigate those risks.



How do you stay informed?

- Internal safety audits
- External safety audits
- Confidential incident reporting systems
- Employee feedback



Staying informed

- How do you detect and correct performance deficiencies before an accident?
- How do you know what is going on in your operations?
- Do you have multiple data sources?



Employees



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Are employees comfortable reporting?

- They are open to report safety problems, if they receive assurances that:
 - The information will be acted upon
 - Data are kept confidential or de-identified
 - They will not be punished or ridiculed for reporting
 - Non-reprisal policy



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“Just” Culture

- People 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



Just Culture

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

- James Reason, Ph.D.





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In Summary

- The people that pay for your services are expecting and counting on a professionally-managed operation.
- What are they getting?





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