

Thought Leadership

The importance of Organisational Leadership

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“Those who cannot learn from history are doomed to repeat it”.

George Santayana, 19th century philosopher

As regulatory authorities develop their State Safety Programmes in response to the ICAO requirements and increasing numbers of aircraft operators, airports, maintenance organisations and air traffic controllers start to formulate Safety Management System (SMS) implementation plans, we receive regular enquiries about where to start. At Baines Simmons we believe the first stage of developing an effective SMS is to understand the purpose of the system and the benefits it can bring by reducing losses.

In the recently published, **“The Nimrod Review”** © (Crown Copyright 2009), the report’s author Charles Haddon-Cave QC, went to great length to consider lessons learnt during the inquiries to other major accidents, notably Piper Alpha, Space Shuttle’s Challenger & Columbia, The Herald of Free Enterprise and BP Texas City to name but a few. In summarising the contents of Chapter 17, Mr Haddon-Cave wrote the following:

Summary

1. The lessons to be learned in the case of Nimrod XV230 are not new.
2. There are 12 uncanny, and worrying, parallels between the organisational causes of the loss of Nimrod XV230 and the organisational causes of the loss of the NASA Space Shuttle ‘Columbia’:
 - (1) The ‘can do’ attitude and ‘perfect place’ culture.
 - (2) Torrent of changes and organisational turmoil.
 - (3) Imposition of ‘business’ principles.
 - (4) Cuts in resources and manpower.
 - (5) Dangers of outsourcing to contractors.
 - (6) Dilution of risk management processes.
 - (7) Dysfunctional databases.
 - (8) ‘PowerPoint engineering’.
 - (9) Uncertainties as to Out-of-Service date.
 - (10) ‘Normalisation of deviance’.
 - (11) ‘Success-engendered optimism’.
 - (12) ‘The few, the tired’.

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3. The Columbia Accident Investigation Board Report emphasised the importance of identifying the fundamental 'organisational causes' of accidents rather than just focusing merely on errors and omissions by individuals. It should be required reading for anyone involved in aviation safety
4. The present case also has parallels with other catastrophic accidents such as the Zebbrugge Disaster (1987), King's Cross Fire (1987), The Marchioness (1989), and BP Texas City (2005). **
5. Columbia and other cases have shown that, usually, there are fundamental organisational causes which lie at the heart of many major accidents, and these have to be addressed in order to learn the real lessons for the future."

There is one clear and consistent message emanating from these reports and that is the importance of **organisational leadership** in shaping the culture of the organisation and its approach to safety.

There will always be a balance to strike between the management and reduction of risk and commercial viability. A balance which if managed correctly can be healthy as it challenges people to innovate and find previously unrealised methods of improving a product or productivity.

One of the greatest step changes in aviation safety came with the advent of the jet engine, a technology that has remained fundamentally unchanged since Sir Frank Whittle's prototype first ran in 1937. The jet engine improved safety because it introduced improvements in design, in material technology, in production and in in-service maintenance.

However as technology is helping to improve safety, organisational failings are featuring more often as contributory causes to accidents. When the focus is lost, when the balance of priorities shifts away from safety, when financial viability seems overwhelming and cost challenges are made without the appropriate risk assessment, hazard defences can become degraded.

At Baines Simmons we support the view that safety is in fact **good business**. Safety is about doing the job right the first time. Not only does this reduce the cost of accidents but of rework, it can reduce the likelihood of early system failures, it improves service delivery, it improves customer satisfaction and reduces employee workload.

It may not always be easy but the management of safety must never become subservient to any other organisational targets, nor "another thing to do" on an already long list of priorities. It is doing more of the things that work well and learning to reduce the causes of failure or organisational losses.

"A key factor in the industry is the prevailing culture, of which safety culture is an integral part. There is a clear link between good safety and good business" Lord Cullen, The Ladbroke Grove Rail Inquiry.

This is the fundamental principle of a Safety Management System.

** Zebbrugge 1987 - Capsizing of The Herald of Free Enterprise ferry when leaving a Belgium port (193 fatalities). Kings Cross Fire 1987 – Fire in a London underground station (31 fatalities). The Marchioness 1989 – Sinking of a pleasure boat on the River Thames (51 fatalities). BP Texas City 2005 – Major explosion at the oil refinery (15 fatalities)