

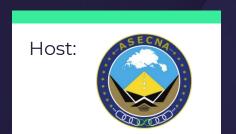
#### SHAPING OUR FUTURE SKIES

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# CANSO AFRICA CONFERENCE 2022

Dakar, Senegal

**5 – 9 September 2022** 



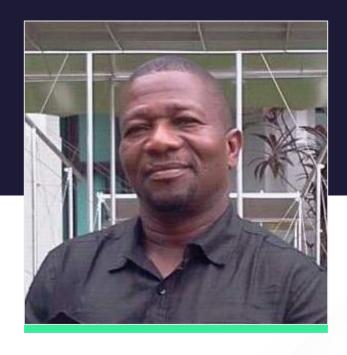


WORKSHOP: SAFETY THE STATUS OF FATIGUE RISK
MANAGEMENT IN AFRICA
(continued)





# **FACILITATOR**



#### William Amoako

Safety, Standards and Quality Assurance Manager / Deputy Chair Deputy Chair Ghana Civil Aviation Authority / CANSO Safety Workgroup





# **FACILITATOR**

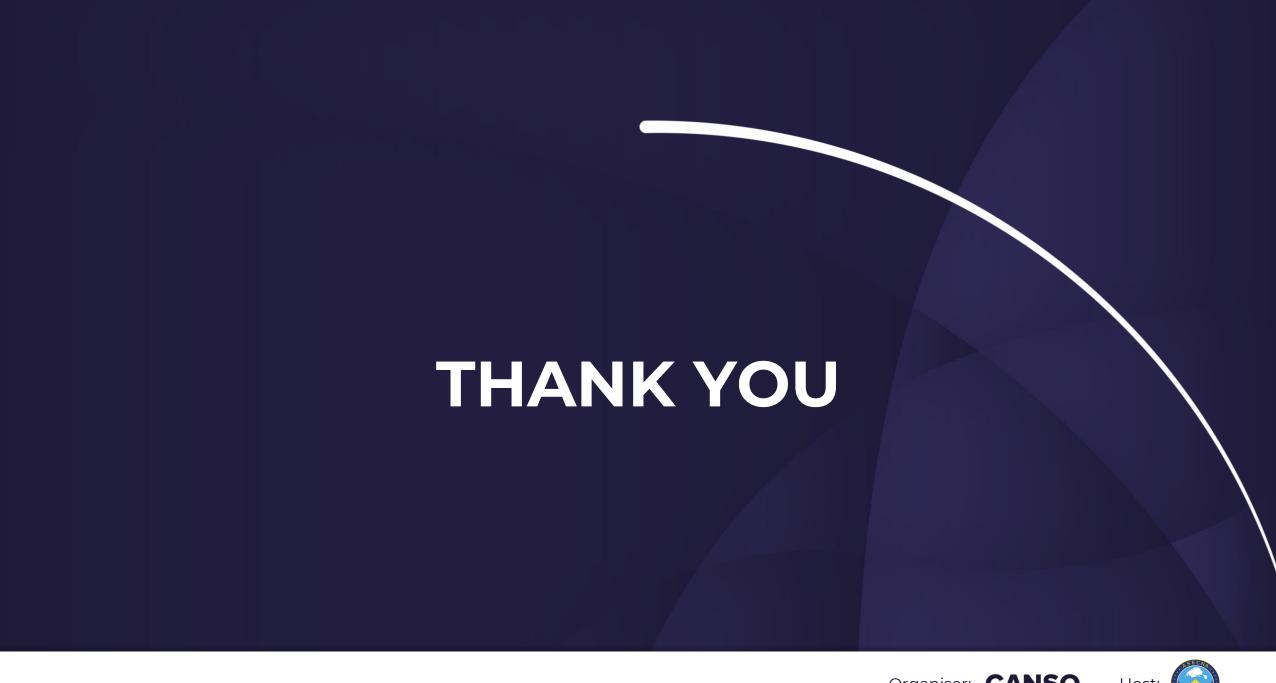


**Matita Tshabalala** 

Human Factors Specialist ATNS









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# **FACILITATOR**



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WORKSHOP: SAFETY FATIGUE MANAGEMENT, JUST
CULTURE AND CISM:
SESSION 2: JUST CULTURE





### **OUTLINE**

Safety Culture What Just Culture is Creating a Just Culture Peer Review **Embedding Just Culture** 



#### INFORMED CULTURE

Those who manage and operate the system have current knowledge about the human, technical, organisational and environmental factors that determine the safety of the system as a whole.

#### REPORTING CULTURE

An organizational climate in which people are prepared to report their errors and near-misses.

SAFETY CULTURE

#### FLEXIBLE CULTURE

A culture in which an organisation is able to reconfigure themselves in the face of high tempo operations certain kinds of danger often shifting from the conventional hierarchical mode to a flatter mode.

#### 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 behaviour.

#### LEARNING CULTURE

An organisation must possess the willingness and the competence to draw the right conclusions from its safety information system and the will to implement major reforms.





## WHAT IS JUST CULTURE

https://www.youtube.com/watch?v=NijhuYOvCPo



A Just Culture is a **key element** of a mature and positive safety culture and **fundamental** to **achieving organisational safety performance**. It is characterised by visible management **commitment** to Just Culture principles, **clarity** with regards to acceptable and unacceptable behaviours and **consistency** in how it treats people when things go wrong.

- How fair and consistent is the organisation across its operations and departments in how it treats people involved in unwanted events?
- How well does the behaviour of the leadership, management and staff reflect and support the organisation's Just Culture policy?
- Do you know where and how well the 'line in the sand' of unacceptable behaviour has been drawn for the organisation?
- Does the organisation have the right enabling tools, capabilities and competences to operate and support a Just Culture?





A Just Culture has to be applied with the knowledge that:

- All management systems can be improved,
- People can and do make mistakes,
- People/groups at all levels may develop unhealthy/unsafe patterns of behaviour, and
- Reckless conduct/Sabotage will not be tolerated.



How will you define a Just Culture?



A just culture definition by James Reason (1997) – "An atmosphere of <u>trust</u> in which people are <u>encouraged</u>, even rewarded, for providing essential <u>safety-related information</u> – but in which they are also clear about where the line must be drawn between <u>acceptable and unacceptable behaviour</u>".

 Moreover, we also subscribe to the baseline definition by Sidney Dekker (2010), where a progressive safety culture is described as "a culture where the manager and company are willing to listen to bad news".





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# Creating a Just culture



## CREATING A JUST CULTURE

#### 1. Focus on Intent

- Seek to learn from the situation to improve the system as a whole;
- Focus attention predominately at identifying and addressing the system/organisation factors that impact reliability and performance,
- A Just Culture recognizes that an employee's intent is critical to properly evaluating safety performance. All staff are responsible for acting safely and in a manner which is commensurate with their training, experience, and the professional standards expected in their job. They adhere to written procedures unless, in the clear interest of safety, it is necessary to deviate from these procedures. Where such deviation is required, staff will be given full and fair opportunity to account for their actions (A39-WP/193, ICAO, 2016).
- A blanket amnesty on all unsafe acts would not be ideal in an environment where safety is of
  critical importance. A "no-blame" culture per se is therefore neither feasible nor desirable (e.g.
  criminal activity, substance abuse, use of controlled substances, reckless noncompliance,
  sabotage, etc.).





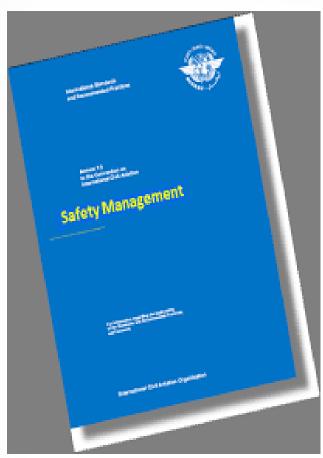
## CREATING A JUST CULTURE

# 2. Reporters, safety data and safety information are protected

- Reporters are protected, although anything not reported into the SMS will not enjoy protection under the JC Policy and the Disciplinary Code will apply.
- Reports submitted via the CAA into the CAHRS will also enjoy protection under the Just Culture Policy provided that it is deemed a safety related matter with proof that it has been reported internally first.







ICAO Annex 19 on Safety Management

#### **5.3 Safety data protection**

5.3.1 A voluntary incident reporting system shall be non-punitive and afford protection to the sources of the information.

Note 1.— A non-punitive environment is fundamental to voluntary reporting.

Note 2.— Each State is encouraged to facilitate and promote the voluntary reporting of events that could affect aviation safety by adjusting their applicable laws, regulations and policies, as necessary.

5.3.2 **Recommendation.**— States should not make available or use safety data referenced in 5.1 or 5.2 for other than safety-related purposes, unless exceptionally, an **appropriate authority** determines in accordance with their national legislation, the value of its disclosure or use in any particular instance, outweighs the adverse impact such action may have on aviation safety.





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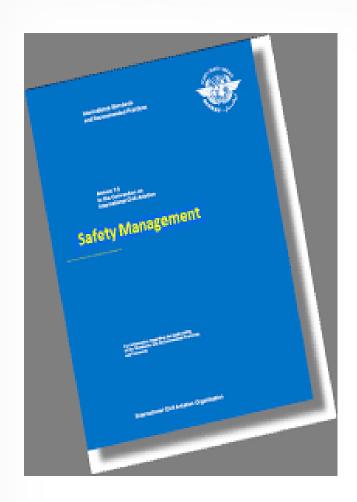






Who is the appropriate Authority?





ICAO Annex 19 on Safety Management Attachment B – Legal guidance.

#### **Protection of data**

**1.5b** Inappropriate use refers to the use of safety information for purposes different from the purposes for which it was collected, namely, use of the information for disciplinary, civil, administrative and criminal proceedings against operational personnel, and/or disclosure of the information to the public;

#### 7. Protection of recorded information

Considering that ambient workplace recordings required by legislation, such as cockpit voice recorders (CVRs), may be perceived as constituting an invasion of privacy for operational personnel that other professions are not exposed to:

a) subject to the principles of protection and exception above, national laws and regulations should consider ambient workplace recordings required by legislation as privileged protected information, i.e. information deserving enhanced protection.



• Protect incident reports by anonymity, confidentiality or legislations (SACAA Regulations part 140, ICAO Annex 13, ATNS CS Directive 1/2016-PAIA Manual, ATNS CS Directive 4/2016 – Confidentiality Policy).

**140.02.1** (3) No information obtained under the voluntary reporting system shall be used against a person reporting in any disciplinary, legal or proceedings relating to the capacity or competence of such person.

140.02.3 (1) The handling of safety data collected through safety data collection and processing systems shall be done with a view to preventing the use of information for purposes other than safety, and shall appropriately safeguard the confidentiality of the identity of the person making the report and of the persons mentioned in occurrence reports, with a view to promoting a "just culture".





#### State Safety Plan

In the State Safety Plan the Director is responsible for the "establishment of systems for the protection of safety data collection and processing systems, where people are encouraged to provide essential safety-related information..." (Section 3.3.2.q).

#### SACAA CATS Part 12.01.10

"Confidential aviation hazard reporting is a tool for accident prevention in that hazards (including human error – Section 1.2) are identified before there is loss of life, injury or damage, i.e. loss. It is not a statistical tool. It is non-punitive."





3. Deciding and getting broad support for who gets to decide what is acceptable and unacceptable behaviour







## PEER REVIEW COMMITTEE

The Peer Review Committee will require a minimum of 4 members to perform a review. The Committee shall consist of any of the below stakeholders, but with 50% of the committee made up of operational peers.

- Investigation & Standards Specialist or Technical Standards Specialist.
- Validated/qualified member of a similar qualification from an alternative ATSU or department trained as a peer reviewer.
- Human Factor Specialist.
- Line manager/supervisor of a similar operational discipline from an alternative ATSU or department trained as a peer reviewer.







## PEER REVIEW COMMITTEE

Committee member review:

The relevant employee involved has the right to review the name list of the peer review committee members and to request a replacement of his/her peer review committee member.

Right to appeal:

An employee has the right to appeal, in writing, any decision arrived at by the SMS Peer Review Committee to the SM: S&R/independent third party who will consider the appeal and will determine appropriate action based on the information presented.

Access to investigation information:

Employees involved in a safety event under investigation has access to all the investigation material via the S&R Section.





## CREATING A JUST CULTURE

- 3. Deciding and getting broad support for who gets to decide what is acceptable and unacceptable behaviour
- This group should understand the complexity practitioners (ATCOs and ATSEPs) have to deal with, be objective and be widely accepted by practitioners;
- Create a fair system which assesses at-risk behaviour, and allows for appeal.

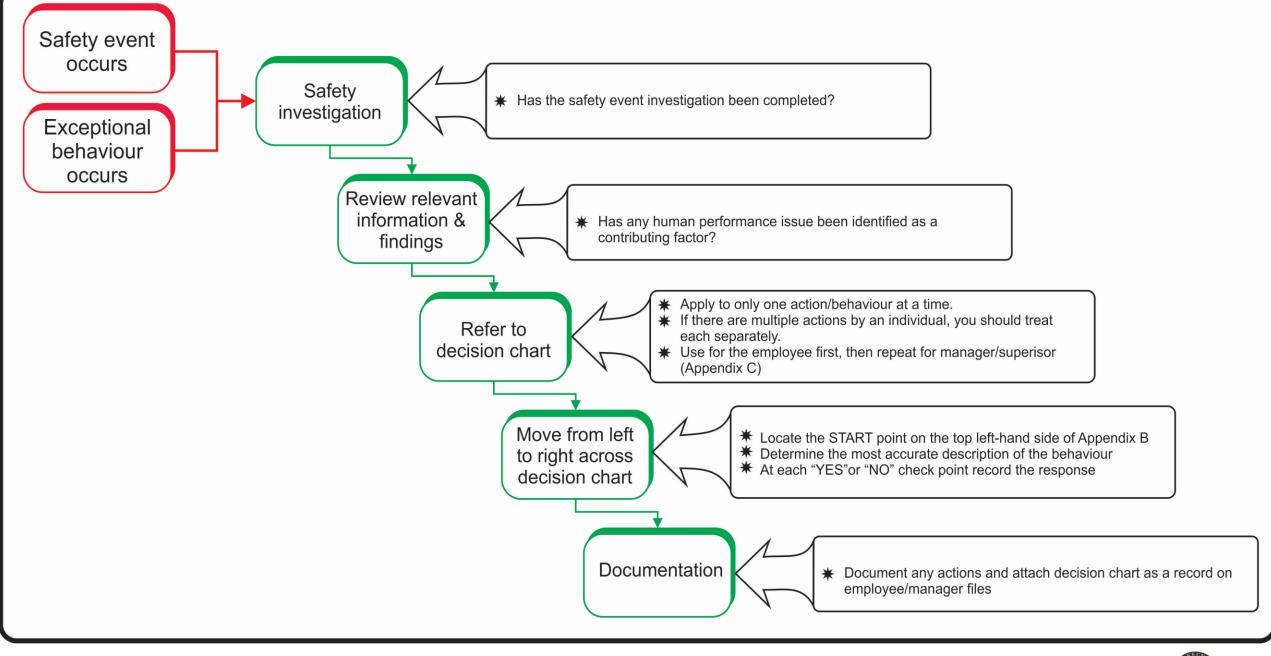




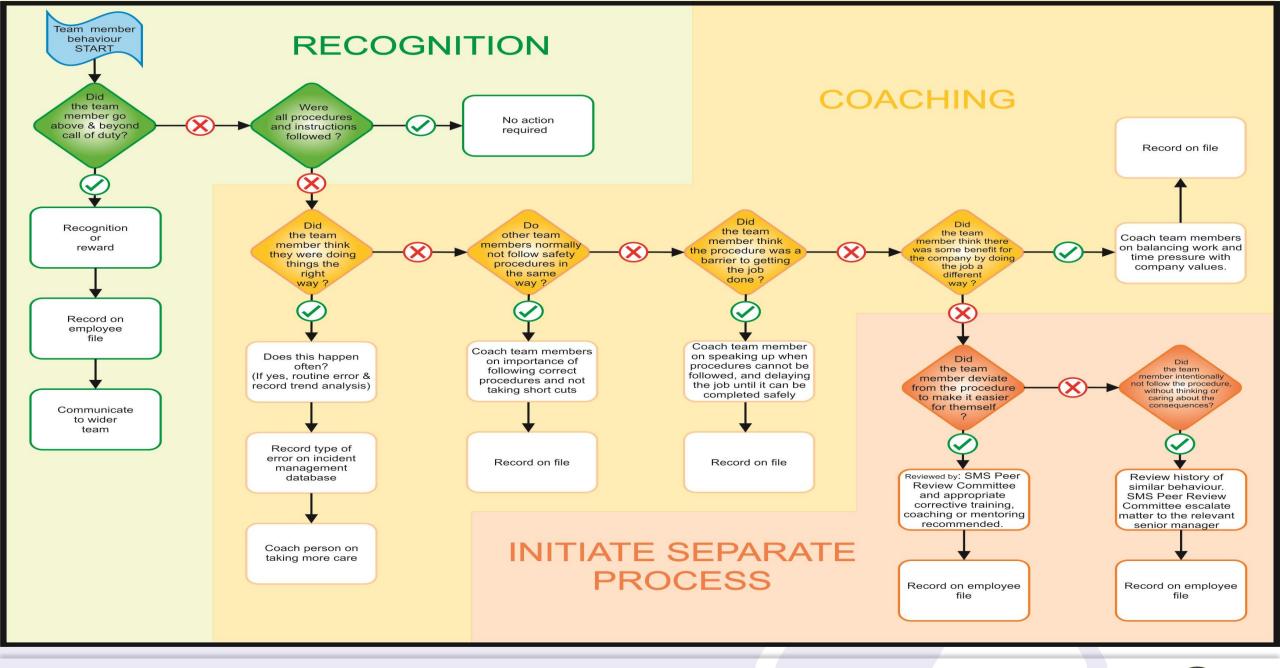
Our choices, actions and behaviours			
GOOD CHOICES	HUMAN ERROR	AT-RISK BEHAVIOUR	RECKLESS BEHAVIOUR
Result of good system design and good choices  Manage through:  Positive reenforcement Recognition Learning from what went well	Inadvertent actions: slip, lapse, mistake  Manage through:  Creating awareness  Better system or work environment design  Processes and procedures	<ul> <li>A conscious choice to act outside of what is required</li> <li>Manage through: <ul> <li>Understand factors leading to change in behaviour/practice</li> <li>Adjust process or system design</li> <li>Policy and procedure review</li> <li>Education and training</li> <li>Monitoring</li> </ul> </li> </ul>	Conscious and/or predetermined disregard of substantial risk.  Manage through:  Remedial action  Disciplinary processes
ENCOURAGE	SUPPORT	COACH	DISCIPLINE















## **CREATING A JUST CULTURE**

- 4. Switching from blame and backward-looking accountability to forward-looking accountability.
- <u>Create trust within the organisation</u>. This includes trust between fellow practitioners and trust between practitioners and management;
- Make it easy to share accounts. Take away hurdles which people might experience when sharing their account;
- <u>Give appropriate feedback to reports.</u> This includes both communication in response to reports, as well as visible action based on reports; and
- <u>Assist all parties involved in safety events and/or accidents.</u> If a system breaks down and safety events and/or accidents happen, practitioners involved suffer emotional labour. It is only just that they receive support to cope with this (CISM Program).



(Havinga and Dekker, 2014)



# **Disciplinary Policy**

VS

**Just Culture Policy** 





## **Disciplinary code – ATS OFFENCES**

#### Discussion

What will you consider as acceptable and unacceptable behaviours





# **Disciplinary code – Just Culture**

- 1. Recklessness
- 2. Gross Negligence
- 3. Wilful Misconduct/Sabotage



# **Disciplinary code – Just Culture**

Gross negligence	Before we deal with gross negligence we first need to understand negligence - Negligence is failure to exercise reasonable care/risks were reasonably foreseeable.  Gross negligence is failure to exercise any care/serious disregard to an obvious risk (Baines-Simmons, 2018)
Recklessness	Recklessness is a careless act that is a gross deviation from the standard of care a reasonable person would exhibit under similar circumstances. Someone who has behaved recklessly will have knowingly taken a risk that will have put others in danger. The recklessness standard is treated much more seriously than the negligence standard, because of the person's disregard that harm could come to other people by their behaviour (Accident Law, accident-law.freeadvice.com, no date).
Wilful misconduct (sabotage)	An intentional act of unreasonable character committed with disregard for a known or obvious risk that is so great as to make it highly probable that harm will follow (ARC 8294B, IAB 11/18/09, Legis iowa.gov)









How do you Embed Just Culture in in your operation?



#### **For Exco**

- Just culture basics (Presentation/workshop)
- Just culture survey results (Conducted during JC Training)

#### For Management

Management driven activities.

- Hold discussions with other managers on a monthly/quarterly basis on how they practice or embed just culture to their staff.
- Conduct staff briefings to explain JC in light of disciplinary code (differences and CAA/ICAO requirements) twice per annum to staff.
- Via file note confirm that staff involved in safety events understand return to duty process.
- During each disciplinary hosted in region, explain to local staff what is considered operational and fitting under JC or not ( (HFS will be available as required by ATS to assist line managers in preparing for the above engagement with staff).
- Safety event review meeting





#### **For Staff**

- Just Culture Quiz (Weekly, bi-weekly, monthly)
- Just Culture Discussion forums (Use safety culture discussion cards)
- Focus group (re. Just culture survey results conducted during JC training)
- Just Culture socialisation (For general staff-Orbit/brown bag session)
- Posters



WORKSHOP: SAFETY - FATIGUE MANAGEMENT, JUST CULTURE AND CISM SESSION 3: CRITICAL INCIDENT STRESS MANAGEMENT





# **FACILITATOR**



**Matita Tshabalala** 

Human Factors Specialist ATNS





# **OUTLINE**

What CISM is

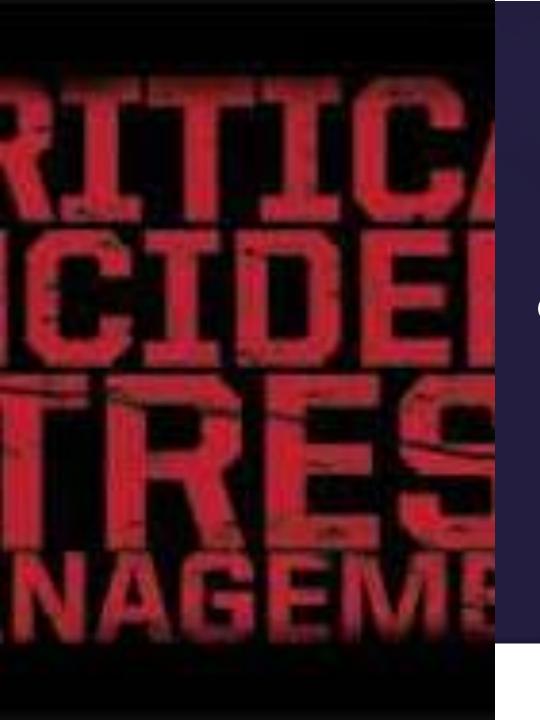
Critical Incidents

CISM Methods and Benefits

Strategies for implementing CISM

CISM vs EAP





Critical Incident Stress Management (CISM)









# CRITICAL INCIDENT STRESS MANAGEMENT

The 373/2017 EASA regulation requires all European ANSPs to have a CISM programme in place by 02 January 2020.

Peer-based support-programme for ATC addressing the special needs of this specified working environment.

What about Africa?

Is there a need?

How far are we?

Do you have this programme in place?



## CRITICAL INCIDENT STRESS MANAGEMENT

What is your understanding of CISM?



# **CISM**

Critical Incident Stress Management (CISM) is a structured and well-established **peer based programme** to support people/colleagues after a critical incident to facilitate **recovery and resilience**.

Eurocontrol, 2020





# **Critical Incident Stress Reaction**





# **CRITICAL INCIDENTS**

What are Critical Incidents?



# **CRITICAL INCIDENTS**

In an ATM-context, following situations may be regarded as possible critical incidents:

- Disasters and occurrences which cause devastating damage and causalities, e.g. severe accidents
- Assaults or threats, e.g. hijacking
- Aircraft emergencies
- Personally experienced/witnessed violence
- Separation infringements
- RWY incursions
- Near misses
- Suicide of a work colleague
- Etc

Eurocontrol, 2021





# **CRITICAL INCIDENTS**

A critical incident (CI) has the potential for being traumatising in the longer term if one or several of the following criteria are met:

- ☐ Feeling of helplessness/powerlessness;
- ☐ Feeling of guilt;
- ☐ Feeling of loosing control;
- ☐ Massive personal dismay;
- ☐ High degree of identification;
- ☐ Threat to life and health;
- ☐ The individual perceives the incident as intense or serious;
- The person has repeated thoughts about the incident that are intrusive and disruptive to the everyday functioning.

Eurocontrol, 2021





#### **Cognitive reactions (Thinking)**

- Slowed thinking
- · Difficulty making decisions
  - · Difficulty concentrating
    - Memory problems
- · Difficulty naming common objects
- · Seeing the event over (flashbacks)

#### **Emotional reactions (Feelings)**

- Anxiety
  - Fear
  - Guilt
  - Grief
- Feeling isolated
  - Anger

#### Typical Stress Reactions

#### **Physical reactions**

- Nausea
- Upset stomach
- Profuse sweating
  - Diarrhoea
  - Dizziness
- · Rapid breathing

#### **Behavioural reactions**

- Change in activity
  - Withdrawal
- · Emotional outbursts
  - Suspiciousness
- · Loss or increase of appetite
  - · Alcohol consumption





# DEFINITION OF CRITICAL INCIDENT





# **DEFINITION OF CRITICAL INCIDENT**

A critical incident is any situation that causes a person to experience unusual strong stress reactions that the person perceives as disturbing or disabling. Besides accidents, also minor events may be experienced as a critical incident specific to this working environment.

Eurocontrol, 2021









# **CISM METHODS**

#### Preventive education and training

Ocurses for managers, members of staff, colleagues of the above-mentioned professional groups or organisations

Different modules, depending on the target groups

#### **Assisting Individuals in Crisis**

☐ Structured individual intervention (SAFER-R) provided by a qualified CISM peer or MHP conducted immediately after the incident.

#### **Defusing**

Structured intervention in homogeneous groups provided by qualified CISM peers or MHPs conducted up to 24 hours after the incident

#### Debriefing

Structured intervention in homogeneous groups provided by a qualified MHP and qualified CISM peers conducted between 72 hours and four weeks after the incident



# **CISM METHODS**

#### **Crisis Management Briefing (CMB)**

The purpose of the CMB is to provide general information about an incident/ accident concerning a bigger group of people of an organisation and potential critical incident stress reactions, as well as the availability of peer support. The CMB is conducted by the unit manager and qualified CISM peers for large heterogeneous groups.

#### Follow-up / referral

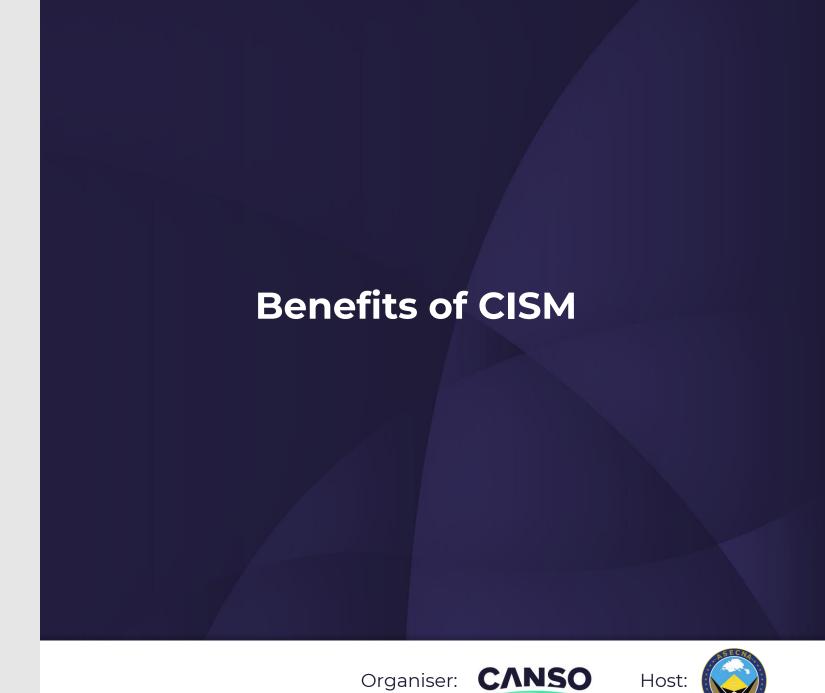
☐ In case the CISM intervention is not sufficient or the involved person shows symptoms that go beyond the actual incident a referral to professional experts is indicated.

#### Family and Organisational support

Counselling relatives and organisations of particularly affected professional groups.

This can include written information and recommendations.







# **BENEFITS OF CISM**

What benefits are derived from implementing CISM?



## Cultural Intangible Costs without CISM

#### Irrational beliefs (Albert Ellis)

"CIs do not cause CIS, they are part of the ATCO's life." "Once an ATCO shows weakness, he is unable to do his work." "There are no weak ATCOs!"

Hidden performance problems
Danger of chronification
No Learning



**Unsafe Culture** 

The global voice of ATM









#### Cultural Benefits of CISM

#### Rational beliefs

"CIS, emotional openness, and sustainable recovery are part of the professional self-conception!"



Performance recovery
Emotional coping
Professional improvement



Safe Culture

The global voice of ATM



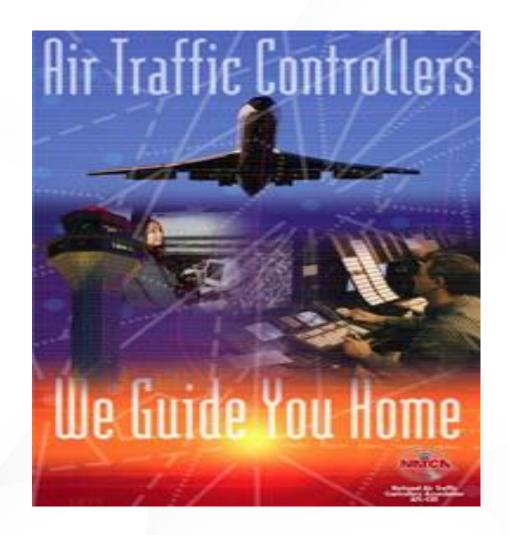






# **BENEFITS OF CISM**

- Reduce short and long-term distressing after-effects.
- Reduce the incidence of sickness and absenteeism.
- Reduce personal, marital and relationship problems.
- Reduce productivity problems at work.
- Reduce anxieties for anyone who may feel threatened or embarrassed if they had to ask for help.
- Reduce anxieties about stress and traumatic reactions being thought of as signs of weakness.











# **ROLE OF THE MANAGER**

What role should managers play in this process? If any?



# **ROLE OF THE MANAGER**



#### Managers should be able to do the following:

- They should offer and activate a debriefing following a traumatic event.
- Regulate and monitor own influence in managing stressrelated aspects of the incident (don't make things worse or say "it is not so bad").
- CISM debriefers are there to support managers in managing staff and their anxiety.
- Managers can help re-integrating the employee after an incident or a period away from work.
- Managers should supervise the progress of re-integration and monitor associated risks.







#### HOW DOES CISM WORK IN YOUR ORGANISATION

#### **Basic principles**

- · It is not part of an investigation.
- Debriefing is the ventilation of emotions in a safe and controlled environment. It also includes normalising the stress reactions and educating on coping.
- The goal is to get the employee back to the job as soon as possible without the effects of the stress hanging on.
- · A confidential process to assist traumatised employees with the recovery process
- · It is offered by volunteer debriefers and CISM workers/trainers.
- · It is a voluntary process and no one will be forced to use the service.
- · It is a service which is supported by top management.





# Strategies for implementing a CISM program



#### STRATEGIES FOR IMPLEMENTING A CISM PROGRAM



- Management support of a CISM program is vital for the program's success (Management training necessary for demonstrating buy-in).
- Develop a robust policy & communication plan (inclactivation/access to peer support).
- Extensively communicate through vehicles such as staff meetings, intranet and notices posted throughout the units, etc.
- Seek employee feedback so questions and concerns may be addressed.
- Provide continuous educational opportunities to encourage the use of services.
- Ensure annual refresher training for peers









# How is CISM different from the EAP services in the organisation?



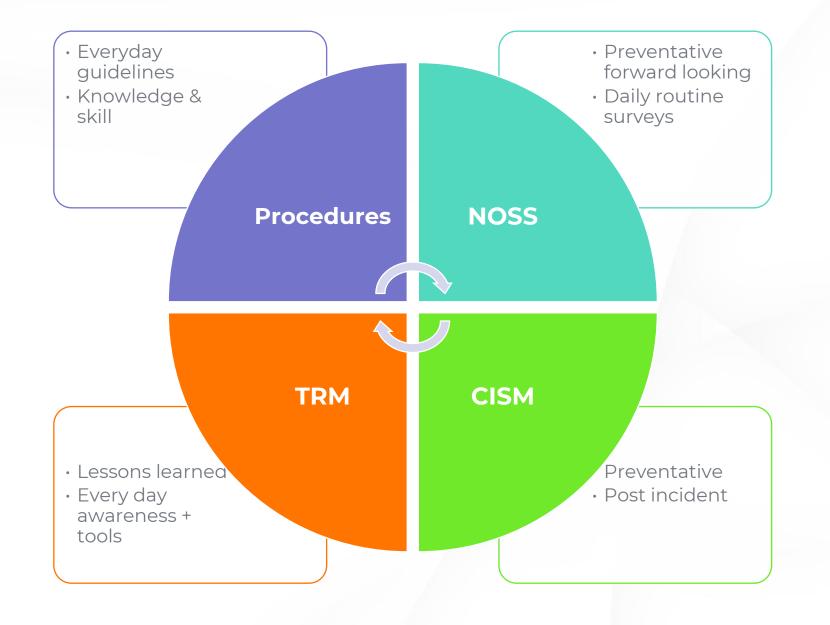
#### **CISM vs EAP**

- · CISM does not replace the Employee Assistance Programmes in the organisation
- It rather provides an additional short term service to employees which is offered by peer debriefers who understand the context and nature of the job, can be "on the scene" much quicker and can share some of their own traumatic experiences.
- These CISM volunteers or debriefers are all trained and will refer the employee for additional help at the EAP if required.



Is CISM a panacea and can solve all our problems?





## SKY IS SAFER WITH YOU

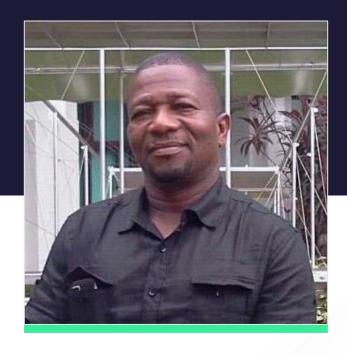


THANK YOU





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### **FACILITATOR**



**Loise Mwangi** 

CANSO Focal Point, Kenya Civil Aviation Authority, and Chair, CANSO Safety Workgroup







## **QUESTIONS AND ANSWERS**





# SUMMARY AND CLOSING REMARKS





## **CLOSING REMARKS**



**Thabani Myeza** 

Director Africa Affairs
CANSO





#### **CLOSING REMARKS**



**Touré Arouna** 

Director of Safety ASECNA





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