Just Culture Employee Handbook

Purpose

The organisation has published a Just Culture Policy to communicate how Core Objectives outlined in the Safety Policy will be implemented from a Just Culture perspective. Just Culture is considered to be an organisational wide concept; one focussed on the delivery of our safe and resilient services through an approach based on systems-thinking.

This handbook provides useful information which all staff can use to understand the implementation of Just Culture within the organisation. A Just Culture is not only in support of our safety management practices although this is the primary focus. The Just Culture Policy and the guidance within this handbook is beneficial to a broader culture of service improvement in aid of strengthening the organisation's reputation.

Scope of Handbook

An introduction to Just Culture is presented including the context of how it is defined in this organisation by adopting and adapting recognised definitions for Just Culture. In line with the Safety Policy the SMS Core Objectives are explained in the context of a systems-thinking[1] Just Culture approach. The topics include:

1. Deliver Safe Services; covering guidance on safety risk assessments and the human dimension including the role of staff within safety risk assessments.
2. Analyse Service Safety Performance; covering guidance on event reporting and internal and external incident investigation. The approach to classifying system behaviours is explained here also.
3. Identifying Service Safety Improvements; covering guidance on the role of identifying actions to improve the safety performance of our services and the involvement of employees and external organisations to aid learning.
4. Controlling Change to Services; covering guidance on how to effectively design and implement changes to the services we provide through a foundation of clearly understanding how the work is done today and how it will change tomorrow.

Management of Handbook

This handbook is owned by the Safety Manager on behalf of the Accountable Executive. It will be updated on an annual basis to reflect our developing understanding of Just Culture within the organisation from our own learning opportunities as well as other general developments from within the aviation industry and other industries.

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[1] https://humanisticsystems.com/2019/11/25/four-kinds-of-thinking-2-systems-thinking/

Introduction

Safety management systems allow us to monitor and improve levels of safety in our operations. The organisation relies on constant and constructive information to both design the services the organisation delivers and validate the safety of those services in operations. A key source of this information comes from our employee input; both management, support staff and front-line operators. A Just Culture is absolutely essential to the sharing and reporting of information within safety-related environments, because people need to feel empowered to raise attention to safety concerns, even though they themselves may be implicated in the uncovering of that safety concern.

Everyone within the organisation has the potential to face situations where an undesirable event is a possible outcome. This is despite their training, expertise, experience, abilities and good will in conducting their tasks. This is because there are limits to human performance especially in those scenarios where there are unwanted and unpredictable systemic influences. Our company seeks to create an a psychologically safe environment in which staff can bring to attention underlying safety concerns and potential improvements without fear of repercussions. The clear exception to this is in cases of wilful and/or significantly negligent acts by an individual or group of individuals. All staff have a responsibility for safety.

Definition of Just Culture

The Just Culture in the organisation is based on systems-thinking. This is where the organisation chooses to analyse the behaviour of the system rather than the individuals within it; except for when it may be judged that an employee demonstrates a disregard for safety through gross negligence, wilful violations and destructive acts. Systems-thinking is the basis for the handbook and the implementation of all safety management and other organisational processes within the organisation.

The organisation recognises that there are multiple definitions of Just Culture. A published definition by the European Commission, Eurocontrol and IFATCA Just Culture is defined directly below.

"Just Culture is a culture in which front-line operators and others are not punished for actions, omissions or decisions taken by them which are commensurate with their experience and training, but where gross negligence, wilful violations and destructive acts are not tolerated"

Whilst the organisation agrees generally with this definition, singling out front-line operators from other staff members, including management, does not adequately reflect the organisation's systems-thinking approach. A systems-thinking approach recognises Just Culture as an organisational wide responsibility and therefore **the organisation has adopted the Just Culture definition below**.

***"Just Culture is a culture in which our understanding of safety, and any unwanted events, is based on the understanding of the system and its environment.** **Only in exceptional circumstances will individual actions be examined to determine whether gross negligence, wilful violations or destructive acts have occurred.**

To further explain Just Culture additional context is provided. A Just Culture is;

1. Where we always focus on understanding the behaviour of the system in our analysis of safety.
2. Building an atmosphere of trust between management and employees to create a positive Safety Culture

3. A way of safety thinking which promotes a questioning attitude amongst all staff, resistant to complacency and fosters both individual accountability and organisation self-regulation of safety matters
4. About fostering a positive and healthy working environment where employees can share their accounts and experiences in the knowledge that this will add to organisational understanding of risk within the organisation
5. Where staff feel empowered to openly and honestly report safety concerns and any unintentionally committed errors within the reporting system without fear of retribution.
6. Staff recognise and understand the difference between acceptable and unacceptable behaviour
7. Individuals will not be blamed for honest mistakes or errors; however, they will be held accountable for gross negligence, wilful violations and destructive acts.

A Just Culture is NOT;

1. Focussing on the individual human behaviours without consideration of the system and environmental context.
2. Finger pointing and apportioning blame as a means to improve performance.
3. Providing complete protection of staff in the event of aviation incidents and accidents. Particularly, it does not offer protection in case of gross negligence, wilful misconduct and/or destructive acts.
4. A blame-less / blame-free culture

Benefits of a Just Culture

"An incentive for a Just Culture is very simple, without it, an organisation won't know what is going on within it - Sidney Dekker, 2007"

A Just Culture is important to the organisation as it creates an environment of trust where staff feel empowered to contribute to safety, for example, by being willing to report any issue that may impact the safety performance of the operation or by challenging existing working practices that are not suitable for operation.

Only when we uncover all the safety issues in our operation can we sufficiently manage them by identifying improvements to the system. The result is improved safety performance within the system which reduces the number of incidents and accidents.

Deliver Safe Services

This SMS Core Objective requires the organisation to create a safety risk picture for the services it delivers. Systems-thinking will form the basis of the process for safety risk assessments and the development of the safety risk picture within the organisation. Hazards will be defined at the service provision level and based on the events that cause loss of system control. Hazards will be defined for each operational scenario within the organisation with support from staff involved in the delivery of services. Hazards will not be defined as human error or failure.

Safety Risk Assessment

The basis of understanding the safety risk in the organisation is based on the contribution from all elements (human, machine, environment and organisation) in the system that ensure the safe movement of aircraft in each operational scenario. It is this contribution that ultimately prevents the hazards and the worst consequences from occurring: i.e. what do the actors in the system do to ensure that these loss of system control events do not occur. The role of the human will never be

isolated from the system context and concepts such as human error will not be used within the organisation.

The Human Dimension

The activities performed by the human and machine actors are not, and will never be, 100% effective. Therefore, the safety risk assessment process will include a supporting analysis that will identify and mitigate system deficiencies that could occur in our operations that could cause activities of the actors to fail or be undermined.

System deficiencies related to the human (human factors) will be identified. Human factors represent the limits of cognitive and physical abilities of human performance. All human factors within this analysis will be identified by staff involved in the delivery of the services. The overall goal of this analysis is to identify mitigations that will maximise the effectiveness of the actor activities. There will be an emphasis on machine based solutions to resolve any human factors identified by following a hierarchy of controls approach.

Training and procedural mitigations will be considered only when appropriate and for factors that identified as low criticality.

Performance Indicators

The identification of safety performance indicators will be part of the safety risk assessment process. Performance indicators will be defined based on the output of the safety risk picture created for each service. Indicators will be defined for both controls (success) and system deficiency (failure) events. For example, understanding the performance of the controls in the context of how often they perform their function as per the design, as well as understanding failure events such as the worst consequences, hazards, and system deficiencies.

The identified performance indicators, as far as reasonably practicable, will be selected to highlight potential factors that may contribute to a serious incident or accident. The value of the system deficiencies being identified as leading indicators is that it provides a more systematic approach to incident investigation and the development of proactive performance intelligence. The use of leading indicators ensures that we have appropriate triggers in place to help us understand the safety risk level of the operation in real-time.

In relation to investigations covered under the next section, the organisation believes that the identification of system wide performance indicators based on a pro-active risk picture is a critical input into event investigation. This means that the way we learn about why incidents occur is in the context of the system wide performance factors rather than specific human error conditions for the individuals involved.

Analyse Service Safety Performance

This SMS Core Objective requires the active reporting, collation and analysis of performance information. The performance analysis will be informed by the safety risk pictures identified for each service within the organisation, i.e. based on the service level hazards. All performance information will be analysed and presented using a strategic analysis of trends rather than single events.

The reporting of events by staff and the approach to investigation forms a significant part of this Core Objective. Guidance on reporting and internal investigation in support of a Just Culture is documented below. Information on potential external investigations is also included in this section and this is based on the State legal framework.

Reporting of Safety Information

Benefit of Reporting

Writing a report after having been involved in an event can often feel like an inconvenient and time-consuming action, however, it is important and helpful for three reasons;

1. Reporting provides opportunities to raise awareness of excellence in working practices within the service operation or ideas for safety improvement.
2. Reporting provides intelligence on the behaviour of the system at the time of an event such that targeted improvements can be implemented.
3. Reporting serious incidents is required to comply with state reporting regulations. Failing to report a mandatory occurrence will place our organisation in breach of the regulation.

Any member of staff who witnesses, is involved in, or has knowledge of a safety concern which they believe poses a potential threat to safety is encouraged at all times to report. If the events are covered by the mandatory occurrence requirements then it must be reported as it is a regulatory requirement. The mandatory occurrence requirements are referenced from the Report Mandatory Occurrences process.

How to Report

The organisation has made available, through electronic reporting forms, two separate methods for reporting. The first covers mandatory occurrences and the second relates to any other voluntary information that staff wish to report. It is recommended that all staff complete the form directly themselves, without involvement from supervisors or other parties, to ensure the event or information is captured independently and correctly as a first-hand account.

Report Content

The content of the report, and the language and style, is important. From a safety point of view it is recommended to provide as much information that is relevant. However, it is best to provide a concise summary of the facts in the documented report.

The report should;

1. Use neutral language
2. Not include names of other staff members
3. Include information that is short and factual in order to protect the participant involved in the event, especially for unintentional incrimination (see language below that should be avoided).
4. Not include emotive language and should not place or infer blame on other parties.
5. Not include judgments, assumptions and / or interpretations.

Avoid using wording in reports such as;

1. I forgot…
2. I assumed…
3. I was not aware…
4. I was sure the aircraft….
5. I thought it might….
6. The pilot promised to….

Incident Investigations

Benefit of Investigations

Conducting investigations into safety occurrences or events contributes significantly to the identification of system factors that have the potential to cause incidents or accidents. Targeting of these factors helps the organisation mitigate any possible undesired outcome which leads to an improvement of the organisation's safety performance.

The objectives of an investigation are to assist in the prevention of accidents, incidents and other series operational events through:

1. Ensuring that relevant events are properly investigated;
2. Learning about what happened and why it happened; rather than attribute blame or liability;
3. Understanding the effectiveness of our operational safety controls;
4. Understanding the trends in system deficiencies;
5. Identifying appropriate mitigations, or modifications, by prompt analysis and exchange of safety data;
6. Improving our competence and professional performance level.

Scope of Investigations

All reported events will be reviewed to determine whether an investigation is required. In general, the investigation process will be applied for all Mandatory Occurrence Reports and selected other events reported voluntary that are deemed useful to the organisational learning.

An initial investigation may be conducted by the supervisor immediately following an incident or event. This is a fact-finding activity and does not necessarily mean that a full investigation will be conducted.

Use of Personal Data

It will be required to collect personnel data from those involved in an event. This will only be to ensure that appropriate information can be gathered and feedback provided.

The organisation will not disclose personnel data without their permission unless required by law.

The Investigation Process – Immediate Assessment

Immediately following an incident or event, the supervisor of the person who participated in the incident will perform an initial analysis of the incident based on the nature of the event, the potential impact on on-going service provision and the health and wellbeing of the individual. The purpose of this initial assessment is to ascertain:

1. If the operation remains fit for service delivery or whether it shall be restricted or the service withdrawn, pending full investigation.
2. If the staff member is fit for continued operational duty or shall be temporarily removed from duty pending an assessment of their health and wellbeing.

The supervisor shall gather and store all available data from the operations to assist in any on-going investigation if one is initiated.

The Investigation Process - Formal Investigation

Where an event has been selected as requiring a Formal Investigation a Lead Investigator will be allocated. The role of the Lead Investigator is to gather all available information relating to the event and conduct an analysis of the incident scenario. The goal of the investigation is to understand the

operational context within which the event occurred, so as to help gather information to inform the performance analysis. Where appropriate the investigation may also identify new mitigations to improve the effectiveness of the system.

Staff will be required to participate in interviews to help learn about what happened and why it happened.

The Lead Investigator will document all information in an Investigation Report. The staff member(s) involved in the incident must be appropriately debriefed by the Lead Investigator regarding the conclusions of the investigation. This may be completed either face-to-face or by telephone, however, it must also be communicated in writing (by email).

As part of the overall Investigation process the behaviour of the system (human, machine, environment etc) will be interpreted. However, the Lead Investigator will not be involved in identifying or classifying the system behaviour. This will be performed by a Just Culture Peer Group as a subsequent activity using the Investigation Report. This is explained further below.

Interpreting System Behaviour

Using the results of the investigation, a Just Culture Peer Group will meet to interpret the system behaviour at the time of the incident. This will happen through a systemic analysis of the incident taking into account all relevant factors, such as culture, technology, procedures and circumstances. A set of system behaviours have been defined to support the Just Culture Peer group make their interpretation. The analysis will involve reviewing the actions of the human and the machine elements to help describe the system behaviour.

In those cases where the system behaviour is interpreted as working outside the system boundary, an assessment of the human behaviour is required. In this case the interpretation of behaviour must be conducted by qualified members of the peer group. The method is used to support the Just Culture Policy by demonstrating how fair treatment will be ensured, illustrating where the 'red line' for culpable action falls.

The method for system behaviour classification has been adopted to meet the needs of the organisation and is accepted by the staff representatives.

The scheme applied in the organisation is based on a systems-thinking approach influenced significantly by the Human Behaviour Classification scheme defined by Brüggen and Kools at www.safetyandjustice.eu. The terminology for behaviour has been adapted to align with systems-thinking and uses "system behaviour" rather than "human behaviour" as used within Brüggen and Kools.

Author _Note:_ _The scheme here is used only as an example and the scheme must be selected that is most appropriate for your organisation and maturity._

The process for establishing system behaviour includes three steps:

1. Interpret and classify system behaviour
2. Determine the most appropriate action.
3. Escalate system behaviour to line management, only where appropriate.

Where system behaviour is identified as being outside the system boundary then the routine and / or substitution test must be applied to determine human behaviour. This step will be conducted by an independent Just Culture Peer Group separate to the line management of the individual involved.

Note that the process must be completed without sharing the name of the individual(s) involved in the event within the Peer Group.

Refer to the *'Investigate Safety Events'* process and the System Behaviour Classification Guidance for further details.

Just Culture Peer Group

The System Behaviour classification will be conducted under the governance of a Just Culture Peer Group. The Just Culture Peer Group should have the following representatives:

1. Safety Manager (Acts as Chair)
2. Operational Peer Group Representative(s)
3. Technical Experts (Design and Operations Representatives)

All attendees of the Peer Group must be trained, on a periodic basis, in the Just Culture Policy and working practices of the organisation. All attendees must remain independent from any individual's involved in the assessment, outside of their line management chain.

The Peer Group does not have responsibility for determining appropriate actions for any individual who participated in the event based on the classified behaviour. Where a system behaviour classification has identified a potential event involving gross negligence, wilful violations or destructive acts of an individual (or group of individuals?), the Peer Group will notify the manager of the individual(s) and the Human Resources Just Culture point of contact.

Behaviour Classification Summary

The organisation has adopted the scheme below to support the classification. The method for interpreting and classifying system behaviour is complex. The following summarises the classification of system behaviours, example situations and some guidance on appropriate action. The scheme also supports drawing the line between acceptable and unacceptable behaviours.

Level	Behaviour Classification	Example situation	Guidance on Human Behaviour
1	System worked as per design in new operational situation.	The system handled the situation using all its capabilities. The machine functioned as per design. The human handled a difficult operational situation with a potentially serious outcome with exceptional skill;	Recognising exceptional behaviour is an important element in a just culture, but it is important to be clear about WHAT you are rewarding and HOW you reward it.
2	System worked as per design in known situation with new working practice.	By thoroughly understanding how the system works, the human was able to apply a new working practice using the machine as designed to handle the situation; considered an improvement within the system boundary.	Improving the system effectively demonstrates a high level of skill. This should be recognised and rewarded, not just for the individual but also because sets a model for other people as how they can apply their expertise and insight to help everybody improve.
3	System working as per design in standard situation.	The machine functioned as per design and the human followed standard working practices, taking action where appropriate.	Working well with the system should not be trivialised. Recognising and rewarding this will establish this way of working as a desirable state. If you do not recognise or reward it, people will see working with the system as dull, boring and unattractive.

Level	Behaviour Classification	Example situation	Guidance on Human Behaviour
4	System not working as expected.	The machine function did not operate as per design or the function was misleading to the human or the human made an error. These can be "slips" or "lapses", where an action was forgotten or the action was unintentional. Or it could be a "mistake", in which the wrong procedure was applied (action was intentional, follow up was not).	Apply the Routine test to determine most appropriate action: - First occurrence; Review whether the procedure as specified for normal work is known, clear and understood by everyone. Consider attitudes of the person to reporting deficiencies in working practices. - Repeat occurrence by same staff member: understanding whether there are system deficiencies (e.g. machine function, training or procedure inadequate) or the persons competencies / attitudes are not sufficient. Temporarily removing the person from the process is beneficial for all parties. - Institutionalised behaviour: serious system deficiencies exist (e.g. machine function, training or procedure inadequate) or a cultural acceptance of deviation is the norm. System and/or cultural improvement required immediately.
5	System not working as designed	The machine performed an action not within known design parameters or the human did not follow the defined procedure as either the rule was not known, or the rule was too ambiguous or complicated to understand properly.	Apply the Routine Test to determine most appropriate action (see above for further details): - First occurrence; - Repeat occurrence; - Institutionalised behaviour;

Level	Behaviour Classification	Example situation	Guidance on Human Behaviour
6	System working outside design boundary for system benefit	The machine functioned as per design but allowed an incorrect (but workable) action to be performed. The human knowingly performed an action that they knew did not meet the rule (and the rule in principle was workable) but they decided that the action was required in the situation.	Apply the Routine Test to determine most appropriate action (see above for further details): - First occurrence; - Repeat occurrence; - Institutionalised behaviour;
7	System working out design boundary for individual benefit.	The machine functioned as per design but allowed an incorrect action to be performed. The human knowingly performed an action that they knew did not meet the rule as it suited their needs and not the needs of the System.	This is potentially reckless and unacceptable behaviour. Clarifying the reasons are critical. Organisational or temporary environmental constraints may have influenced the decision making. Natural blame biases (or Fundamental Attribution Error) must be guarded against. Situations like this need to be dealt with immediately and with clear action. Apply the Routine Test to determine most appropriate action: - First occurrence; - Repeat occurrence; - Institutionalised behaviour; The Substitution Test must be performed, considering whether a different person (well-motivated, equally competent, and comparably qualified) have made the same error under similar circumstances. If "yes" the person involved is probably blameless, if "no", then negligent behaviour should be considered

Level	Behaviour Classification	Example situation	Guidance on Human Behaviour

Incident Investigations - External

State Accident Investigation Authority and Judiciary Investigations

There are two types of external investigations that could be conducted following an incident and details surrounding the key differences between the investigations are listed below.

[This information MUST be confirmed for each State]

External Investigations	
State Accident Investigation Authority	**Judiciary**
To be defined.	Apportions accountability and culpability. *Legal investigations do not follow Just Culture Principles.*
To be defined.	*Reference any applicable state laws associated with criminal investigation*

Employee Involvement in Judicial Investigations

It is foreseeable, based on international experience relating to serious incidents and accidents, that the State Judiciary may get involved in prosecutions of individuals as a result of an incident in the State. The type and the scale of the incident that may qualify for judicial investigation is not known but generally relates to events that endanger the public. As the Judiciary is bound to the law there is little to no scope to deviate from it for the benefit of Just Culture and/or the accused – it is subject to a case by case appreciation by the competent judicial authority.

The organisation will support all staff in these circumstances subject to the result of the internal investigations relating to acceptable and unacceptable behaviour i.e. applying Just Culture principles. It is important to note that Judiciary Investigations will not necessarily follow Just Culture Principles. The judiciary process is exactly interested in allocating blame to person(s).

Please note these key messages:

1. You are entitled to legal representation
2. You will be required to provide a statement to the criminal investigator
3. During the judiciary investigation your licence(s), certificate may be suspended/ revoked

Outcome of Judiciary Investigations

This section should be completed based on local State activities

Identifying Service Safety Improvements

This SMS Core Objective advocates the identification of short, medium and long-term improvement actions to improve safety performance of our services. This is through a collaborative approach with our employees, customers and suppliers and other aviation stakeholder parties.

Employee Involvement

Our approach to safety improvement is a collaborative process that seeks engagement from all staff involved in the lifecycle of the system that delivers our services. We look at resolving issues by making permanent changes to the system rather than using shorter term measures such as training, procedural updates and safety bulletins. However we recognise that such measures may be required in the interim to mitigate the system issue.

Our staff are best placed to understand the most effective improvement opportunities. Staff should actively raise their ideas for improvements, for example, through the voluntary safety information reporting process.

Working with other external parties

Learning from those outside our organisation is a critical part of our overall safety improvement approach. As an organisation we encourage our staff to engage with other organisations within our industry and other mission critical or safety related industries. Active participation in work groups and research by our staff is valuable to the organisation's development and reflects our desire to continually improve our operations.

Controlling Change to Services

This SMS Core Objective requires the organisation to understand how the system operates in the current environment before assessing the impact of any proposed changes. This enables the organisation to understand the potential impact of changes on safety risk levels.

Understanding the system in current environment

To be able to understand the impact of change the organisation will ensure that there is a clear description of how the human and machine actors within the system, including actors outside the organisation, work together to deliver the service or services that are impacted as part of the change. The focus will be on understanding the working system from a *work-as-done* perspective as far as reasonably practicable. This will require active collaboration between operational staff and the project design staff to detail the current working arrangements.

Understanding the impact of change

The desired 'to-be' system that the organisation aims to implement will be described, as far as reasonably practicable, following the same contextual understanding of the current environment. This will be based on knowledge of operational staff working closely with the project design staff.

The description of the change will start with assessing any changes to what the system delivers as part of the services. In many cases 'what' the system delivers will not change but instead 'how' the system delivers the service will change. The description of the change will detail the changes to all actors within the system, including those outside the organisation as mentioned above. For the human dimension any change in responsibilities of the staff across the entire lifecycle of system operation will be noted.

Safety risk assessment of changes

The safety risk assessment of the change will follow the same process for assessing the safety risks of the baseline service. Safety risk will always be presented for the service that is being delivered and never for the 'change' itself.

The safety risk picture created for the service will be used as the key input into the change processes. A detailed impact analysis of the risk picture based on the change description will be performed with support from staff from all stages of the system lifecycle. The risk models will be chosen by reviewing all hazards associated with the phase of service delivery that is being changed. However, it must be noted that changes to the system that delivers one particular phase of service may impact the safe delivery of services within an adjacent phase.

The safety risk assessment method should then focus on the effect of the change on the elements within the safety risk picture that have been identified as impacted, for example, a specific safety control, system deficiency or the mitigation to manage the system deficiency. Similar to the risk assessment process for the baseline services, an analysis of new system deficiencies will also be conducted with support from staff from all stages of the system lifecycle. This will include any new system deficiencies, or human factors, linked to human performance.

The outcome of the safety risk assessment will be an expert judgement of whether the likelihood of the hazard has increased or decreased, or whether the likelihood of the consequences has changed. This will be used to understand the impact of the safety risk level. Note: In the majority of cases the severity of the consequence will not change as a result of the change being implemented as the users and environment the service is delivered will not change.

References

This Handbook has been generated from material from the following sources:

1. *Just Culture Tool Box; Authored by ATM Partners for Just Culture, September 2018.*
2. *Just Culture Manual for ATCO, ANSE & ATSEP - Behavior after an incident and further proceedings, Swiss ATCA, 2018.*
3. *Human Behaviour Toolset, Bruggen and Kools,* www.safetyandjustice.eu.