



## Lessons In Safety Leadership

**Directors and Senior Managers, clients and contractors, take note. The loss of a military aircraft over Afghanistan, and with it the lives of the 14 personnel on board, might not seem the most obvious context for the latest learning in safety leadership. However, the recent publication of the findings of an inquiry into the causes of a mid-air explosion on board a Nimrod aircraft in September 2006 includes a master class in how not to approach safety leadership, providing lessons which are in fact applicable across the public and private sector.**

The report is the product of a 20 month inquiry, staffed by a team of lawyers and headed by Charles Haddon-Cave QC. Evidence was taken from over 100 witnesses, several thousand documents were read and input was received from several experts.

Whilst much of the report is dedicated, as one would expect, to the chain of events which directly led to the fire during a mid air refuelling exercise, and triggered the fatal explosion, it also features a detailed analysis of the attitudes, behaviour and the culture of the organisations involved which could just as easily be a description of many well intended busy private or public body.

The report highlights events which amounted, in the opinion of the inquiry team, to "a failure of leadership, culture and priorities".

One of the most interesting points made is the danger of starting from a point of complacency in the context of safety matters. In the case of the Nimrod fleet, in respect of which a change in law had introduced a requirement for the production of a "safety case", the report observed that at the outset of the task the general mindset by those in charge was that the fleet of Nimrods were safe.

There had been relatively few incidents involving Nimrod aircraft. Although each was investigated at the time, the report concluded that they had been regarded wrongly as isolated matters. Had someone stood back and taken an overview, the report concluded that vital clues would have been visible about the risk of a catastrophic fire during mid air re-fueling.

Added to the comfort gained by this past performance, there was also a strong belief that the Nimrod had been a great success story due to its valuable role in combat. This mindset produced a "malaise" which, according to the report, diluted the robustness of the exercise to assess the safety of the fleet.

The task of producing a safety case had been allocated to a contractor but the report found that the client had not acted as an intelligent customer. The specification lacked detail and no clear agreement had been reached on methodology.

The quality of the contractor's work was severely criticised in the report. Information held by operators and maintenance operatives was not sought out and numerous hazards identified were simply not closed out by the time the safety case was handed over to the client.

The client's willingness to sign off the contractor's work was also heavily criticised. The safety case produced had not been read by the client; had it been, numerous errors and omissions would have been spotted. Instead, the contractor's overly optimistic presentation was relied upon without any probing.

The organizations culture also came under criticism as witnesses spoke of airworthiness having become eclipsed by 'business' with functional reporting lines replaced by business units and stream lining which had removed important layers of "checks and balances".

So too was evidence heard of a shift in priorities towards 'business' and financial targets, at the expense of functional values such as safety and airworthiness and that blanket instructions to save money had taken no account of the impact on safety.

The report concluded that there had been a "yawning gap between the appearance and reality of safety" and that each of the organisations involved was guilty of a wholesale failure to do their job.

This report is a timely reminder of the catastrophic loss of life and reputational damage which can flow where safety is poorly managed. Osborn Abas Hunt has considerable experience in providing training and advice on safety leadership. Please contact Madeleine Abas for further information.