Assessment and evaluation of the safety culture in the air operations organisation of AirExample

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Classification

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Executive Summary

Task and description of work

SIG Aviation has been requested to assist AirExample with an independent assessment of the safety culture present in the organisation. For this purpose, SIG Aviation used a bottom-up approach where interviews with staff were based on the results of a survey conducted a week before SIG Aviation arrived in [City]. The goal of this approach was to identify possible hotspots and their origin in the safety culture. Various manuals, procedures, reports and correspondence was reviewed as part of the preparation scope. During the visit in [City] from 4 – 7 March 2024, in total 21 interviews with staff members were held in various locations in [City], [City2] and [City3]. These staff members represented all layers of the organisation.

Results and Conclusions

There are clear indicators present from the SMART survey that point towards a hotspot in the AirExample organisation with respect to the awareness and behaviour related to safety culture. By means of the interviews, it was confirmed that this identification is correct and likely related to the soft skills or behavioural patterns exercised by the AOC management.

The AOC organisation does not function as one entity, but instead is divided into two sides. One of these sides can be described as 'conservative' and the other as 'get things done'. One of the interviewed staff added to this last description 'yes, they want to get things done – **at all costs**.'

It is clear that the organisation faces challenges related to cost control, route optimization and staff turnover. However these challenges are not unique, and an experienced ACM can find a balance between upholding safety principles and pursuing a competitive course. All staff interviewed expressed understanding for this necessity. The management style of the ACM can be described as autocratic and authoritative. Staff describe micro management, interference reducing efficiency, bullying, incorrect decision making and safety recommendations being ignored. The majority of these observations trace back towards the actions of the ACM, and the group that he surrounds himself with.

The ACM is hungry for power, and seems driven to obtain more irrespective of organisational goals. This points towards the ACM not fulfilling expectations and requirements with respect to safety management and organisational continuity required for this position. The ACM is the frontman of the AOC. Revocation of trust in the person holding that position can jeopardize the AOC itself. Surprisingly, this organisational risk that clearly results from the behaviour of the ACM has not been recognized.

Doing nothing is no longer a valid option, and the perception that the ACM is part of the core problem raises the decision making to the level of the CEO. It is recommended for the CEO to take decisive action to restore the situation. Not taking a decision, will be perceived as an endorsement and will likely result in a further deterioration within the organisation. Consider replacing the ACM by a person that has more operational credibility and sufficient business instinct to implement a collaborative management style whilst pushing the organisation forward and regain credibility from both CAA and AirExample staff. CAA should be included as a trusted party in the decisions taken to ensure they remain onboard. The 'deputy ACM' position should be retracted from the organisation to restore clarity in responsibilities. When vacant positions are filled, ensure that staff capable of independent thinking is placed there. Ensure that the changes are closely monitored as part of the Management of Change process defined for the AOC.

SIG AVIATION

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1 Introduction

Safety can only be regulated to a certain extent, and even organizations that are fully 'in compliance' with regulatory frameworks are not necessarily the safest. At one moment, ensuring safety is no longer only about regulatory compliance but more about how all the people that are part of the organisation recognize and act on events that might have an effect on safety. This is considered to be the organisation's safety culture. This assessment uses the EASA SMART method to measure the presence and level of this safety culture in AirExample's air operations organisation.

1.1 What is safety culture?

Whether an organization realizes it or not, it will have a number of different "safety cultures" that reflect group-level attitudes and behaviours. No two organizations are identical, and even within the same organization, different groups inside that organisation may have various ways of thinking about safety, talking about safety and acting on safety issues.

Having these different safety cultures is the natural consequence of having humans in the aviation system. It is an expression of how safety is perceived, valued and prioritized by management and staff, based on a variety of social conventions, knowledges and commitments.

"The safety culture determines how people behave in relation to safety and risk when no one is watching"

Safety culture is the way in which safety is perceived, valued and prioritised within an organisation. It reflects the real commitment to safety at all levels of the organisation. In short, it is the set of values, behaviours and attitudes relating to safety matters, which are shared by the entire human group that is part of the organisation, from the executive management to the front line operators. This is not something that can be imposed or achieved easily, as it also includes the behaviour we adopt when nobody is watching, or when we think nobody watches.

Measuring the presence and scope of safety culture in an organization is challenging as it involves assessing intangible aspects such as values, beliefs, and attitudes.

Without doubt a culture of safety can only materialize and foster when management is truly committed: it that sense it is a product directly related to the efforts of management. Traditionally, there are regulatory elements that address this management commitment such as requirements for a policy and management system for safety. In most organizations however, the behavioural patterns of management will influence the functioning and perception of safety culture to a much larger and direct effect than those regulatory components. Actions of management, visible to staff, that (seem) contrary to the key promotors of a safety culture, will have a direct and significant effect on the organizations ability to achieve its safety goals.

"Safety arrives by foot, and departs by horse"

1.2 SMART method

SMART is an acronym of Safety culture Measuring, Assessing and Rating Tool. The method is the product of an EASA task to develop a tool to assess the safety culture throughout an organization. The terms of reference of this task already identified that the safety culture of an organization is defined as the way safety is perceived, valued and prioritized in an organization.

The SMART method recognizes that all levels in an organization play a significant role in how this culture actually functions, is nourished and produces something intangible as 'safety'. It is the real commitment to safety **at all levels** within an organization that displays a functioning positive safety culture. In the higher levels of an organisation, the safety intelligence resides whilst in the operational level a safety mindfulness must exist to create an actual safety level.

The SMART method uses a generic organizational model to describe organizational layers that exist in the majority of every air transport organization, either small or large. In the tool, these layers are described as 'roots'.

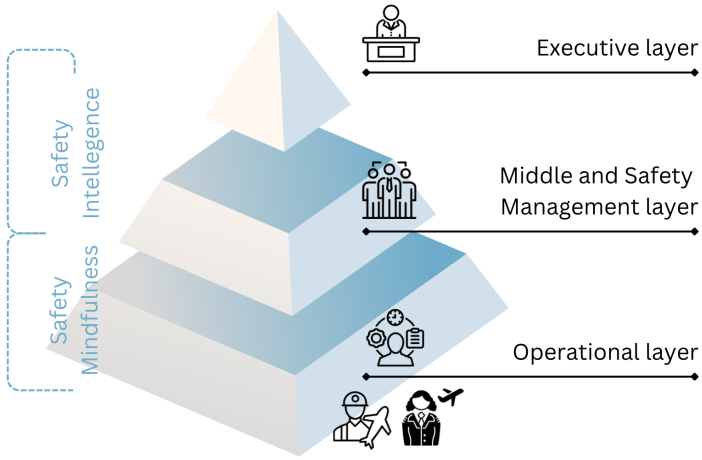


Figure 1-1 Different applications of safety for different organisational layers

A safety culture refers to the values, beliefs, and attitudes that are shared by an organization's members on how to create safety whilst achieving the other organizational goals. There are several elements of a safety culture that are essential for creating a safe environment. Each of these elements are grouped in SMART into safety dimensions.

These roots and dimensions can be considered to be a matrix, and visualized as a three-dimensional object that both represents the organisations' structure, and the safety elements that would represent a safety culture throughout that entire organisation.

In terms of 'safety culture', a large number of elements can be identified that are essential for creating 'safety'. The existence, functioning and interaction between these elements will determine how safety is experienced and managed in the organisation.

In the SMART methodology, these elements are grouped logically into six high-level dimensions. The extent to which these six dimensions are experienced throughout the organisation determines to what level the existing culture can be described as positive towards safety.

Figure 1-2 – SMART safety dimensions

The basic methodology of SMART is to assess the presence and functioning of each of the safety dimensions throughout the various organisational levels or safety roots. The result is a matrix that combines the roots and dimensions of safety.

The assessment process is facilitated using a surveying method. For each of the safety dimensions, specific statements applicable to the safety root have been developed. The response to these statements creates an insight on how that safety dimension is represented at that organisational level.

2 AirExample SMART results

The SMART survey was distributed to 120 employees by AirExample's Manager Safety and Security. In total 72 employees completed the survey, resulting in a response rate of 48%. All organisational layers were represented in the survey responses. The response rate is above the average benchmark for similar organizations. The survey was completed before the work at the offices of AirExample in [City] commenced. No survey inputs were supressed.

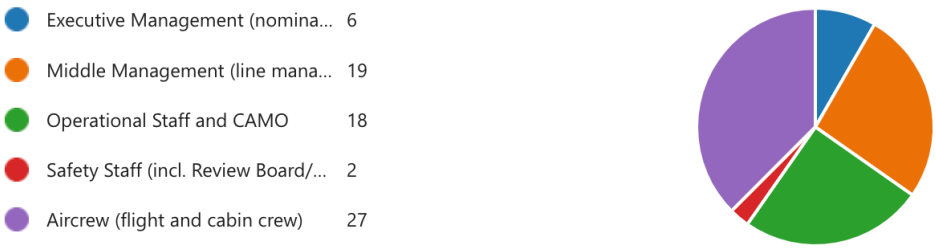


Figure 2-1 – Survey responses through the organisation

	Awareness & Behaviour	Commitment & Engagement	Effectiveness	Promotion & Information	Identification & Reporting	Training & Knowledge	Grand Total
Exec	7,0	10,0	8,4	10,0	9,6	7,3	8,5
Middle	4,6	7,2	6,9	8,0	9,5	5,5	6,5
Safety	8,0	8,7	8,6	10,0	10,0	7,3	8,5
Ops	5,2	7,3	8,4	10,0	10,0	10,0	7,9
Aircrew	6,0	8,4	6,8	10,0	10,0	8,3	7,7
Grand Total	6,1	8,5	7,8	9,7	9,8	7,4	7,9

How people are (soft skills) What people know (hard skills)

Figure 2-2 – SMART Dashboard for AirExample

After processing the results of the survey, the SMART method produced a matrix combining the organisational levels and safety culture dimensions. In this matrix, lower scoring combinations are coloured towards red, and higher scoring combinations are coloured green. With this colour coding, it becomes possible to identify areas of interest.

In the matrix produced from the AirExample survey results, the 'awareness and behaviour' dimension scored overall lowest. In relation to the safety culture this is significant, as awareness and behaviour are typically more related to "how people are" and lesser to "what people know".

2.1 Why 'awareness and behaviour' are significant factors

Awareness and behaviour on safety are crucial aspects of ensuring a safe and secure environment in any setting, including aviation. In the context of aviation safety, awareness refers to having a deep understanding of potential hazards, risks, and safety protocols, while behaviour pertains to the actions and decisions individuals take to maintain safety.

Safety awareness not only includes compliance with aviation regulations, standards, and best practices. It also involves identifying potential risks and hazards in aviation operations and implementing effective risk management strategies to mitigate these risks.

Behaviour not only relates to how an individual acts, but also how the behaviour of others is perceived and interpreted. Particularly the behaviour of higher management staff has a significant impact on the perception of the safety culture within that organisation for the observer. For high reliability organisations, the C-level staff should be ideally perceived as 'safety leaders' or their actions should at least promote the development of a safety culture. In any case and regardless of the situation, the perception should never be that at this level normal industry best practices with respect to creating a safety culture are opposed or disrespected.

2.2 Validation of AirExample SMART matrix

The tool is not designed to generate 'findings' on the safety culture of an organisation. Its intent is to facilitate an open discussion on the existing safety culture and its maturity. Like any model, it only represents the reality to some extent and validation is required to ensure the results are valid. The aim of this validation is to identify if challenges exist that could restrict further development of the safety culture.

"Safety culture is fragile, and should be treated like this in all efforts to quantify and improve it"

To validate the outcome of the SMART matrix, interviews with various individual staff members throughout the organisation were conducted. During these interviews, the principles of the just culture model were emphasized and the SMART method was explained. The results for AirExample were presented, using the zoom function to visualize the positive and negative contributions on a particular safety dimension. For AirExample, the following positive and negative contributors scored highest.

Table 2-1 – Visible positive and negative contributors to safety culture in AirExample

Organisational level	Positive contributor	Negative contributor
Operations staff	When a decision needs to be made, and safety is affected, I will mention that to the person who is responsible	I feel insecure when reporting safety events in this organisation
Aircrew	When a procedure has a negative impact on safety, I will mention that to the person who is responsible	Reporting safety events in this organisation could affect my career progress
Executive	I give staff feedback regarding their safety behaviour, such as praise or criticism for actions	Anonymous reporting can be misused by disgruntled staff and therefore should be discouraged

During all interviews both the positive and negative contributors were briefly discussed, followed by the question: “Do you recognize this picture?”.

The majority of interviewed individuals, representing all organisational levels, positively confirmed the presence of (one or more) negative contributors for the safety culture. The interview then continued with a goal to identify what exactly, in view of the individual, was the cause of these negative contributors being present.

The following list summarizes how the interviewed staff (through all organisational levels) reacted to the above negative and positive contributors that were identified in the SMART survey.

1. The overriding management style of the ACM is characterized as “authoritative and autocratic”:
    a. The communication process is driven top down by the ACM.
    b. The work processes and staff are closely monitored and controlled by the ACM directly.
    c. The working method of ACM is perceived as micro management.
    d. Staff complaints that their normal work processes are disturbed and placed under (unnecessary) pressure, resulting in efficiency losses and error inductions.

2. As a consequence of the management style of the ACM, employees with documented responsibilities in the management system, are being bypassed in the decision making process on topics under their area of responsibility. The consequence is that all staff becomes uncertain on what to report to whom and normal hierarchical structures are not followed. Staff is becoming increasingly more frustrated as individuals interfere (on direction of the ACM) in various areas not under their original responsibilities, further increasing the frustration.

3. Operational irregularities are closely followed up with attributions of blame to individuals involved in the irregularity. This results in a perception of a blame and finger-pointing culture for staff in the air operations organisation. Various people interviewed stated that the overriding question is related to 'who' instead of 'why' irregularities occur. The effect is that staff at all levels tries to hide errors from the organisation, particularly the ACM, to prevent being blamed.

4. The difference in personality, vision and management styles between NPFO and ACM is openly visible for the air operations staff, effectively dividing that part of the organisation into two sides. The side represented by the ACM tries to 'get things done' and is driven by (quick) results, where the side represented by the NPFO tries to adhere to documented procedures and hierarchical structures. By operational staff, the result driven line-to-take is perceived as reducing the safety of the organisation whilst the procedural following line-to-take is perceived as governance for staff and procedures.

5. Last minute changes in the flight schedule disrupt the robustness of the crew planning schedule significantly, resulting in a significant amount of extra work, costs, fatigue and subsequent errors in crew planning.

6. The ACM promotes and hires staff on a principle that could be described as transactional. Meaning that the majority of staff/management hired by the ACM could be categorized as 'non-critical thinkers'. During the interviews this pattern of thinking became visible.

2.3 Bypass of Management System

There are various examples of the organisation's management system being bypassed from a communication and decision making point of view. This bypass is enabled by the promotion of the 'assistant to the ACM' to 'deputy ACM' without defining the role, responsibility and authority of the deputy ACM.

Up to the moment in time of this promotion, the position of ACM was deputised to the NPFO – as is usual within air operations organizations. The MSM describes in detail the responsibilities of all nominated staff and accountable manager, as well as for their deputies. For all nominated staff, the description of their responsibilities includes a section that limits the authority of a deputy. For the ACM this section is not present, which is essence provides the deputy ACM with the exact same authority as the ACM. In real life, the deputy ACM and the ACM are continuously present in the organisation. The management style of ACM, combined with the absence of defined tasks, responsibilities and lack of experience in management for the deputy ACM have resulted in a bypassing of authority within the organisation.

What contributed to the further deterioration of the management system was that the NPFO had been deputized as ACM before the promotion of the assistant to the ACM, and has lost the competition to become the next ACM from the present ACM. For any person that is used to hierarchical structures, the removal of the deputy title could easily be interpreted as a demotion. In particular the fact that the new deputy ACM would also start functioning as a First-Officer creates the potential for a further bypass in normal hierarchical structures, and is at the least very unusual in an AOC organisation.

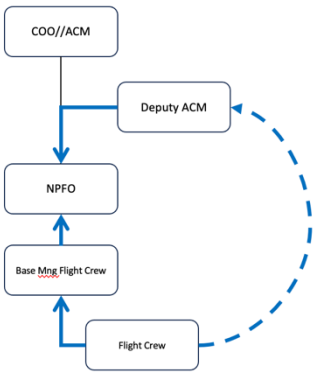


Figure 2-2 – Hierarchical position of Deputy ACM

It's important to note that bypassing authority can have both positive and negative implications. While it can lead to quick decision-making, innovation, and agility in certain situations, it can also undermine the established hierarchy, create confusion, and erode trust within the organization. Once the chain of hierarchy is broken, it's typically difficult to restore the negative aspects.

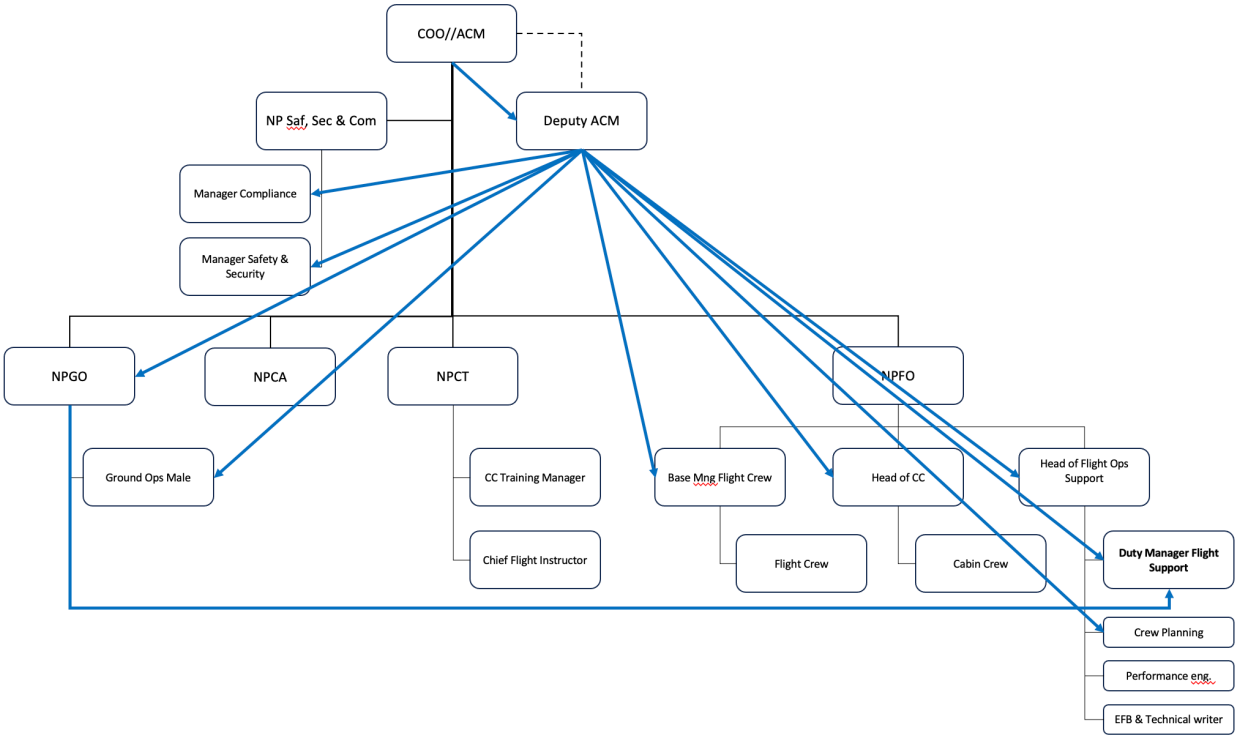


Figure 2-3 – Observed bypasses in management structure

Throughout all interviews, it became clear that the authority structure designed as per the MSM is being bypassed on multiple occasions, and that this resulted in a lack of trust between key staff in the management organogram.

2.4 Overriding observed management style

The ACM displays tendencies related to an autocratic authoritative management style. This type of management follows a top-down approach, with one-way communication from bosses to employees. This is the most controlling of the different management styles, with the management making all workplace decisions and holding all of the power.

Employees are treated as drones, to be monitored closely as they perform within clearly defined perimeters. Staff is not encouraged to ask questions, submit ideas, or share their thoughts on improving processes, and are in some cases actively discouraged from doing so.

In this style, managers dictate exactly what they require their subordinates to do and punish those who do not comply. Employees are expected to follow orders, not question the authority of management, and perform their tasks the same way each time.

Managers monitor the employees closely, micromanaging their performance without placing trust or confidence that their employees can achieve their goals without direct and constant supervision. These types of managers believe that without this supervision, employees will not operate successfully.

Table 2-2 – Consequences of an Autocratic Authority management style

Pro's	Con's
This management style allows quick decision making, and creates clearly defined roles and expectations.	Includes an increase in the dissatisfaction of employees, which leads to higher turnover, resentment, a lack of professional development and employee engagement, and the formation of an 'us' versus 'them' mentality between employees and management.
With unskilled workers or large teams, setting clear and solid expectations can allow workers to operate without uncertainty.	Innovation is stifled and inefficient processes will remain in place.
Productivity will increase, but only when the manager is present.	

When to use this style: If decisions need to be made and executed quickly, for example, in a time of organizational crisis, this management style can be used successfully. It should otherwise be avoided.

2.5 Definition of tasks and responsibilities

The MSM contains in chapter 3 an overview of the accountabilities, responsibilities and duties of the accountable manager, nominated persons and their deputies. The staff interviewed were asked to identify and mark their responsibilities on a compiled list that summarized all responsibilities listed in the MSM chapter.

None of the interviewed persons was able to correctly identify items listed under their responsibility in the MSM. There seems to be a large difference between perceived and attributed responsibilities. As an example, the table below displays the perception of the deputy ACM on his area of responsibility.

Table 2-3 – Overlap in perceived responsibilities

Responsibility assigned (per MSM chapter 3)		Perception of deputy ACM
Position or area	**Number of responsibilities listed**	**% Overlap in responsibilities assumed by deputy ACM for that area**
ACM	19	21 %
NPSM	**18**	**27 %**
NPCM	**17**	**30 %**
NPFO	**21**	**15 %**
NPCT	16	6 %
NPGO	20	10 %
NPCA	30	0 %

It seems likely that the, per MSM chapter 3 defined, assigned responsibilities were not evaluated or clarified after the promotion of the deputy ACM resulting in interference in responsibilities that is negatively perceived by nominated persons and staff. From the table above it is clear that the deputy ACM has a perception that his tasks and responsibilities are more related to the areas of safety, compliance and flight operations than to those assigned to the post of accountable manager. Acting in accordance with this perception can easily result in interpersonal friction between the deputy ACM on one side and nominated persons and staff on the other side. Particularly as the deputy ACM displays typical patterns that point to a limited management experience. In his own words, it frustrates him of having to remind people on his hierarchical position to get them to do things.

2.6 What does this mean for the safety culture?

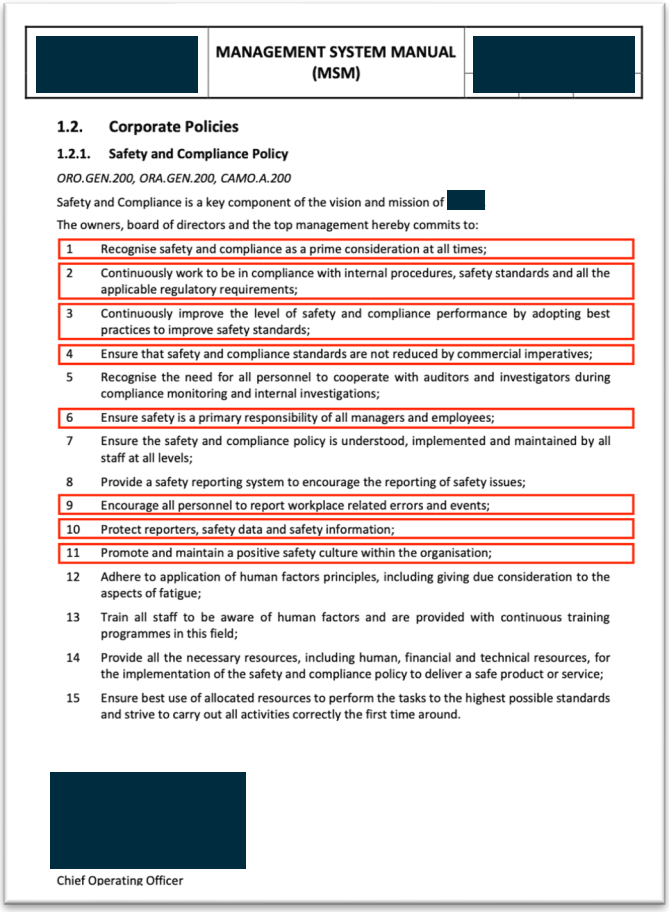
Safety is not a tangible parameter that can easily be measured. Instead, safety experts and civil aviation authorities rely on methods and elements to identify, quantify and qualify the organizations systematic approach to manage safety.

For example, AirExample has published its safety policy in the MSM. That safety policy represents the organizations vision with respect to safety management. When reviewing this safety policy against the validated SMART results, conflict with at least 8 topics and goals of the safety policy exist:

1. The current working method of ACM does not promote that work is performed in compliance with the documented procedures and responsibilities defined in the Management System Manual. The ACM himself still does not accept and ignores valid recommendations from the internal deputy safety manager arising from safety investigations.

2. For some operational issues (OTP and Cabin Defect Deferral) there are clear signals that the ACM prioritizes commercial imperatives over safety concerns raised by staff. The authoritative personality of ACM results in qualified staff being bypassed or ignored in tasks and responsibilities. This results in decision making by a few people who are not nominated or qualified at the correct level. In addition, as an effect of the management style, staff becomes increasingly resentful and demotivated.

3. The autocratic and authoritative management style that is applied by the ACM and has been adopted by his proxies, is functioning contrary to staff being encouraged to report safety issues, errors and events.



[redacted] | MANAGEMENT SYSTEM MANUAL (MSM) | [redacted]

1.2. Corporate Policies

1.2.1. Safety and Compliance Policy

ORO.GEN.200, ORA.GEN.200, CAMO.A.200

Safety and Compliance is a key component of the vision and mission of [redacted]

The owners, board of directors and the top management hereby commits to:

1	Recognise safety and compliance as a prime consideration at all times;
2	Continuously work to be in compliance with internal procedures, safety standards and all the applicable regulatory requirements;
3	Continuously improve the level of safety and compliance performance by adopting best practices to improve safety standards;
4	Ensure that safety and compliance standards are not reduced by commercial imperatives;
5	Recognise the need for all personnel to cooperate with auditors and investigators during compliance monitoring and internal investigations;
6	Ensure safety is a primary responsibility of all managers and employees;
7	Ensure the safety and compliance policy is understood, implemented and maintained by all staff at all levels;
8	Provide a safety reporting system to encourage the reporting of safety issues;
9	Encourage all personnel to report workplace related errors and events;
10	Protect reporters, safety data and safety information;
11	Promote and maintain a positive safety culture within the organisation;
12	Adhere to application of human factors principles, including giving due consideration to the aspects of fatigue;
13	Train all staff to be aware of human factors and are provided with continuous training programmes in this field;
14	Provide all the necessary resources, including human, financial and technical resources, for the implementation of the safety and compliance policy to deliver a safe product or service;
15	Ensure best use of allocated resources to perform the tasks to the highest possible standards and strive to carry out all activities correctly the first time around.

[redacted]

Chief Operating Officer

Figure 2-4 – Mismatch between actions and words

Conflict between the defined safety policy and the actual behaviour, such as observed above, points towards a lower score for the “commitment and engagement” dimension. For the executive level, this is contrary to what is indicated in the SMART dashboard. However due to the numerous confirmations received in the interviews, the authors agree that the real commitment and engagement of the executive level is significantly lower as indicated in the survey.

With respect to the SMART outcome, the interviews conducted and the analysis of these results, there are clear indicators present that point towards a decline in safety perception and culture within the AirExample organisation.

It is the opinion of the authors of this report, that the personality and decisions of the ACM have directly contributed to or caused this decline and deviation from the safety goals of AirExample.

2.7 What does this mean for the organisation?

For now, the observed decline in safety culture has not resulted in safety related events. At the same time, this decline in safety culture also translates itself in a reduced capacity for the organisation to proactively mitigate safety risks. In other words, the capacity of AirExample to detect gaps in safety is increasingly reduced.

In addition to this worrying effect is the organisational perspective. The organisation is unable to proactively identify, manage and resolve the factors that resulted in the current situation as part of the Management of Change process that should have been followed. Today, the problems are clearly visible and are known by the AOC management. Yet they have been allowed to continue to exist and deteriorate the work environment, evolving into factors that now represent significant organisational risks. The authors of this report strongly believe that the personality of the ACM is debit to this situation. On at least two events that were visible for the authors, the recommendations from the internal compliance and safety department are disregarded, and remain unanswered.

2.7.1 From safety concern to organisational risk

The working atmosphere in the [City] office is contrary to what would be expected for a young organisation that has recently obtained an AOC. Instead of a youthly thriving work-related energy that is usually present in new AOC organisations, the atmosphere feels depressed and down with people whispering and looking anxiously around. There is no visible joy and comradery present between office staff.

In order to increase revenues, the organisation needs a second aircraft on the AOC as soon as possible. In addition to fleet expansion, an urgent optimization is required in the form of an ETOPS approval. This will allow more direct flights between departure and destination airports and cut operating costs. Next to these AOC changes, the organisation needs to obtain a Part-145 approval to facilitate a second aircraft.

Trust between CAA and AirExample is the oil that lubricates the AOC and Part-145 approval and variation process. For all of the above topics, a positive relationship with CAA is of vital importance to ensure these goals are achieved. Due to the visible struggle in the management system, AirExample is at a critical stage of losing the remaining goodwill of CAA - with a high risk for administrative delays and possible denials in the AOC variation and Part-145 approval process. The ACM has been notified clearly that CAA was miffed with a discussion on a level 1 finding. This finding could have been avoided if the ACM had taken the recommendations from his own Head of Safety, Security and Compliance.

During the SMART assessment, the NPFO announced that he had resigned from his post prior to the start of the assessment process. On his request, this information was not shared with the rest of the AirExample staff. As main reason for this resignation, the NPFO stated that he no longer felt able to fulfil his responsibilities due to, what was described by him, a toxic work environment. Irrespective of any truth to this statement, the resignation of a person

that is highly regarded by the organisation – particularly in a position as NPFO – can have a draining effect on the staffing numbers for flight and cabin crew. In order to start operations with a second aircraft, the staffing numbers for flight and cabin crew will need to at least maintained. The loss of qualified staff that is trained at a high cost should be avoided as much as possible, even though there might be personality differences. For the authors of this report there are indicators that the ACM in fact had a goal to replace the NPFO by a person that would be more personal favourable to his decisions, and that ACM based his actions on this goal.

During the interview with the ACM it became clear that the above organisational risks had not been identified, assessed and dealt with properly and sufficiently by himself. For staff employed at the C-level in an organisations such as AirExample, it can be reasonably expected that they understand organisational risk principles and display abilities to set aside personal vendettas and agendas to realise organisational goals.

It was intriguing to observe that both ACM and Head of Engineering and Maintenance stated that, even with the knowledge they possess at this moment in time on the fallback of the generator event in December, they would not change anything in their behaviour towards the organisation or people involved. This raises both questions on their perception of ‘no blame’ principles as well as how their personal feelings supersede organisational goals.

3 Recommendations and options

3.1 What do we recommend?

Doing nothing is no longer a valid option, and the perception that the ACM is part of the core problem raises the decision making to the level of the CEO. The ACM is simply not impartial to the situation AirExample finds itself in.

The knowledge that the NPFO has resigned, and how this information is communicated between colleagues will turn any decision that does not affect the ACM into an endorsement. During the development of this report, signals were received that the ACM continued on his track to replace staff with likeminded people. The deputy ACM has been proposed forward as NP Safety, Security and Compliance, and the Head of Engineering and Maintenance is proposed as deputy ACM. It is likely that ACM will nominate a person as NPFO that is favourable to him to further strengthen his grip on the AOC. There is a high risk that the existing situation, as well as appointing proposed persons by the ACM will be interpreted as a win for the ACM. Both by the ACM, and as well as the staff observing this. The consequence of this will be a high likelihood of entering in a downward negative spiral due to the subsequent further decline in trust in the organisation and specifically the C-level.

The phrase ‘where two quarrels, two are to blame’ is applicable also in the context of the friction between ACM and NPFO. Both have their agenda’s and failed to recognize the organisational risk in pursuing their courses. The dynamics between the two personalities is difficult to describe, but for sure their negative interaction was amplified due to ‘conservatism’ on one side and ‘get things done’ mentality on the other side. The ACM is the person that should balance between these opposite sides. In that sense it might not make sense to re-appoint the resigned NPFO as ACM, as this will likely swing the balance to the other side at a moment where the organisation needs to move forward rapidly. To understand this balance, both (flight) operational and business instinct are required to a higher extent than is currently present within the ACM and NPFO. The ACM lacks in operational experience providing him with credibility, and the NPFO misses the business instinct. In addition the ACM has lost the trust and respect of staff under his supervision, further making progression on important business goals difficult.

The recommended course of action would be to replace the ACM, and appoint a new NPFO from within the organisation. This will give a clear signal to staff and CAA. Provided an NPFO is chosen from within the organisation, who already has support and standing with the flying corps, this could offset a possible outflow of crewmembers and restore trust. Regarding the ACM, it would be recommended to appoint an external person who would ideally have experience in the Maldives and a relationship with CAA.

In addition it is recommended to revise and clearly reconfirm the responsibilities of ACM and nominated persons. By now, AirExample has an operational understanding, and it will be easier to translate the abstract definitions into more tangible descriptions. The management team could work on this together as part of a new team building process.

The position of ‘deputy ACM’ should be abandoned or reverted back to an ‘assistant to’ position. In reality, the reason for the creation of this post was related to the ACM lacking local and operational knowledge combined with a desire of the ACM to be working out of Dubai and wanting local feet on the ground for control. A valid conclusion is that this has not been beneficial to the organisation. It is recommended to remove this duality on working locations for the ACM position. The ACM should be visible in the operational organisation, and for AirExample the decision is taken to establish the operating base in [City]. Removing from [City], either in part or in its entirety, will likely not be perceived well by CAA.

Following option table is provided to support the CEO in the decision making process. It highlights the possible changes in staff and their positions, as seen by the authors of this report, and is not intended to replace the CEO's decisions.

Table 3-1 – Options to consider for CEO

Name	Present position	New position	Pro's and Con's
Person X	Deputy ACM	ACM AOC	+ Known by CAA – No track record as ACM – Limited credibility with AirExample staff – Cannot be combined with flying as F/O
		NP Safety, Security and Compliance	+ Known by CAA – No airline experience in Compliance/Safety – Management style not matching with requirements – Risk of outflow of existing C&S managers and staff – Cannot be combined with flying as F/O
		F/O A320 quality pilot	+ Known by CAA + Fills a vacant position for Quality pilot + Ensures return on Type Rating investing AirExample + Positive signal for organisation
Person Y	Base Manager	NP Flight Operations[1]	+ Proven qualities as deputy NPFO + Positive signal for flight crew/organisation – No track record in position
Person Z	-	ACM AOC	+ Known by CAA and most AirExample staff + Proven track record as ACM in Maldives + Management style and capability to restore – External hire
Person A	Manager Safety & Security	NP Safety and Security	+ Known by CAA + Proven qualities in Safety position + Positive signal for organisation + Manageable workload considering experience
Person B	Manager Compliance	NP Compliance	+ Known by CAA + Proven qualities in Compliance position + Positive signal for organisation + Manageable workload considering experience
Person C	Head of maintenance	ACM Part-145	+ Clear separation between CAMO and Part-145 + Matches experience

[1] *This promotion would only be recommended in combination with the nomination of a new ACM for the AOC.*

4 About

4.1 Who is who in this report

Position	Name
CEO	
COO // Accountable Manager (ACM)	
Deputy ACM	
NP Flight Operations (NPFO)	
NP Ground Operations (NPGO)	
NP Crew Training (NPCT)	
NP Safety, Security and Compliance	
Base Manager Flight Crew	
Head of Maintenance	
NP Continuing Airworthiness	
Sr. Manager Flight Operations Support	
Manager Compliance	
Manager Safety and Security	
Head of Cabin Crew and In-flight Services	

4.2 The authors

Mr. Wim OVAA
Has managed for over a decade the provision of aviation safety regulations training and advisory services to the [country] aviation community. He has a proven track record working for and with National Aviation Authorities (NAAs) and regulators. He is Safety/Quality Manager of a Part-145 AMO, CAMO and Part-21 Subpart G Production Organisation Approval (POA).

Captain Sander STARREVELD
Developed the SMART method for EASA, and is an external expert for EASA on (flight operational) safety matters. Has a proven track record as ACM, NPFO and NP Compliance and Safety for various AOC's. Has provided the CAA and various [country] operators with numerous trainings related to the AOC process, Compliance and Safety and Special Approvals.

4.3 The safety dimensions defined

4.3.1 Awareness and behaviour

Awareness and behaviour on safety are crucial aspects of ensuring a safe and secure environment in any setting, including aviation. In the context of aviation safety, awareness refers to having a deep understanding of potential hazards, risks, and safety protocols, while behaviour pertains to the actions and decisions individuals take to maintain safety and create the preconditions for safety to exist.

Safety awareness includes an emphasis on compliance with aviation regulations, standards, and best practices. This ensures that safety requirements set by regulatory authorities are complied with. Safety awareness involves identifying potential risks and hazards in aviation operations and implementing effective risk management strategies to mitigate these risks.

Recognizing human factors that may influence safety, such as fatigue, stress, and distractions, is essential for this dimension.

4.3.2 Commitment and Engagement

Commitment and engagement in safety are critical elements for maintaining a strong safety culture in the organisation. When all individuals, from executive level to front-line employees, demonstrate a high level of commitment and engagement in safety, it creates an environment where safety becomes a core value and is integrated into all aspects of operations.

The executive and middle-management levels must demonstrate commitment to safety. They set the tone for the organization by prioritizing safety and allocating adequate resources to safety initiatives. Employees are empowered to take ownership of safety. They are held accountable for adhering to safety procedures and making safe decisions in their respective roles. It is essential that sincerity exists and is perceived likes this throughout the organisation.

The organization's commitment to safety is formalized through a clear and well-defined safety policy that is in line with how the organisation aims to function with respect to safety. This policy outlines the organization's commitment to safety as a fundamental value and sets specific safety objectives to achieve. The organizations commitment is demonstrated through investments in safety initiatives and non-mandatory programs, such as specific safety campaigns and fatigue risk management programs.

Addressing safety issues in regular staff meetings and open channels of communication allow employees to discuss these issues, share best practices, and receive updates on safety-related matters. The aim of to provide a platform for employees to actively participate in safety-related matters.

4.3.3 Effectiveness

An effective safety culture is a critical characteristic of any high-reliability organization. It refers to an environment where safety is deeply ingrained in the organization's values, beliefs, and behaviours at all levels. An effective safety culture prioritizes safety in such way that the number of unexpected safety events reduce over a period of time. It is characterized by the following key attributes:

- Open Communication: There is open and transparent communication about safety matters throughout the organization. Employees feel comfortable reporting safety concerns, incidents, and near-miss events without fear of reprisal.
- Non-Punitive Reporting: A non-punitive reporting culture is encouraged, where individuals are not blamed or penalized for reporting safety issues. Instead, the focus is on learning from events and making improvements.
- Safety Risk Management: A systematic approach to safety risk management is adopted, where potential hazards and risks are identified, analysed, and mitigated to ensure proactive safety management.
- Safety Performance Measurement: The organization regularly monitors safety performance through safety indicators and metrics. Data analysis is used to identify trends and areas for improvement.
- Integrated Safety Processes: Safety is integrated into all aspects of the organization's operations, from strategic planning to day-to-day activities. Safety considerations are part of decision-making at all levels.
- Strong Safety Reporting System: An effective safety reporting system is in place to capture safety-related data and facilitate analysis and action on safety issues.

4.3.4 Promotion and Information

Safety promotion and information dissemination are vital components of a comprehensive safety management system. They contribute to creating a strong safety culture, reducing the likelihood of accidents, and ensuring that lessons learned are communicated.

Dissemination of safety information help raise awareness of potential hazards and risks. By providing relevant safety information, individuals are better equipped to prevent accidents and incidents. Safety promotion encourages a proactive approach to risk management. Identifying and addressing safety concerns before they escalate, helps prevent incidents and disruptions.

Safety promotions keep safety at the forefront of employees' minds. This continuous reinforcement fosters a safety-conscious culture where safety is a priority for everyone. When employees are knowledgeable about safety procedures, they can respond effectively to potential threats and emergencies.

4.3.5 Identification and Reporting

The identification and reporting process serves as a foundation for a proactive safety management approach in aviation. It encourages transparency, accountability, and a commitment to safety. A robust reporting process promotes a safety reporting culture where employees feel encouraged to report safety concerns, incidents, and near-miss events without fear of reprisal. A functioning reporting culture is vital for gathering valuable safety data.

The identification process helps in recognizing potential hazards and safety risks. Hazards can be related to aircraft, equipment, procedures, weather conditions, human factors, or other elements that may compromise safety. By identifying these hazards early, the organization can proactively manage and mitigate risks before they escalate into safety events. It supports the philosophy of continuous improvement, driving a cycle of identifying, analysing, and implementing safety enhancements.

4.3.6 Training and Knowledge

Staff training and knowledge are fundamental elements for establishing and nurturing a strong safety culture within an organization. They empower employees to prioritize safety, identify and manage risks, and maintain a proactive approach to safety management.

The executive and middle-management level represent part of the organisation where the safety intelligence resides. By receiving safety training, managers become safety leaders who actively promote and prioritize safety within the workplace. In the more operational levels of the organisation, the safety mindfulness resides. Safety mindfulness or safety conscious behaviour, refers to a state of heightened awareness and focus on safety in all aspects of one's work or activities. It involves being present in the moment, constantly alert to potential hazards and risks, and taking proactive measures to ensure the safety of oneself and others. Training is required for both safety intelligence and safety mindfulness for staff to fully understand their roles and responsibilities.

This awareness fosters a safety-conscious mindset, where safety becomes a top priority for the entire organisation, from executive to operational level.

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