



NTSB National Transportation Safety Board

Aviation SMS

Process:

Transferable to

Pipelines?

Presentation to:

PHMSA Pipeline Safety
Management System Workshop

Name: Christopher A. Hart

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Outline

- **NTSB's SMS Recommendation**
- **Model for Organization-Level SMS**
- **External Issues**
 - **Role of the Regulator**
 - **Role of Manufacturers**

NTSB Report, Marshall, MI (2012)

- Probable Cause: The rupture and prolonged release were made possible by *pervasive organizational failures* at . . . (Enbridge) that included the following:
 - Deficient integrity management procedures . . .
 - Inadequate training of control center personnel . . .
 - Insufficient public awareness and education . . .
- Finding No. 28. Pipeline safety would be enhanced if pipeline companies implemented safety management systems.
- Recommendation to API: Facilitate the development of a safety management system standard specific to the pipeline industry that is similar in scope to your Recommended Practice 750, Management of Process Hazards.



Safety Issues in Complex Systems

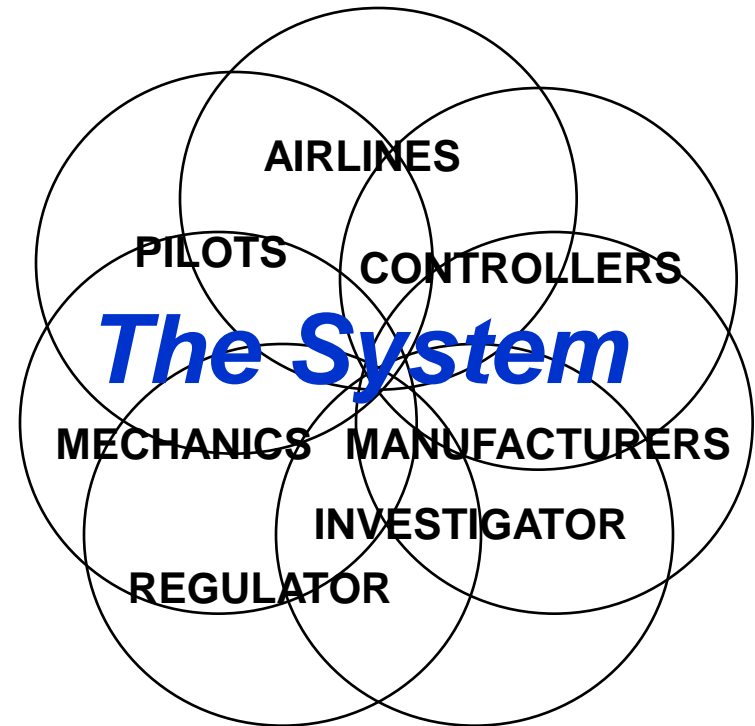
- **More System**

 - Interdependencies*

 - Large, complex, interactive system
 - Often tightly coupled
 - Hi-tech components
 - Continuous innovation
 - Ongoing evolution

- **Safety Issues Are More Likely to Involve**

 - Interactions Between Parts of the System*



Effects of Increasing Complexity:

More “Human Error” Because

- **System More Likely to be Error Prone**
- **Operators More Likely to Encounter Unanticipated Situations**
- **Operators More Likely to Encounter Situations in Which “By the Book” May Not Be Optimal (“workarounds”)**

The Result:

Front-Line Staff Who Are

- Highly Trained
- Competent
- Experienced,
- Trying to Do the Right Thing, and
- Proud of Doing It Well

... Yet They Still Commit

**Inadvertent
Human Errors**

The Solution: System Think

Understanding how a change in one subsystem of a complex system may affect other subsystems within that system

“System Think” via Collaboration

Bringing all parts of a complex system together to collaboratively

- **Identify potential issues**
- ***PRIORITIZE* the issues**
- **Develop solutions for the prioritized issues**
- **Evaluate whether the solutions are**
 - **Accomplishing the desired result, and**
 - **Not creating unintended consequences**



When Things Go Wrong

How It Is Now . . .

You are highly trained

and

If you did as trained, you
would not make mistakes

so

You weren't careful
enough

so

You should be **PUNISHED!**

How It Should Be . . .

You are human

and

Humans make mistakes

so

Let's *also* explore why the
system allowed, or failed to
accommodate, your mistake

and

Let's **IMPROVE THE SYSTEM!**

Fix the Person or the System?

Is the **Person**
Clumsy?

Or Is the
Problem . . .

The *Step???*



Enhance Understanding of Person/System Interactions By:

- Collecting,
 - Analyzing, and
 - Sharing
- ## Information

Objectives:

Make the System

***(a) Less
Error Prone***

and

***(b) More
Error Tolerant***

Aviation Industry-Wide Success

83% Decrease in Fatal Accident Rate,
1997 - 2007

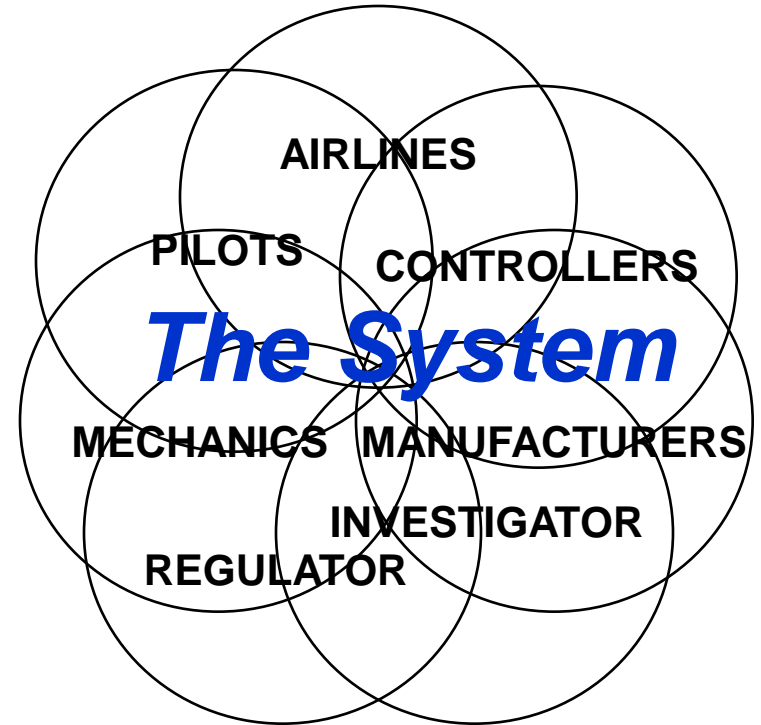
largely because of
System Think

fueled by
***Proactive Safety
Information Programs***

**P.S. Not only did the process improve safety, it also
improved productivity!**

Aviation “System Think” Process

- Engage All Participants In Identifying Problems and Developing and Evaluating Remedies
- Airlines
- Manufacturers
 - *With the systemwide effort*
 - *With their own end users*
- Air Traffic Organizations
- Labor
 - *Pilots*
 - *Mechanics*
 - *Air traffic controllers*
- Regulator(s) [Query: Investigator(s)?]



Moral of the Story

Anyone who is
involved in the *problem*
should be
involved in the *solution*

Collaboration: A Major Paradigm Shift

- **Old: Regulator identifies a problem and proposes solutions**
 - Industry skeptical of regulator’s understanding of the problem
 - Industry resists regulator’s solutions and/or implements them begrudgingly
- **New: Collaborative “System Think”**
 - Industry involved in identifying problem
 - Industry “buy-in” re interventions because everyone had input, everyone’s interests considered
 - Prompt and willing implementation
 - Interventions evaluated . . . *and tweaked as needed*
 - Solutions probably more effective and efficient
 - Unintended consequences much less likely



Challenges of Collaboration

- Human nature: “I’m doing great . . . *the problem is everyone else*”
- Differing and sometimes competing interests
 - Labor-management issues
 - May be potential co-defendants
- Regulator probably not welcome
- Not a democracy
 - Regulator must regulate
- Requires all to be willing, in their *enlightened self-interest*, to leave their “comfort zone” and think of the System



System Think at Other Levels?

- **“System Think” can be successful at any macro/micro level, including**
 - Entire industry
 - Company (some or all)
 - Type of activity
 - Facility
 - Team
- **Persistent workplace problem?**



External Factors: The Regulator's Role

- Emphasize the importance of System issues *in addition to* (not instead of) worker issues
- Encourage and participate in industry-wide “System Think”
- Facilitate collection and analysis of information
 - Clarify and announce *policies for protecting information and those who provide it*
 - Encourage other industry participants to do the same
- Recognize that *compliance* is very important, but the *mission is reducing systemic risk*

External Factors (con't): The Manufacturer's Role

Some aircraft manufacturers seek input, from the earliest design phases, from

- *Pilots* (User Friendly)
- *Mechanics* (Maintenance Friendly)
- *Air Traffic Services* (System Friendly)

Conclusions

- **A properly structured collaborative safety improvement process includes all SMS elements**
- **The industry-level collaboration success provides a model for collaboration at the operator level**
- **The regulator plays a key role in enabling operator creation of a collaborative process**
- **Manufacturers can also play a role in improving an operator's collaborative process**



Thank You!!!



Questions?