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English only

ACCIDENT INVESTIGATION AND PREVENTION (AIG) DIVISIONAL MEETING (2008)

Montréal, 13 to 18 October 2008

Agenda Item 1: Annex 13

1.7: Attachment E to Annex 13

Agenda Item 4: Management of safety data and representation

TEXT OF INTERVENTION BY NEW ZEALAND ON THE PROTECTION OF SAFETY INFORMATION AND THE SAFETY MANAGEMENT SYSTEMS (SMS) APPROACH

(Presented by New Zealand)

1. INTRODUCTION

1.1 Post event investigation of accidents and serious incidents has provided the international aviation safety community with a very rich body of information to mine to improve aviation safety.

1.2 Based upon the value of this information the international aviation community has made a policy choice to generally protect the information in a no-fault investigation from disclosure and use for judicial and other punitive purposes.

1.3 The principal aim of this protection is to ensure that there is full disclosure for the purposes of the investigation and to ensure that this information continues to be made available for future investigations.

1.4 New Zealand agrees with this policy choice and considers that information used to inform an investigation must be protected to ensure the investigator has all the information he or she needs to determine the contributing factors so that future occurrences can be prevented.

2. DISCUSSION

2.1 That said we should recall that post-event no-fault safety investigation forms part of a broader aviation safety system, in which States have regulatory oversight of the aviation activity under their control.

2.2 A State's safety oversight system is intended to continually influence safety behaviours through education and outreach, rule making, entry certification control, compliance monitoring and enforcement action.

2.3 We note that these components and elements are emphasised in the proposed text for a States safety programme as circulated in State letter AN 12/51-07/74 of 7 December 2007.

2.4 The emphasis of a State's safety oversight system is on pre-event interventions to reduce or eliminate behaviours and situations that could lead to an accident or serious incident.

2.5 As element 8.1 of the Elements of a State's safety oversight system require, a State must "use a documented process to take appropriate corrective actions, up to and including enforcement measures, to resolve identified safety issues"¹.

2.6 As a result of a no blame investigation there are frequently recommendations made to change regulations and regulatory practices designed to influence behaviours and prevent future deaths and injuries.

2.7 The approach to safety oversight that is reflected in the Global Aviation Safety Plan, and the SMS, approach focuses on identifying trends in unsafe behaviour so that targeted pre event interventions can be made.

2.8 Central to this concept is the requirement for good data and good intelligence.

2.9 In essence this approach recognises that for a number of states, further increases in aviation safety will come from a focus on precursors to an accident since major accidents are, thankfully, fairly rare events.

2.10 This approach will only yield results if regulators are able to access information that identifies precursors and allows them to make a proportionate response to address these and prevent an accident. Thus, we need to be very careful that we do not deny a safety oversight system the very information it needs to do its job.

2.11 New Zealand has based its safety regulatory oversight system on a proto-SMS system for some 17 years. While we agree with the direction of SMS, we do think that the SMS approach requires a rethink of the principles of data protection for pre event use. We doubt that the blanket protection in paragraph 5.12 is consistent with the principles of SMS.

2.12 In short we think that the balance between two competing public interests, which has been struck for the protection of no-fault safety investigation, may need to be revisited for pre event data. The move to SMS and the need to focus on targeted risks based on safety data highlight a previously hidden third leg of the stool. There is a public interest, and public expectation, that a regulator should take appropriate action when it becomes aware of a safety problem. We consider that this factor needs to enter the equation.

¹ See p APP 5-1 of Appendix 5 of Annex 6.

2.13 We recognize the need for some protection for certain types of information in respect of employment relations and criminal proceedings. Notwithstanding, we consider that state authorities need to be able to use safety information to make targeted interventions using administrative tools. Since decisions to use these tools are able to be reviewed in administrative courts, we consider that the public interest associated with pre-event intervention requires a different balance to be struck for general safety information than that in standard 5.12.

2.14 We consider that a requirement to take a proportionate response when safety information raises a safety concern may be a more appropriate way to manage the use of safety information than a simple prohibition. In this regard ICAO could usefully set parameters on what forms a proportionate regulatory response.

3. CONCLUSION

3.1 With these considerations in mind we consider that the proposal to adopt a definition of “Just Culture” may be premature. We appreciate the significant effort that has been put into the concept, but note that much of it appears to deal with the particular circumstances of one entity. We query whether the term Just Culture is the correct term and wonder whether a name like safety culture may be more appropriate. We note that some of the terminology like gross negligence has no meaning in New Zealand law. Thus, we favour the view put forward by CANSO in WP 60.

3.2 We would like to propose that this meeting

- a) decide that the use of Annex 13 to deal with the issues of just culture and the use of safety data is not appropriate, and that these issues may belong in a new Annex;
- b) recommend ICAO establish a working group on the use of safety data;
- c) recommend that this group generate guidance on the use and protection of safety information as suggested by Singapore in WP/58 and by the United States in WP/43;
- d) recommend that such a group consider how and when safety information can be used so that a state’s regulatory oversight system can meet the overarching eight elements of a state safety oversight system;
- e) recommend that such a group work on the question of the required culture to support reporting under SMS; and
- f) consider whether Chapter 8 should be relocated to an Annex that focuses on pre-event safety data analysis and safety management systems.

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