THE SAFETY SIGMA

Mission Readiness through Operational Safety

A PRODUCT OF THE NAVAL SCHOOL OF AVIATION SAFETY

FROM THE DIRECTOR—
HOW "JUST" IS YOUR CULTURE?

The CO and the Culture. Here at the SAS I do a lecture series on command climate and organizational culture. I discuss how the commander owns his command climate and how that climate can drive the squadron culture. In "Organizational Culture and Leadership," Schein discusses how managers work within their organizational culture boundaries while leaders actively change the organization's culture to fit their vision. How do leaders change their culture? Schein discusses six primary culture-embedding mechanisms:

- what leaders pay attention to
- how leaders react to critical incidents or crises
- observed criteria by which leaders allocate scarce resources
- role modeling, coaching and teaching
- observed criteria by which leaders allocate rewards
- observed criteria by which leaders select, promote and ex-communicate organizational members.

These are the primary methods in which CO's change/reinforce the squadron's culture. This is followed by the mechanisms which reinforce the organization's culture. These reinforcement mechanisms consist of: an organizations structure, SOPs, rituals, stories, legends and the formal statements of the organizations philosophy, values and creed. The biggest take-away I get from Schein is, a CO's actions make much more of a difference than what they say or write down. Schein asserts that formal statements are reinforcement mechanisms only. A CO's primary squadron cultural-embedding mechanism is what Sailors and Marines observe from what the CO values, how the CO acts, and who the CO promote or punishes.

In "Leading Change," Kotter points out that the best way to break through the forces that support the status quo is though vision. He discusses how the leader presents a vision, discusses it and "walks the talk" will get the buy-in to generate the sought-after change. We

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In this issue:

can all get Kotter. His 8 steps to cultural change inspires the imagination. It makes me think of POA&M's, PBFTs, process management, and the way we change culture by utilizing all the program management tools we have. Schein brings out a different model, one that actually makes you say…*WHAT*? This culture change is tied more to me than to a plan? One that makes you think managing cultural change may not be as easy as an 8 step process. This culture change is based on how you as the CO make decisions every day. What do you value? Are your NCO/CPO's being ranked higher if they are in production work centers or if they are in the QA shop? Where do you put your talent and 'go-to' people? Do you value efficiency over thoroughness? What about your Safety Petty Officers and NCOs? Are the below-average NCO's put in Safety billets because that is where they will do the least damage? If time is a scarce resource (as most in Naval Aviation would agree), how much time do you as the CO give aircrew training vs. maintenance training? What do you pay attention to? Who do you reward and what do you punish? According to Schein, these are more active in supporting cultural change than any 8-step process. What you say is secondary to how you act, what you value and who you reward. If you value operations above all else, you will get operations above all else. Unfortunately you will not have the max readiness you could have achieved due to the potential loss of assets and personnel to mishaps. The CO saying "safety is my #1 priority," while not personally applying risk management, is as dangerous as it is a cliché.

What is a Just Culture and how does it make us more mission-ready? The International Civil Aviation Organization (ICAO) has defined Just Culture as, "a culture in which frontline operators or others are not punished for actions, omissions or decisions taken by them that are commensurate with their experience and training, but where gross negligence, willful violations and destructive acts are not tolerated."

The question that Commanders should ask themselves is whether or not their current policies, actions, and reactions to crises are supportive of their safety program.

Some things to ponder:

- Is it more worthwhile to reduce mishaps by learning from incidents (from incidents being reported openly and communicated back up the chain of command) or by punishing Sailors and Marines for making mistakes?
- Does the threat of discipline increase a Sailor's or Marine's awareness of risks or at least increase one's interest in assessing the risks? Does this heightened awareness outweigh the learning through punishment?
- By providing safety information and knowledge, are people more interested in assessing the risks? Does this heightened awareness outweigh the learning through punishment?
- How does your command treat human error? Does your command make the Sailor or Marine aware of their mistake? Can the Sailor or Marine come forward if they make a mistake so that your command can learn from the event?
- A Just Culture supports learning from unsafe acts. Any event related to safety, especially human errors, must be considered as a valuable opportunity to improve operations through experience feedback and lessons learned.

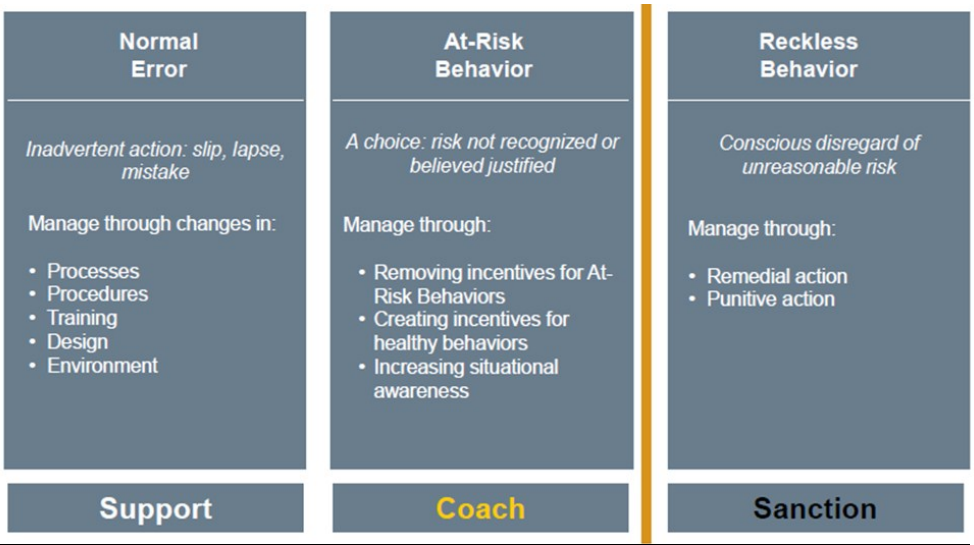
Near misses, HAZREPS and 'incidents' are considered by commands with good safety cultures as lessons which can be used to avoid more serious mishaps. There needs to be a strong drive to ensure that all events are reported and investigated to discover the root causes, and that timely feedback is given on the findings and remedial actions, both to the personnel within the squadron involved and other squadrons of the same T/M/S. This 'horizontal' communication is particularly important. As Reason stated, "organizations need to understand and acknowledge that people at the sharp end are not

usually the instigators of accidents and incidents and that they are more likely to inherit bad situations that have been developing over a long period." This is particularly important today in Naval Aviation. We have gone through numerous transitions while being resource-limited due to budget constraints. Those two organizational forces can create new hazards that will be inherited by our Sailors and Marines. We need every Sailor and Marine to be a sensor against the potential "Blue Threat" and openly report errors, hazards and incidents. We need to speed up our OODA loop and get inside the Blue Threat's turn radius before we lose an aircraft or aircrew to potential bad situations.

Human error will never be eliminated, only moderated. The effectiveness of countermeasures depends on the willingness of individuals to report their errors, which requires an atmosphere of trust in which people are encouraged to provide essential safety-related information (Reason, 1997).

Finally, I would like to discuss David Marx and his book "Whack A Mole." Marx discusses how societies' "no harm, no foul" approach to personal accountability does not reduce behaviors that lead to mishaps or make our systems more resilient to human error. Marx takes a different look at unsafe acts than Reason. Marx notes three things that can lead to a mishap: human error, at-risk behavior, or reckless behavior. Human error is the honest mistake: hitting the wrong switch, skipping a step in the checklist, etc. These are known as skill-based errors in DODHFACS. At-risk behavior is when we cut the normal safety margin by bending the rules. Going 65 MPH with a 55 MPH speed limit is a good example of this. These speeders have no intention of causing an accident. They think they can continue to safely operate the vehicle with this reduced margin of safety. They do not see the hazard of this excess speed. This is known as a routine violation in the DODHFACS world. Reckless behavior is when we know the risk of a certain behavior, know the risk is not worth the reward, understand that the behavior could lead to a mishap, but do it anyway. To use the traffic analogy, this is the motorcyclist who drives 115 MPH in a 45 MPH zone. One of my students did that while I was XO of VT-3; needless to say we recommended attrition. In DODHFACS language we would say this is the extreme violation.

Based on what behavior caused the 'incident' we can apply tenets of Just Culture in order to embed it into the behavioral norms of our squadrons. Marx suggests that human error can never be eliminated. However, it is up to the organization to identify where those errors will happen and put controls in place to reduce the frequency of those errors. Figure 1 shows management techniques for dealing with the three different behaviors discussed.



Three behaviors and management techniques, adapted from Marx.

Having a Just Culture is vital to having a learning and reporting culture. Without a Just Culture you will not see hazards before they become mishaps. Without it you will not have a proactive safety culture and will remain reactive, like trying to "Whack a Mole!" Get it? —*CAPT Jody "Caveman" Bridges, USN—Director*; jody.g.bridges@navy.mil

MAN — OBSTRUCTIVE SLEEP APNEA

Over the past 20 or so years, leaders and aviators alike have become more attuned to the issue of fatigue. Most commands are thorough in their study and assessment of the problems and risks associated with long duration missions, high OPTEMPO, and circadian shifts associated with travel across multiple time zones. One area that has not received as much consideration as it deserves is fatigue brought on by Obstructive Sleep Apnea (OSA).

Apnea is cessation of breath and OSA entails repeated episodes of partial or complete blockage of the airway while sleeping. When this occurs, the muscles that control breathing have to work harder to bring air into the lungs. Following an apneic episode, breathing usually resumes with a loud gasp, and/or a body jerk. These episodes can occur many times each night and obviously interfere with sound sleep. They can also reduce the flow of oxygen to vital organs, cause irregular heart rhythms and contribute to various long term medical illnesses.

Many people with OSA do not realize they have the condition as they have no complaints regarding their own sleep. Unless noticed by someone who observes the patient sleeping, it can go on for quite some time before being diagnosed. Symptoms if present may include, sudden startled awakenings, difficulty getting up in the mornings, daytime fatigue, trouble concentrating, forgetfulness and irritability. It is estimated that 5-7% of US adults suffer from OSA and while anyone can be affected, cases are more commonly seen in older, heavier adults. While a history and brief exam may offer some clues, an accurate diagnosis is best made following the completion of a sleep study where various bodily functions are monitored. Individuals who meet the criteria for diagnosis are then offered options as to the management of the condition. These can range from education and lifestyle modifications, mechanical therapy such as machines that keep the airway open (Continuous Positive Airway Pressure-CPAP), and devices that assist with the proper positioning of the airway. In some cases, surgery may be offered.

Congress is finalizing legislation that would force the FAA to go through a formal rulemaking process to institute new sleep apnea measures. This would entail any pilot with a body mass index of 40 or higher having to undergo a sleep study in order to be cleared to maintain their certification. Such a requirement would end up costing many individuals a significant amount of time and money and as such has caused some apprehension amongst the entire U.S. civilian aviation community. A decision is expected in the near future but the final outcome is likely to be delayed while both sides continue to fight for what they feel is proper.

In Naval Aviation, OSA is being seen more than in the past and accounts for the majority of requests for sleep-related waiver submissions. CPAP, which is considered the treatment of choice in Naval Aviation may be used by aviators both on shore and at sea (provided certain conditions are met). Waivers will be considered for OSA in designated aviation personnel with various treatments, provided there is complete resolution of symptoms and documentation of no excessive daytime sleepiness on formal testing.

The number of cases of OSA is not likely to decline in the near future and it can be just as dangerous to aviation safety as any of the more commonly considered issues that contribute to fatigue. Since it also may negatively impact long-term health, there is even more reason to consider this entity in individuals who either exhibit signs or have risks of fatigue-related conditions. A quick discussion with your flight surgeon should bring answers to any questions you may have.

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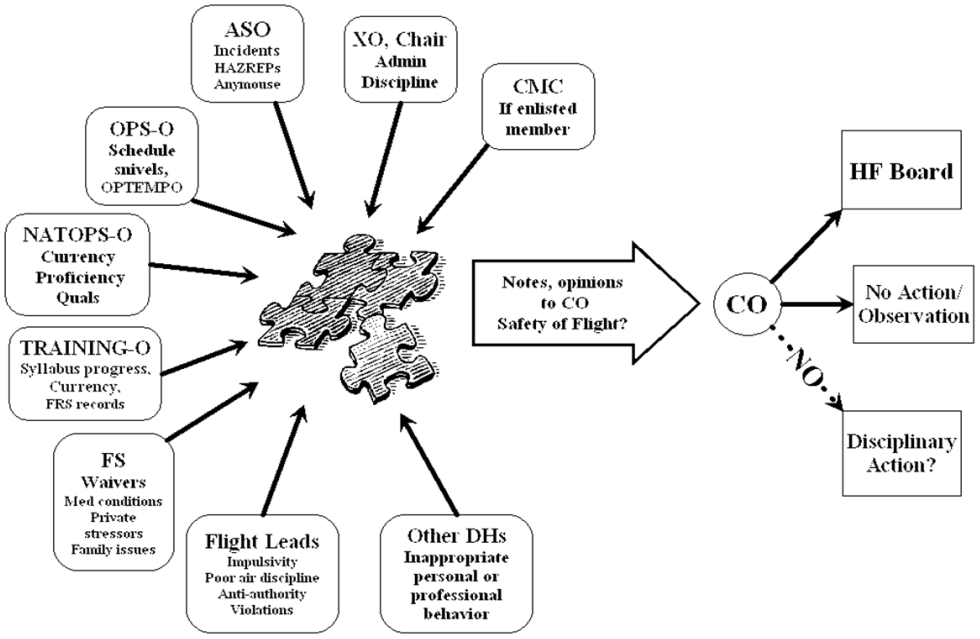
MEDIUM — DEMYSTIFYING THE HUMAN FACTORS BOARD

It's great to be back in P'Cola! I PCS'd here back in October from a liaison billet with the FAA Regional Headquarters, located in Renton, WA. I thought, "How great it would be to get to the sun and warmth of FL heading into the winter months." Little did I know we would have one of the coldest winters on record! Despite the reality check, I am enjoying my tour of duty at the School of Aviation Safety.



Retrieved from HFC/HFB Instruction, CNAF 5420.2 Series

Something I picked up on during the first few months of class is that over the last 22 years of Naval Aviation, perceptions of Human Factors Boards have not changed much. A portion of aviators continue to view HFBs as a punitive action… performed as a pre-FNAEB/FFPB. This perception may be part of a cultural issue for certain communities. Back when I was an Ensign, I thought my personal life wasn't affecting my job performance, until I failed a NATOPS test. I thought that this lapse was just a fluke. However, a few days later I received a ready-room down. Soon after, I was told the command was going to hold an HFB on me. At the time, I had no idea what it was, so I asked around. The more I asked around, the more I panicked. The picture of an HFB was horrifying! Once the HFB convened, I soon learned that the HFB was simply a tool for the command to help identify any Human Factor issues I may have, and… get this… they said they were here to HELP ME SUCCEED!! During the HFB, the command became aware of several life stressors that were full of insidious hazards. End result, the command assisted me in devising a plan to get my life straightened out and back on to a successful career path. As a result of my HFB, there were three articles submitted and published in Approach magazine attempting to correct any misperceptions of HFBs.

So, why, after 22 years, is there still a belief among some that HFBs are a negative thing? If we look at the HUMAN FACTORS COUNCIL AND HUMAN FACTORS BOARD POLICY AND PROCEDURES instruction, HFBs are designed to be used for several purposes, one of which is, "a preponderance of life stressors or unknown personal stress that may affect flying performance." Why is a tool that is designed to help save lives and prevent damage to aircraft viewed as a negative? Is it a lack of educating our aviators? One of the four pillars in the Safety Management System is "Promotion." Are we fulfilling the scope of what a great Promotion pillar demands? Some communities have been able to influence the "bad" image of HFBs by doing them on a regular basis, enabling aircrew to see that they are helping them. How does your command view HFBs? Is your command using them regularly, or only as that pre-cursor to the FNAEB/FFPB? A challenge to you is to review how your command views HFBs and see if it's healthy. If it is, great! If not, what are you doing to help?

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MACHINE — VIBRATIONS & CONDITION-BASED MAINTENANCE

Whether you fly fixed-wing, rotary-wing, or tilt-rotor aircraft, you have probably been taught that vibrations have a negative effect on your aircraft. The answer isn't quite that simple. A vibration is generated in a rotating system whenever an imbalance of aerodynamic or mechanical forces is experienced. Some of us have more opportunities for these imbalances than others. We all have engines with spinning parts… a "rotating system" as I mentioned above. Of course, non-fixed-wing aircraft have a few more rotating parts than others. Regardless, the concepts are valid for all aircraft. As for the negativity of these vibrations? Well, if the structural components can absorb the motion of the components which are oscillating, then we may not have a problem. Perfectly balancing a prop-rotor system or compressor section of an engine is nearly impossible. We can, however, balance these rotating systems within certain tolerances. The vibrations which are generated within those tolerances are determined to have minimal impact on the aircraft structure and humans (when applicable!) within that structure. Nevertheless, with a certain amount of time, oscillations, and displacement, the structural components and their connections to each other will begin to fail. Therein lies our lack of fondness for vibrations in our aircraft!

So what can cause these aerodynamic or mechanical imbalances? Quite a number of things. The forces generated due to motion through air of our wings, turbine blades, rotors, prop-rotors, even pylons, can potentially cause an imbalance in aerodynamic forces. On a helicopter rotor system, for example, one blade exhibiting significantly greater lift than the others will transmit that additional force to the rotor head, swash-plate, and other components of the aircraft. That additional force is being applied through one section of a rotating system, creating an imbalance of forces. Mechanical imbalances can be created in a system with a mass imbalance, such as propeller blades with significant (outside the established tolerances) differences in weight. Besides mass imbalances, changes to components which affect stiffness and damping properties of the structure will also have an impact on those mechanical forces. Cracks are a good example of such a structural change.

Through years of testing and collecting data, aviation manufacturers and maintainers have developed excellent data for estimating a time-based threshold of component degradation and failure. The resulting severity of such failure necessitates a 'margin of safety' of significant magnitude that structural failures of key aircraft components rarely, if ever, occur while "on wing." Think about that for a moment. If the components are removed prior to any possibility of failure, then we're removing many parts that have useful life remaining.

Enter the concept of Condition Based Maintenance (CBM). The idea behind CBM is that components are replaced only when they actually show signs of wear, as opposed to a time-based metric based on when other similar parts began to show wear or degradation or computational models predicted a failure. Through CBM, mission readiness can be enhanced by spending less time performing preventive maintenance of aircraft. Naturally, there is a fiscal benefit, too. So how do we know when a part is beginning to wear? Through vibrations! As the parts and structures of our aircraft begin to wear, crack, or deform, the resulting vibrations from, through, or around that part will change and be recorded by assorted sensors in the aircraft. The trick is to tie a sensed vibration to a degraded component. This takes a significant amount of testing and data. As an operator of these machines, you want to know when something is breaking but you also don't want any false alarms which cause you to cancel your flight. Finding that balance requires information… information which you help collect if you have a CBM system on your aircraft. Every flight collects more data on vibration signatures of the aircraft. When a damaged component is found, engineers and manufacturers can link the recorded vibrations to the worn parts. From the pilots ensuring that recording systems are operating to the squadron maintainers conducting informal and formal inspections, to quality assurance personnel collecting and discussing data with factory tech reps, everyone plays a role increasing our mission readiness and effectiveness. —*LtCol Stephen "Bender" Dickerson, USMC—Rotary-wing Aerodynamics Instructor;* stephen.m.dickerson1@navy.mil

MISHAPS — BOLDLY EXPLORE ALL DODHFACS TIERS

Navy and Marine Corps aviation mishap boards (AMBs) are charged with the unique responsibility to report the entire truth they discover in the course of an investigation. Asking, investigating, and answering the question 'why' can be an uncomfortable process because of the typical characteristics of a military officer and aviator. We expect excellence from ourselves and one another and do not embrace anything that smells like an excuse. We also are groomed to become leaders and the foundation of leadership is setting a good example of followership. In military operations there is a necessity to respect the chain of command and obey lawful orders without question because there is often no time for debate. This concept can be a hindrance to an AMB as it searches for causal factors in a mishap due to a tendency to trust and support the chain of command. The AMB must understand that they are ordered to accept a different role while investigating a mishap and recommending action that will ensure the mishap will not happen again. To effect lasting change, the correction to an identified causal factor requires action at the supervisory and organizational level. These upper tiers have the power to increase funding, update curricula, and correct procedures. Therefore, AMBs must seize the opportunity to generate appropriate recommendations for the upper tiers of our chain of command.

Incorporated in OPNAV 3750.6S (also in 3750.6R), DoDHFACS (Human Factors Analysis and Classification System) is an invaluable asset in advancing the cause of Naval Aviation Safety. DoDHFACS serves as a tool to help an AMB explore multiple potential causal factors within the Act, Precondition, Supervisory, and Organizational tiers. By following the DoDHFACS model, the AMB is likely to identify separate causal factors that would otherwise be overlooked. Appendix D of 3750.6S provides a description of the nano-codes that apply to the accepted causal factors. The DoDHFACS nano-codes are entered in the Safety Investigation Report (SIR) to document specific identified causal factors. Naval Safety Center collects this data for trend analysis well beyond the individual events. To avoid skewed data, the AMB should ensure "only one tier with associated category, sub-category and nano-code combination is used with one accepted 'who'" (8-20). However, the analysis for an accepted causal factor can and should include the same failure in the verbiage of multiple accepted causal factor paragraphs to explain 'why' an act occurred and 'how' the failure is related.

3750 gives the AMB a level of flexibility while still complying with certain mandates. For example, 3750 requires that each recommendation in an SIR must apply to an accepted causal factor (8-21) and each identified hazard must have a corrective action assigned (10-1). 3750 also indicates: "Once the investigator has fully devolved into the preconditions and has recorded all preconditions for the act, the focus must move on to supervisory and subsequent organizational issues that contributed to the precondition"(C-15). The AMB has two options when addressing a latent supervisory or organizational failure. With option 1, the AMB can accept the supervisory or organizational failure in a separate accepted causal paragraph with an applicable nano-code. An accepted causal factor at the 'act' level would also include this supervisory or organizational failure in the analysis but the nano-code would only appear once. With option 2, the AMB can include the supervisory or organizational failure in the nano-codes of an accepted causal factor at the 'act' level, thus helping to explain 'why' an act occurred, but not list that failure as a separate accepted causal factor. Each of these options identifies and explains how a latent supervisory or organizational failure was causal to the mishap. Only option 1 provides a distinct accepted causal factor paragraph for the supervisory or organizational failure and thus a better opportunity for a precise recommendation. Option 1 also affords the endorsing chain the opportunity to overtly discuss the specific supervisory or organizational failure.

The AMB must remember the goal of the report—to prevent mishaps. The AMB should have no fear that accepting supervisory or organizational causal factors is a betrayal. To the contrary, the AMB is making an honest assessment of the entire chain of command that will ultimately result in improved operations and increased safety.

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CRM — IMPORTANCE OF CRM IN AUTOMATED COCKPITS

CRM in highly automated aircraft presents special challenges, particularly in terms of situational awareness of the status of the aircraft. Today's pilots have to know not only what flight information is needed at any given time, but how to find it in the system in order to punch it up on a screen.

Modern aircraft feature a variety of automation technologies to help the pilot with such things as checklist execution, navigation, descent planning, engine configuration, and system monitoring. One of the goals of automation is to improve the pilot's situational awareness. A related goal is to decrease the workload required to maintain a given level of awareness. Pilot reaction to automation varies from highly favorable to highly critical depending on both the pilot's background and how effectively the automation is implemented.

After more than a decade of experience with the advanced systems in automated cockpits, operators and researchers are finding that the promise of improved flight safety is still largely unfulfilled. Some observers contend that increased automation may actually be creating new hazards. The automation issues which impact safety include flight crew workload, avionics failure modes and degradation of basic piloting skills. Along with the safety issues, the automation technology may have decreased the ability of pilots to maintain situational awareness.

Workload. Aviation researchers have discovered disturbing trends among the crews of the new generation of automated aircraft. Remembering that automation was supposed to reduce workload to free the crew to perform higher level tasks, they are finding that most workload reductions are occurring when work levels were already low, such as during cruise. As workload is decreased, there seems to be a trend toward increased complacency, lack of vigilance and even boredom among the crews of highly automated aircraft. In historically high workload situations, such as departure and arrival, automated systems can actually increase crew activity, detracting from critical vigilance for outside traffic and awareness of position, terrain, and the general ATC situation.

Degradation of Basic Skills. There is growing, but as yet unsubstantiated, concern regarding degradation of pilot skills and proficiency through the use of extensive automation. Flight crew concern may be an effective counter to the development of problems in this area. While a majority of pilots are concerned about skill deterioration when flying automated aircraft, only some believe their skills have been affected. Carefully designed standard operating procedures can play an effective role in maintaining proficiency in routine operations.

Failure Modes. Recognition and recovery from automation failures can prove to be very difficult and involve very high workloads. Research has shown that many crews are reluctant to override an automatic system, even though there are obvious discrepancies in data being presented to the crew. There is growing concern that automated systems can fail in ways that are both unanticipated and untrained. This difficulty in detecting system errors requires the crew to cross-check primary flight and navigation displays to ensure proper performance of the automated systems.

There has been a series of commercial aviation accidents involving highly automated "glass cockpit" aircraft. America's two recent fatal air crashes – the Asiana Boeing 777 passenger jet on final approach into San Francisco international airport and the UPS Airbus A300 freighter coming into land at Birmingham airport in Alabama – are cases in point. Both situations point to distractions the pilots faced while trying to take control of the aircraft. In both instances, the pilots seem to have been unaware, until the last few minutes, of their proximity to the ground and of how slowly their planes were flying. Both finished up crashing short of the runway. In both instances, federal investigators have found little evidence of equipment failure before the crash.

The way pilots use modes and the implications for managing the flight are issues of discussion and concern in the aviation

community. Indeed, airlines address this issue by designing specific training modules, developing specific procedures, and articulating a philosophy for using flight-deck automation. Nevertheless, evidence from accidents and thousands of pilot-reported incidents suggests that confusion regarding mode behavior is still a chronic problem in these human-machine systems. It also appears that this trend is bound to escalate as newer automated systems are developed. CRM is crucial to the automated cockpit. It becomes a three-way challenge between the pilot flying, the pilot not flying, and the automation. Pilots of automated airplanes must have a deep commitment to the principles and practices of CRM.

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MCAS Futenma, Okinawa.

MV-22 Containerized Flight Training Device.

USMC photo by LCPL Michael P. Granaham/Released.

Spring Milestones in the U.S. Sea-going Services

- *April 12, 1911: LT Theodore Ellyson, USN, qualifies as the first Naval Aviator*
- *April 21, 1951: USMC carrier-based planes made their 1st aerial contact with enemy planes over the Korean front lines. Three enemy planes were shot down and one was damaged.*
- *May 1, 1942: Two USCG planes located a lifeboat with 13 survivors and landed in open seas and took injured men ashore as others were rescued by lifeboat.*

SEMPER PARATUS — "FOUR P" VIEW OF MARKETING AN SMS

Consideration of the "Four Ps" of marketing works in the business world, so why not for marketing a Safety Management System? New products require some amount of creativity and energy to help achieve "buy-in" in the market. Our market is our respective service, inclusive of Headquarters through air stations or squadrons. The "Four Ps" are comprised of: Product, Price, Placement, and Promotion.

Product. For Coast Guard aviation, an SMS likely won't be seen as a brand new product, but as a product improvement. We have many healthy elements of an SMS already running. The challenge to the FSO is to get air station personnel to believe that the SMS is not a singular "product" of the safety department, but a "system" which everyone takes some amount of ownership in. Some of the more experienced members of the hangar deck have seen a dozen young FSOs come and go in their career. They may not be waiting in anxious anticipation to hear the brand new FSO talk about the advent of a Coast Guard SMS the first time he or she grabs the microphone at the next all-hands call. It may be hard to teach old dogs new tricks, but as seniority accrues, a professional's focus on and need to leave a proud legacy grows. This is a selling point of an SMS. An SMS is a long-term commitment, not a consumable item. We need our experienced folks to recognize how valuable their participation in it will be.

Price. At the air station level, there really is no true price for embracing the SMS, at least not in terms of dollars and cents. However, from the perspective of the average pilot or aircrewman, price is measured in pain. How painful is this safety program going to be to me? How much added time and energy will I have to devote to filling out an ASAP report after a future flight? How much longer is a new ORM program going to make my flight brief? While you can never discount the end-user's concerns for ease-of-use or time requirements in personally supporting an SMS, new and improved programs (like the Hazard Assessment Tool) are for the benefit of the system which we are a part of. Personal concerns need to always be balanced with the legacy-minded view of long-term improvements, but the pain we may or may not feel is for the benefit of the system. Our participation is an investment with expected, positive returns.

Placement. For a consumer product, placement might be as simple as knowing the optimal shelf for displaying the product. A department store would never display their XL-Tall shirts on the lowest shelf. Connecting the user with the product needs to be sufficiently easy. In the absence of a DOD-style ASAP (anonymous reporting) system, CG FSOs in the past have found ways to make participation in the program easier. Safety reporting links on ALMIS (a system we use on a regular basis anyway) were great ideas. Wouldn't it be easier to be able to report hazards without the need to be logged onto a CG WSIII computer though? Perhaps an "app" will be next. Broader placement of the products, with easier access, supports the reporting culture which in turn supports an informed culture. Everybody wins.

Promotion. With product, price, and placement in order, promotion will have a fighting chance. There are safety champions at all levels of our organization, from the headquarters level down to the air station. All have different audiences, with occasional overlap. CG-1131 promotes the cultures and programs supportive of an SMS through interaction with flag officers, participation on the Commandant's Safety Board, conferences with senior leaders, FSO standardization courses, air station audits, etc. At the air station level, it should be abundantly obvious to all-hands who the FSOs are by the way they promote and support operational readiness through safety initiatives. Posters, literature, and newsletter are just the start. Healthy "Eagle Eye" incentive programs, visible mutual support within the local Tri-P, and appropriate protection of reports and reporters as part of a just culture are some of the more advanced stages of the healthy SMS. If the program is respected, it will promote itself very well.

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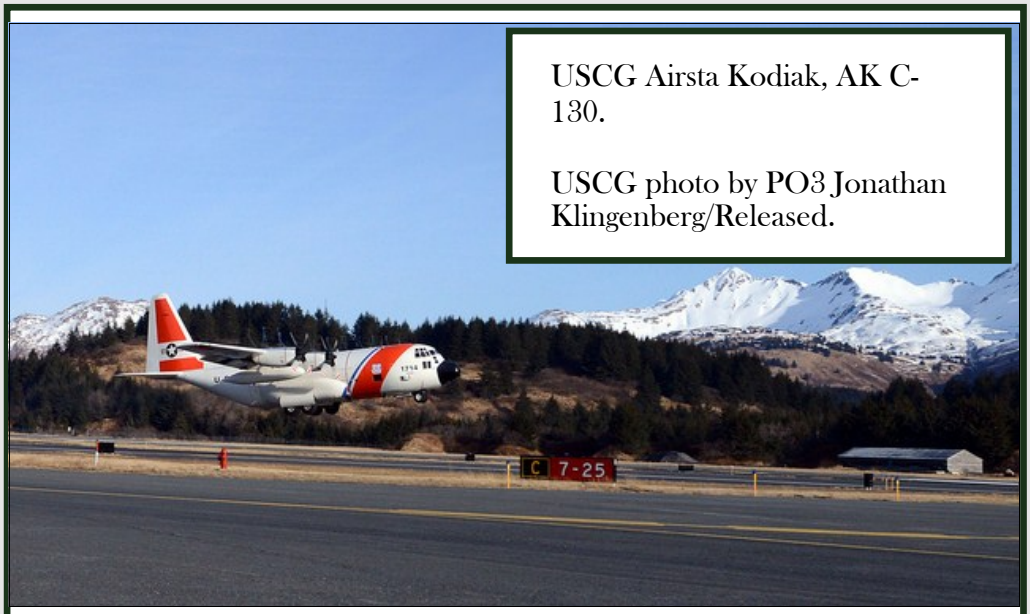
Also, if you would like to be removed from future emails, please email LT Bates (info above) with name and approximate dates of your class attendance.



USCG Airsta Kodiak, AK C-130.

USCG photo by PO3 Jonathan Klingenberg/Released.

SPECIAL POINTS OF INTEREST

"DOC" BANK MEMORIAL DISTINCTION: STUDENT RECIPIENTS

The *Milt "Doc" Bank Memorial Distinction*, recognizes the student or students in each graduating ASO class who best exemplify the characteristics of the late, great Milt "Doc" Bank, PhD: motivation, intelligence, imagination and aptitude to be a potential future ASO Instructor. The recipient of this award for ASO Class 14-3 was LCDR Colin Bernard, USN. Congratulations! ASO 14-4's awardee was Capt Jacob Zaborowski,USMC

SAS FACEBOOK PAGE

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