LOOK TO THE SKIES

Former child protection worker **Chris Mills** and retired British Airways pilot **Trevor Dale** on what the aviation industry has to teach about minimising risks within social work

Social work is a safety critical activity. Most of the time, things go well. Sometimes, however, they can go very wrong and service failures can have tragic, even fatal, consequences.

It's surprising, therefore, that social work has not been quicker to embrace the approach to safety developed in other safety critical industries, such as civil aviation. In the last 25 years, the major airlines have developed an approach based on understanding how and why things go wrong and how to put them right. These are grounded in what is called a system approach to human error – an approach that focuses on understanding the impact of working conditions on individuals and on building defences to reduce errors in the workplace or mitigate their effects. It draws on an understanding of how and why we make mistakes and the implications of this for organisational design. In short, it concentrates on human factors.

CULTURE

The first thing that has to change is culture. In the post-Second World War era the culture of many airlines was authoritarian and hierarchical. The figure of the God-like autocratic captain was more than just a caricature. The belief that highly qualified and experienced people did not make mistakes was widespread. Thinking began to shift after the world's worst civil aviation disaster at Tenerife North in 1977, where crucial mistakes were made by a highly experienced and respected captain whom the crew were unable to challenge successfully. Gradually it became clear that if human error was to be tackled the culture would have to change.

The aim was to develop a responsive safety culture in which people always prioritised safety and in which everybody was equipped and enabled to contribute to safety improvements on a daily basis.

One of the first casualties of this new approach in civil aviation was rigid hierarchy. The idea that junior crew members never challenged captains or managers had to be abandoned. It had to be accepted that if somebody thought something was unsafe it was their duty to speak out, not just meekly obey orders. Others had a duty to listen and to take action if appropriate.

The other casualty was blame. It was quickly realised that blaming people for mistakes made in good faith was counterproductive. If people thought they would be punished for drawing attention to errors, they would remain silent and important learning would be lost. A great deal of attention was given to creating what safety expert Professor Sidney Dekker calls a just culture, where blame is reserved only for those who act with malign intent, and in which the expectation is that everybody will be frank and open about human error.

HOW ERRORS OCCUR AND HOW THEY CAN BE PREVENTED

These developments were paralleled by a better understanding of how workplace errors and organisational accidents occur. The approach, based on the work of psychologists such as James Reason, sees workplace errors not as occasional aberrations caused by individual weaknesses. Rather they are seen as being routine events, something we all do quite a lot of the time as a normal and inevitable part of everyday practice. Organisational defences offer some protection against serious unwanted outcomes, but these in turn are imperfect. From time to time the trajectory of an error, or series of errors, aligns in such a way that all the defences are bypassed and a tragedy occurs. The key to safer services is not to blame individuals for their human weaknesses, but to improve the quality of the defences progressively, by understanding where the failure points in them are to be found. Gaining such an understanding depends crucially on openness about error. Rather than hiding service failures or pretending that mistakes don't happen, all employees are expected to welcome the opportunity presented by an unwanted event for learning about human error and developing ways to avoid it in future.

TRAINING

In the 1990s the airlines, building on academic research undertaken at the University of Texas, developed training, initially called 'Crew Resource Management' but now more commonly referred to as 'human factors'. In addition to stressing the need for a just culture and giving employees a basic understanding of the psychology of human error, this kind of training concentrates on developing non-technical skills, usually in the following six areas: situation awareness, decision-making, communications, teamwork, leadership and authority and working in difficult or stressful environments. For example, employees are taught how to recognise the signs of loss of situation awareness, and factors which predispose to it, and they explore how safer decisions can be made and more successfully reviewed. The emphasis is on acquiring and improving practical skills which can help people work more safely.

Training of this sort spread rapidly and in the 1990s it was made mandatory for all airlines in Europe and North America.

SYSTEMS

Learning from mistakes requires information. What are the kinds of things which routinely go wrong and what are their causes and effects? Information of this type needs to be collected, aggregated and analysed. A simple day-to-day system for collecting information about what goes right and what goes wrong is debriefing. The idea is to take just a few minutes after a discreet piece of work to reflect and learn. That now happens routinely on the flight deck, after every landing. Where the crew identify important safety issues during a debriefing, these can be escalated for management action. The other side of the coin is briefing. Learning from yesterday can be passed on to today's team.

More structured, perhaps, are systems to capture data about critical incidents and near misses. Since the 1980s, civil aviation in Great Britain has developed systems like CHIRP (the UK confidential reporting programme for aviation and maritime), which permit pilots, cabin crew, controllers and engineers to report confidentially an incident in which they believe safety has been compromised. The data is submitted to an independent body, so that nobody can be identified and blamed. It is subsequently aggregated and analysed, with the results being published.

CAN A SIMILAR APPROACH BE DEVELOPED FOR SOCIAL WORK?

Since the turn of the century, human factors thinking has spread to medicine, space and nuclear industries. We believe that it can also be adopted in social work. The kinds of errors that lead to disasters in child protection or safeguarding vulnerable adults are strikingly similar to the human errors that cause aviation accidents – people lose situation awareness, make bad decisions or communicate ineffectively.

The issue of the blame culture, and its negative impact, is one with which social workers are only too familiar. It is not only the popular media that are quick to blame social workers when things go wrong, but the profession's own regulators seem to be frequently involved in proceedings against social workers whose actions would be better addressed by re-training and providing better support, rather than disapproval and punishment. The tone of Ofsted reports is often hectoring and censorious and a negative inspection often has a profound negative impact on the careers of those found wanting. Although there are no academic studies of the impact of blame and fear on the quality of social work services, everyone in practice knows that they inhibit openness. And that means that mistakes are hidden and covered up, not understood and not creatively addressed. Some may argue that mechanisms for learning from error in social work have already been devised, sometimes with mixed results. For many years, the Serious Case Review (SCR) was the preferred method of learning from tragedies involving children. But there are many things wrong with this approach, not least that SCRs narrowly focus only on unrepresentative, usually fatal, events. The SCR process also became increasingly bureaucratic, even formulaic, and the spectre of identifying and blaming front line practitioners haunts many reviews. In some cases, those involved in service failures have been unwilling to co-operate fully in the SCR process.

Rather than focusing on learning only from disasters, there is a need to learn on a daily basis by recognising and understanding all the routine errors and failings which are part of practice. That is what happens every day on the flight deck and it is what pilots and other airline employees are now taught to do.

Undoubtedly, the hardest thing to change is culture. But change can happen bottom-up and the indifference of policymakers and senior managers can be overcome. That happened in the airlines, with a great and lasting impact on safety. It can happen in social work too.

How to create a safety culture in social work

- When things go wrong, be slow to blame and quick to learn
- Try to influence all colleagues, including your managers and leaders, to develop a just reporting culture
- Develop your understanding of the psychology of human error and the study of organisational safety
- Help collect and analyse information relevant to understanding the kinds of things that go wrong routinely
- When trying to understand service failures, address not only the question 'How?' but also the question 'Why?'
- Don't just describe errors and service failures: analyse them
- Use your learning to develop and enhance your non-technical skills in situation awareness, decision-making, communication, teamwork, leadership/authority and working in difficult and stressful environments

Chris Mills is a former child protection social work manager who blogs about child protection. Trevor Dale is a retired British Airways 747 training captain who now specialises in providing human factors training. They have devised a day course for social workers on safety culture training – see www.atrainability.co.uk. Both are also members of the Safer Safeguarding Group which campaigns for a human factors approach in child protection and adult safeguarding