ACHIEVING COST SAVINGS FROM LEARNING OPPORTUNITIES

THE HONOURABLE COMPANY OF MASTER MARINERS

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The Issue

There is insufficient understanding of why it is critically important for business health to efficiently gather the enormous harvest of learning opportunities' or learning events (near misses and unsafe acts & omissions) that are happening every day on our ships. Such events are commonplace and therefore it makes good business sense to calculate their financial costs based on their worst probable outcomes. This especially so in the case the high potential events, where, but for luck, the incident would have realized its worst probable outcome and the uninsured costs to the organisation, and sometimes to the wider industry (see the below example), would have been substantial. Such an approach would allow individual companies, and indeed the entire industry, to focus upon the high-risk issues that are the most cost beneficial to reduce.

For a number of reasons, only a fraction of these learning events are reported thus, self-evidently, widespread remedial action then cannot be taken. This is critically important because a real, robust and healthy incident reporting system is absolutely essential to both business and safety success, with safety and efficiency being two sides of the same coin.

The Facts

Confidentially, seafarers will admit to frequently cutting corners and breaking procedures and will also admit to not reporting these and other incidents. This is particularly true when it involves their own errors and omissions. The existence of all these unreported learning events means that the industry is effectively practicing having accidents without the knowledge of shipowners. Equally, it is common for boards of directors from many industries, not just shipping, to be labouring under the illusion that the Key Performance Indicator (KPI) covering their Near Miss reporting quota, is being met, with each incident being acted upon. Sadly, when closely examined this rarely proves to be the case, as is evident from scrutiny in many organisations from a variety of industries.

The fuel that powers healthy reporting is a mature safety culture that is at least at Level Four (Proactive) and preferably at the highest, Level Five (Generative). For this Paper we shall call the latter a Learning Culture. It is wishful thinking to believe that reporting will happen if the culture is not embedded at these levels. At a company level, the desired culture can only be generated from committed boards of directors, each of which must be well led by an enlightened CEO who genuinely understands the business as well as the safety imperative of achieving a Learning Culture. Even then, it takes a number of years to achieve since mutual trust is slow to grow. This also holds true at an industry regulator level, where it must be understood that nothing produces world-class industry efficiency and safety as well as does the widespread adoption of Learning Culture. Safety and efficiency go hand in hand.

It is the absence of Learning Culture that dooms the industry to continue to only learn from accidents and this is the most questionable and expensive way to benefit from experiences. Even then, there is a tendency to call lessons identified, lessons learned despite the undeniable absence of positive actions being taken to put in place long-term measures to prevent repetition. It is like driving a car with the windscreen covered and only using the rear-view mirror. This absence causes people to take chances and cut corners because it is sometimes perceived that using a non-approved method is the only way to get the job done in a timely manner – and so the vicious circle continues.

Recent Example

The HCMM has learned of anecdotal evidence indicating that high sided, fully laden, ultra large container vessels have suffered Learning Events of a similar nature to that which led to the demise of the EVER GIVEN that grounded in the Suez Canal. However, due to the prevailing industry culture, even when the

incident is reported to and considered by the individual company (which very often doesn't happen), there are insufficiently robust mechanisms in place to ensure that wider industry benefits from these free learning events. Opportunities are missed to avoid avoidable costs.

How do we achieve a Learning Culture?

Put simply, we have to create a 'one team' environment in the steady pursuit of operational excellence. In this culture, people, at all levels, are:

- Properly trained in both technical and non-technical skills, including leadership and management (especially at management and supervisory levels ashore and onboard). Training must then be validated through coaching and mentoring to ensure ongoing competencies.
- Trusted, empowered, treated like adults and listened to.
- Happy and encouraged to report all incidents, including personal errors. This willingness is generated through hard-earned trust in the fact that the reporter will not be penalised for reporting, unless the act was wilful, deliberate or malevolent and this type of violation is quite rare.
- Asked to identify their challenges within a safe environment, to offer solutions to those challenges and then be allowed to implement changes for themselves, with the help and support of their managers. When asked, people tend to offer ideas on how to simplify, improve and make operations safer, and also more efficient. This works because people are committed to their own ideas and believe in their own solutions.
- Involved with the derivation of all procedures so they become owned by the workforce. When this is the case, procedures will tend to be simple, relevant, brief, ship-specific, useful and, most importantly, used.

Conclusions

Much productive learning can be achieved from the myriad of learning opportunities, provided they are reported. They are unlikely to begin to be reported unless and until the company has at least declared its sincere intention to pursue a Learning Culture and then, in close cooperation with the workforce, follow that statement of intent with actual actions.

When boards of directors recognise the need to embrace this change, so they are able transparently to see the cost savings to be made (albeit *invisible* ones). They can achieve this by encouraging and then analysing such reports, especially those of high potential, thus setting their company on the road successfully to pursue safety and business excellence. Reports of this sort have the capacity to generate, to transform and then maintain the company Learning Culture. When learning events are identified in good time, they prevent the chance of them becoming *actual* losses, because the cost-beneficial corrective actions are put in place in a timely way and the tendency towards corner cutting and risk taking can be proportionally reduced.

HCMM Actions

The HCMM as a body of professional mariners is committed to encouraging and supporting all efforts to ensure that lessons identified become lessons learned. Accordingly, to help achieve a Learning Culture in our industry and/or within individual companies, over time the Honourable Company intends to pursue the following matters:

1. The HCMM will work at industry regulator level, to encourage the relevant bodies to help individual companies to understand that:

a. The quality of leadership at all levels, both ashore and afloat, is critically important to success and that weak leadership costs money.
b. An effective Learning Culture can only be generated from committed boards of directors, each of which must be well led by an enlightened CEO who genuinely understands the business as well as safety imperatives and that ignoring this imperative does not cost but rather saves.
c. A key component of world-class industry efficiency and safety is a developed Learning Culture.
d. Safety and efficiency are two sides of the same coin and are inseparable.

2. The HCMM will continue to advocate though its contributions to professional organisations, seminars and industry debate that senior managers, both ashore and afloat, are trained to recognise the value of Learning Events and to actively seek them out and praise the reporters. They must be encouraged not to focus absolutely on seeking out and punishing the guilty but must recognise that this approach, carried to extremes in the absence of a well-developed Learning Culture is largely counterproductive.
3. The HCMM will work to achieve an environment of co-operation between maritime organisations within the United Kingdom to develop a one-team culture, promoting safety and personal wellbeing. This could then be a template for the world to follow.

4. The HCMM will advocate the creation of a workforce incident recording method (simple booklet carried by all, for example, BC Ferries' booklet "**A**ll **L**earning **E**vents **R**eported **T**oday (ALERT), iPad / computer entry, etc) Workforce ownership will ensure it is simple and used.

5. Similarly, we will advocate the use of either available commercial software, or the development of bespoke methods, designed to do some or all of the following:

a. Provide a software system for all Incidents and Learning Events to be entered.
b. Calculate **initial estimated**, **actual** and **worst probable** costs associated with each actual high consequence incident, together with each high potential learning event.
c. Assemble associated workforce-owned, cost beneficial, corrective actions for each. The software can be developed to feed into all other major company operating systems and software, for example Legal, Insurance, Finance, Human Resources, Training, Maintenance Management and Operations & Logistics, etc.
d. From the calculated financial costs of corrective actions and associated control measures, as set against incident costs if they had reached their worst probable outcome, advocate development of the software to provide organisations with the cost benefits of introducing the measures that reduce the chances of a repeat incident to **A**s **L**ow **A**s **R**easonably **P**racticable (ALARP). Reasonable Practicability is enshrined in UK and many other country's laws and its meaning is very well understood.