ANG Safety

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this issue

The Operations Occurrence Report: A Refresher

The following is an excerpt from the ICAO Safety Management Manual.

'Accurate and timely reporting of relevant information related to hazards, incidents or accidents are a fundamental activity of safety management. The data used to support safety analyses are reported by multiple sources. One of the best sources of data is direct reporting by front line personnel since they observe hazards as part of their daily activities. A workplace in which personnel have been trained and are constantly encouraged to report their errors and experiences is a prerequisite for effective safety reporting'.

In Air Niugini, data collected through the reporting system can be analysed with other data as part of the Safety Management System. One source of data is the Operations Occurrence Report, the yellow reporting form available to all personnel. Another is the Hazard Report form, the green form used to report existing hazards detected by airline staff.

The Operations Occurrence Report serves two purposes. One is to provide safety information to the airline for further investigation or analysis and the other is to provide information to CASA PNG in accordance with our obligations under Part 12 of the Civil Aviation Rule. The Hazard Report form on the other hand is there to ensure that when company personnel observe a hazard they have the means to communicate their concerns directly to the company and have that hazard addressed. These are forms that, if used correctly, can make a major contribution

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"Just Culture" Policy

Extract from ANG Safety Management Systems Manual , Section 5.2

Air Niugini's "Just Culture" Policy is a non-punitive policy based on the principles of 'good faith' and 'reasonable care'. Under these principles, if an employee's actions cause or contribute to an accident or incident, no blame is placed on that person provided all of the following conditions are met:

- The employee's actions were in 'good faith'.
- Reasonable care taken by employee while performing his/her actions.
- The employee freely admits to having made a mistake after first having had explained the reasons that their action contributed to the accident or incident.
- There is no history in the person's file of serious negligence, insubor-

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Report Cites Human Error in 2013 Lao Air Tragedy

Asia Pacific aviation experts are calling for more emphasis on pilot training as countries in the region prepare for rapid growth in passenger flights in the coming decades.

Lao Airlines released the official report into the cause of the crash of a domestic flight last October that killed all 49 passengers and crew including foreigners.

Lao Airlines flight QV 301 was flying from the capital Vientiane to Pakse in southern Champasak province in October 2013 when the twin-engine turboprop crashed in a heavy storm on its second landing attempt.

The tragedy killed everyone on board, including nationals from 10 countries, including Australia, France, Thailand, South Korea, Vietnam, China, Taiwan and the United States.

The Lao Government released the official report into the accident to the Lao media as well as relatives of the victims specially invited as guests of Lao Airlines.

Pilot error

Details were also broadcast on Lao TV. The TV report told how in the midst of a storm the pilot had at the last minute decided to halt the descent to the airport, to attempt a second landing but at an altitude below recommended levels and in a steep right turn.

Instead, the plane clipped trees on an island in the Mekong. Its fuselage struck the bank and the plane plunged into the river. All on board perished on impact, the report said.

The victims included an Australian family of four, Gavin Rhodes, his wife, Phoumalaysy, originally from Laos, and their two small children. Gavin's father, Geoff Rhodes, 71, from Sydney, spoke of how he had wanted to 'represent' his son at the report's release. He summed up the report's findings.

"My interpretation was that there were three errors; pilot error, system error, and equipment error. And the recommendations that they are making as to how they can improve seem to me to try and consider all three. Does it make any difference to how I feel? No. No I don't feel any different," Rhodes states.

The report on the tragedy comes as the Asia Pacific aviation industry is seen on a pathway for rapid growth in the coming decades.

Call for safety measures

The International Air Transport Association (IATA) recently called for the continued strengthening of safety measures and improved low cost infrastructure and environmental controls.

Globally some 3.3 billion passengers are expected to board flights this year, and this is forecast to grow to 7.3 billion by 2034. IATA says that over the coming two decades the Asia-Pacific is expected to account for about two thirds of global growth.

But Hugh Ritchie, chief executive of Aviation Consultants International, says growth is often outpacing the region's aviation sector's capacity to build up skilled human resources to cope with the rapid changes.

"My problem with air safety in this part of the world is that they are growing exponentially. They are trying to build systems which are international standards. On the outside it looks like they are doing it but if you go behind the scenes and look at much of the functionality, I don't think they are achieving these levels," Ritchie explained.

Ritchie says too often in Asia there is a hesitation to make key decisions that will impact the Asia Pacific aviation industry going forward. Some efforts are underway.

The Asia Pacific Regional Aviation Safety Group, of 20 governments and 12 international organizations, including IATA, is improving the sharing of critical safety information. Institutions such as the Asian Development Bank are providing funds for air safety infrastructure.

The questions remains, is enough being done, quickly enough, to avoid tragedies like the crash of Flight QV 301.

http://www.jacdec.de/2014/11/28/2013-10-16-lao-airlines-atr-72-crashed-intoriver-near-pakse-final-report-out/

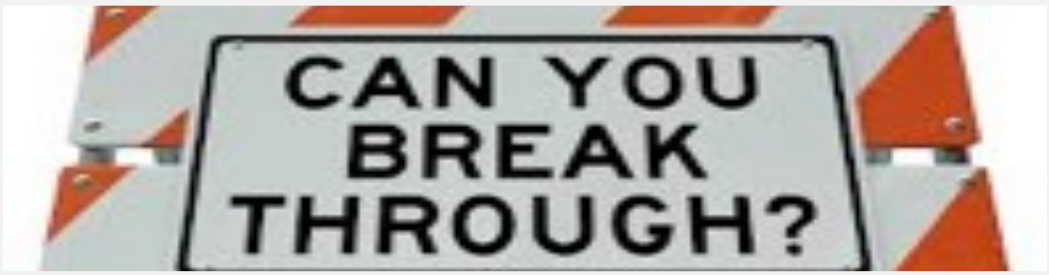
Aviation Industry faces new risks despite improved Safety

Despite several recent disasters, the aviation industry's safety record has improved over the long term, although new risks are presenting a threat to the industry, according to a new report from Allianz Global Corporate and Specialty.

Currently, there are fewer than two deaths per 100 million commercial air passengers, a massive improvement over when the commercial jet industry was in its early stages, Allianz says. Between 1962 and 1971, there were 133 deaths per 100 million passengers, it suggests. However, the "increasing likelihood of cyber attacks, greater reliance on automation and the anticipated growth of drones in commercial use" are all presenting risks to the aviation industry moving forward. "New generation aircraft are highly exposed to cyber crime due to the prevalent use of data networks, onboard computer systems and navigation systems," Ludovic Arnoux, AGCS's global head of aviation risk consulting commented in a statement on the report.

"Data breaches and cyber attacks are perceived to be growing risks," Arnoux added.

https://www.allianz.com/v_1417617209000/media/press/document/AGCSGlobal-Aviation-Safety-Study-2014.pdf



Impediments to Reporting

By Robert Baron, Ph.D (The Aviation Consulting Group)

The company's SMS is in place. The reporting system is up and running and employees have been trained about the importance of reporting hazards and unsafe conditions. Yet, during informal interviews with employees, many admit that they have not—and probably will not—use the reporting system.

Reasons include:

- "I don't have the time to fill out those reports."
- "I don't trust management with the reports, even though they claim they are non-punitive and confidential."
- "I'm sure other people will make the reports."

As a manager, now what do you do? You know the importance of the reports (they are integral to your proactive hazard identification and risk assessment process).

Here are some suggestions:

Regarding time, time is a relative thing. People use the excuse that they don't have enough time when, in fact, they might just be trying to say that they are not genuinely interested. Many employees feel that they have nothing to gain from submitting a report. This is mostly attitudinal and can be changed during the training process by explaining to employees the importance of reporting (especially during SMS induction training). Be explicit. Talk about the overall benefit to not only the company but also to individual employees (they may be preventing their own accident or incident).

Regarding management trust, why is there a lack of trust? Is it actual (an employee was fired for submitting a voluntary, "non-punitive" incident report)? Or is it perceived (I just don't trust management?). If it's actual, it's a management issue and management needs to make a quick correction to get the trust back.

This can be a protracted and arduous process but "talking the talk" and "walking the walk" are absolute management requisites for a successful SMS. If it's perceived, then it's an employee issue. It's normal for employees not to trust management. The job, then, is for management to foster a culture of trust. This can be done in a number of ways, but for the most part it involves management commitment to safety, good role modeling, high visibility, and good (open and transparent) communication.

Regarding other people making the reports, this may be due to pluralistic ignorance, which means that employees assume that "someone else will take care of it." This may also be known as diffusion of responsibility. When everyone thinks this way then nothing gets done—it becomes an organizational norm.

Of course there is a lot more to talk about but I just wanted to highlight some of the more common impediments to reporting. Hopefully, management, employees, and trainers will absorb a few good nuggets from this piece and reports will start to increase!

Continue from page 1: 'Just Culture' Policy

dination or incompetency contributing to the creation of risk or of injury to a person or damage to property.

The above conditions define the line between acceptable and unacceptable actions or activities:

Rules governing employees –

- Employees do not have automatic immunity from disciplinary actions and it is only when the employee's manager (or Department Head) has established that all of the above conditions have been met that the "no blame" provision comes into effect.
- Negligence and deliberate violations are not tolerated by management and employees who cause or contribute to an accident or incident through negligence or a deliberate violations will be disciplined, including termination of employment where considered warranted.
- Department Heads are responsible for implementing the Air Niugini "Just Culture" Policy.

Air Niugini employees who feel they have been blamed or disciplined for an accident or incident in contravention of the "Just Culture' Policy may appeal to the Board (including Board Safety Sub-Committee) and the CEO who have the authority to review any individual case.

Dr. Bob Baron is the President and Chief Consultant of The Aviation Consulting Group (TACG). His specializations include Human Factors (HF), Safety Management Systems (SMS), Crew Resource Management (CRM), Line Operations Safety Audit (LOSA), and Fatigue Risk Management (FRM). He consults with, and provides training to, hundreds of aviation organizations on a worldwide basis.
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FOOD FOR THOUGHT—COMPLACENCY REVISITED

Complacency occurs when we step back and relish our accomplishments, but we shouldn't lose focus of what got us there and rest on our laurels too long.

Roger Hughes, President, Decoding Human Factors Inc.

We are used to looking at human factor problems with a focus on the employee, so let's turn this around and look at human factors problem focused on management. I'll only look at one issue: complacency. In this respect, complacency is failure to act appropriately and resting too much on our laurels.

Complacency, at first blush, is not a problem. Don't we have a moment of complacency when we have completed a big project and reflect on what was accomplished? It becomes a problem when it hinders other activities or blinds us to other problems. Excess complacency is the problem.

People tend to become overconfident after becoming proficient in a certain task, which can mask the awareness of dangers

There was an accident on the "L" train blue line going to Chicago's O'Hare Airport. The operator failed to stop and ran through the boarding area, went through the barriers and proceeded partially up the escalator toward the airport terminal. It was all caught on a security camera and was a devastating accident. Surprisingly, no one was seriously injured. The investigation revealed that several safety devices were designed to stop the train automatically. The barrier at the end of the track had failed in its task. The train operator admitted that she had dozed off just as the train entered the terminal — aha, a victim was found and terminated. The train was not speeding but the train had produced enough kinetic energy even at slow speed to climb the escalator to the airport terminal. The train operator was a fill in, so she works different shifts at different times to fill in for manpower gaps. The operator was trained properly; however, she had a previous incident with dozing off and missing a stop. What would you do?

The transit authority has had a "zero accident" policy in place for some time. Its instant decision was to fire the train operator and also find out why the safety devices, although activated, failed to stop the train. I see this all too often — "let's have a fair trial right after the hanging." All in all, this sounds like a reasonable approach, a perfect example to tag some "Dirty Dozen" labels on it and put it to rest. Fatigue comes up immediately; we can also add a cup of lack of awareness and complacency and throw in a dash of pressure and a pinch of stress. The recipe all points to a person, the operator, being the cause — but does it solve the problem? Aren't they missing something?

I'll admit that all those Dirty Dozen labels fit but they should lead us to a root cause. The Dirty Dozen is not a list of root causes or any kind of cause. The Dirty Dozen is a list of symptoms and the finger is always pointed toward the employee. We are good at addressing symptoms and shooting the last person to touch the object because it is staring us in the face. Get rid of the symptom and you don't have anything staring at you. Remove the obvious and we can pretend that the cause has also disappeared and we can be content with being oblivious. Unfortunately, the Dirty Dozen is seen as the great list of causal human factors. We place too much emphasis on its usage. It has become a crutch to lean on to identify causes but problems persist. I wonder why.

Setting people up for failure

It's quick and simple solution — get rid of the person. If it weren't for people mucking up the works, everything would work perfectly. Really? Think again. Machines break, wear, and need maintenance and upkeep. If your car gets a flat tire, do you get rid of it and get another car, thinking that solved the flat tire problem? That sounds ridiculous, doesn't it? In the previous scenario, the train crashed due to the operator falling asleep because the system had her working relief shifts and she crashed the train. Will firing the train operator fix the problem?

If you have ever worked a relief shift, you know the problems that can arise. You get off work at 4 p.m. and go home expecting to have a nice quiet evening, planning to retire to bed around 10 p.m. At 8 p.m. you are called into work the late shift, midnight to 10 a.m. This

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Cont. from previous page— Complacency Revisited

will put you in a sleep-deprived mode from going more than 24 hours without sleep. Add to the fact this is a midnight shift that strains a human's circadian rhythms, even when it is your normal shift. This is a recipe for disaster.

We continually set people up for failure. Managers are surprised when the failure occurs and they blame the individual. I never could understand that. I am always reminded of the scene in Casablanca when Captain Renault, Claude Rains, shuts down Ric's Café, stating, "I'm shocked, shocked to find gambling is going on in here," as the croupier hands him his winnings from the table. Management becomes complacent with settling for the status quo. We seek quick answers and short-term results.

Zero Tolerance

While employed at a major airline, I went through a root cause training session. It was a robust training course in sound root cause analysis, but the odd thing was that the root cause analysis was done after employee discipline has been administered. Yes, you read that correctly: ready, shoot, aim. This is zero tolerance at work; complacency is illuminated because it simply won't be tolerated. t.

Zero is an absolute. Zero-tolerance policies are upper management's message to everyone that we don't trust you to do any thinking so we will do it for you. Crash a train and you're fired, get a paper cut and you're fired. Wait a minute, that's ridiculous. Hey, zero is zero, remember? If we allow paper cuts, what else will be on the allowed list? If zero isn't zero anymore, then what is it? Now everyone is confused.

Complacency occurs when we step back and relish our accomplishments, but we shouldn't lose focus of what got us there and rest on our laurels too long.

BP was celebrating six months of achieving its goal of zero quality escapes when it incurred the largest oil disaster in American history. Surprisingly, the celebration was on the platform that exploded. No executives were injured in the blast although several employees were killed. Aiming for zero quality escapes and zero accidents is a noble goal but it also has a tendency to promote what you are trying to prevent. Zero is also a fleeting accomplishment and not sustainable. When touched upon, it is time for celebration but with the reality that it is temporary. Trying to sustain that level is distressing; however, letting up is not an option. I'll age myself with this analogy but you have to wind a clock every day to maintain the time; if you don't wind it enough, it loses momentum during the day and doesn't keep accurate time. Wind it too tight and it breaks. Seeking zero as a goal is winding things too tight.

What's wrong with chasing zero?

Zero sounds like a logical target. Unfortunately, zero accidents and zero quality escapes set up what is referred to as binary thinking. You are either perfect or a failure. Upper management message of "zero accidents" or "zero defects" or "zero tolerance" sends a mixed message because they are just words without substance and actually exacerbate what they purport to denounce. The pursuit of zero sets an admirable but unachievable goal. Unachievable goals frustrates the workforce and reduces productivity. With a zero mentality, anything less than zero is a failure, so why put forth extra or any effort when failure is inevitable?

The argument will no doubt come up that if I am not pro "zero accidents," "zero defects" and "zero tolerance," then my goal is to plan for accidents and defects to occur and I'm tolerant of all aberrant behaviour. This is thought-limiting mentality and binary thinking in action again; life is not black and white and just comprised of zeros and ones. The fact that I see the fallacy in perfection doesn't mean that I pursue imperfection. On the contrary — I recognize imperfection for what it is and don't hide behind the perfection poster. I also recognize that the phrase "all incidents are preventable" is hindsight thinking that cannot predict future events, as many may think. It should more correctly be stated, "All incidents were preventable." We need that hindsight as a learning tool but it is not predictive. It is our nature to learn from our mistakes and the mistakes made by others, the idea is not to repeat them.

More on predictive actions

That seems to go right in the face of proactive activities that are designed to prevent things from occurring before they happen. It is true that this is a predictive action but it is based on probability and severity.

Aliens from another planet could attack us tomorrow. If they wanted to destroy us, we would be helpless. Should we gain international support and promote huge capital expenditures to develop a defense against an interplanetary attack? That's not going to happen. Even though the severity of the attack means the annihilation of the human race on this planet, the probability is too low to take action. It is better to spend money on defenses that are more be necessary even though the severity is less than total extinction. We refocus but it doesn't mean that we completely ignore this issue. We might revisit it occasionally to see if the probability has changed. Never be complacent, even if it is absurd.

Zero is not sustainable and if it is reached, we should not be complacent. We should be attentive enough not be lured into a sense of permanence, knowing that zero is temporary.

Thomas Jefferson said, "Our new Constitution is now established, and has an appearance that promises permanency; but in this world, nothing can be said to be certain, except death and taxes".

Cont. from page 1 — The Operations Occurrence Report: A Refresher

to worker and passenger safety.

Information on the correct use of these forms is available in company documentation but some points deserve extra clarification.

The OOR.

Traditionally, forms such as the OOR have been designed with the technical crew in mind. In the past they were simply called pilot reports and that concept of document 'ownership' has carried on to the present day. The form is technical because pilot reports by their very nature have to be precise and thorough to allow an effective investigation, but the effect on non-pilot employees is that they are faced with a document that can be intimidating if not confusing.

For non-pilot employees this form may appear to be a pilot's only document. It may even appear to be a captain's only document because of the makeup of the 'Primary Detail' section at the head of the page. This is not the case. If you observe or are involved in an incident or accident and you carry an Air Niugini staff card this is your document.

The form can be filed confidentially and the same applies to the green Hazard Report form. A confidential hazard report may mean we never have to file an occurrence report for a hazard left unchecked.

The document is not a loan or driver's license application. There is no requirement to fill out every section and every box in order for the document to be valid. Some items such as the 'Tech/ Maint. Log' entry are required under certain conditions but for non tech crew employees the report can be brief and to the point. The basic information we require to conduct an investigation is no different to that required by any investigating authority. Items such as time, date, location, vehicle or aircraft identification, flight number and registration and a description of the incident or hazard. Any further information can be provided by the reporter as required once the form has been received by the safety office.

A brief description of the incident is important and remember to ask yourself what you would need to see if you were receiving such a report.

- Make it legible. The document will be faxed so block letters rather than handwriting is preferred.
- Avoid using jargon, acronyms and other technical terms if possible.
- Keep it relevant. Avoid naming individuals or expressing personal opinions about staff or passengers.
  Report what you see.

If you can file a report with just the basic details and a simple and accurate description that will enough for the safety office to begin the investigation. The rest of the form can be left alone.

Never assume that another employee will file a report. If you believe that an incident has occurred and it needs a report then fill out a form and forward it to the safety office by fax before depositing it in the locked confidential deposit box in your department. If you do not have immediate access to a fax machine you can phone the safety office or another office listed on the back of the form and advise us that you have a form to file. We will arrange for collection.

In summary, a few points bear repeating:

- This is <u>your</u> form. If you have an employee badge it is your document to file as you see fit.
- This document belongs to all departments. If you work in engineering, catering, security, operations, customer support or any other department you still use this form.

The form can be intimidating but all you need to fill out are the basic details and a description of the event. If no form is available you can even use a simple piece of paper instead.

If you don't have access to the OOR or hazard forms ask your department manager to contact us for new stock. If you still can't access the form a simple piece of paper with contact details will suffice. If you find yourself unable to file any printed report you can contact the safety office by phone or email or through operations or your fleet office. If you file a report shortly before leaving the country for leave, days off or on duty we ask that you contact us before doing so to allow us to proceed with the investigation in a timely manner.

Submitting OOR and Hazard Reports

Air Niugini has Operations Occurrence and Hazard Report boxes at the following locations—

- Pilot Briefing room (JAX Domestic Terminal)
- Cabin Crew Briefing room (JAX Domestic Terminal)
- JAX Airside Ramp Manager's Office
- Cabin Crew briefing room (JAX International Terminal)
- Cargo Compliance/Operations Office

OORs and Hazard Reports can be dropped off at the above locations or faxed to Safety Systems Office, **fax No. 327 3454.** They can also be emailed to :

- Moses Yuki (myuki@airniugini.com.pg)
- John Bogana (jbogana@airniugini.com.pg)
- Darrel Patiken (dpatiken@airniugini.com.pg)

Effects of Alcohol on Human Performance

Drug and alcohol use by aviation professionals can have a detrimental impact on aviation safety. Important cognitive and psychomotor functions necessary for safe operation of an aircraft can be significantly impaired by drugs and alcohol.

Many organizations have automatic mandatory drug and alcohol testing after events involving maintenance activities or Flight Operations.

Air Niugini has a zero-tolerance policy in relation to employees and contractors reporting for duty or carrying out their duties under the influence of alcohol and other drugs. The permitted level of Blood Alcohol Content (BAC) is 0.019%. Any employee or contractor in a critical operational function who returns a BAC reading of 0.020% or higher when checked/tested is in breach of this policy.

Alcohol, taken even in small amounts; impaired brain and body functioning, induced acidosis (excessive production of lactic acid), induced Ketoacidosis (when your body burns fat instead of sugar because not enough insulin is being produced to convert the glucose into energy), induced sleep deprivation, produces a dulling of judgement, comprehension and attention, lessened sense of responsibility, a slowing of reflexes and reduced coordination, decreases in eye efficiency, increased frequency of errors, decrease of memory and reasoning ability, and fatigue.

Alcohol is absorbed very rapidly into the blood and tissues of the body. Its effects on the physiology are apparent quite soon after ingestion and wear off very slowly. In fact, it takes about 3 hours for the effects of 1 ounce of alcohol to wear off. Nothing can speed up this process. Neither coffee nor hard exercises nor sleep will minimize the effects of alcohol.

The presence of alcohol in the blood interferes with the normal use of oxygen by the tissues (**histotoxic hypoxia**). Because of reduced pressure at high altitudes and the reduced ability of the hemoglobin to absorb oxygen, the effect of alcohol in the blood, during flight at high altitudes, is much more pronounced than at sea level. The effects of one drink are magnified 2 to 3 times over the effects the same drink would have at sea level.

A person's judgement is impaired under the influence of alcohol. His/her reactions during ascent to higher altitudes are unpredictable. He/she may become belligerent and unmanageable and a serious hazard to the safety of the flight.

The rule for both pilot and passengers in relation to alcohol quite simply should be **"No alcohol in the system when you fly"**. Air

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Aviation Humor

The flight attendant watched a passenger try to stuff his hopelessly overloaded bags into the overhead locker. Finally she informed him that he would have to check the oversized luggage.

"When I fly other airlines,' he said irritably, "I never have this problem!"

She smiled and said, "Sir, when you fly other airlines, I don't have this problem either."

An airliner was having engine trouble, and the pilot instructed the cabin crew to have the passengers take their seats and get prepared for an emergency landing.

A few minutes later, the pilot asked the flight attendants if everyone was buckled in and ready.

"All set back here, Captain," came the reply, "except the lawyers are still going around passing out business cards."

ATC—"Flight 1234, for noise abatement, turn 45 degrees."

Pilot—"But Centre, we are at 35,000 feet. How much noise can we make up here?"

ATC—"Sir, have you ever heard the noise a 747 makes when it hits a 727?"

Tower: "Aircraft on final, go around, aircraft on runway."

Solo Student Pilot: "Roger" (Continues descent.)

Tower: "Aircraft, GO AROUND"

Solo Student Pilot: "Roger" (Continues descent.)

Tower: (Screaming) "AIRCRAFT, GO AROUND!!"

Student:: "Roger" (Continues descent.)

So, the student pilot plunks his airplane down on the numbers, taxies up to where the twin is sitting in the middle of the runway, GOES AROUND it, and continues on to the taxiway.

http://www.urcaptainspekin.com

Cont. from page 7 — The Effects of Alcohol on Human Performance

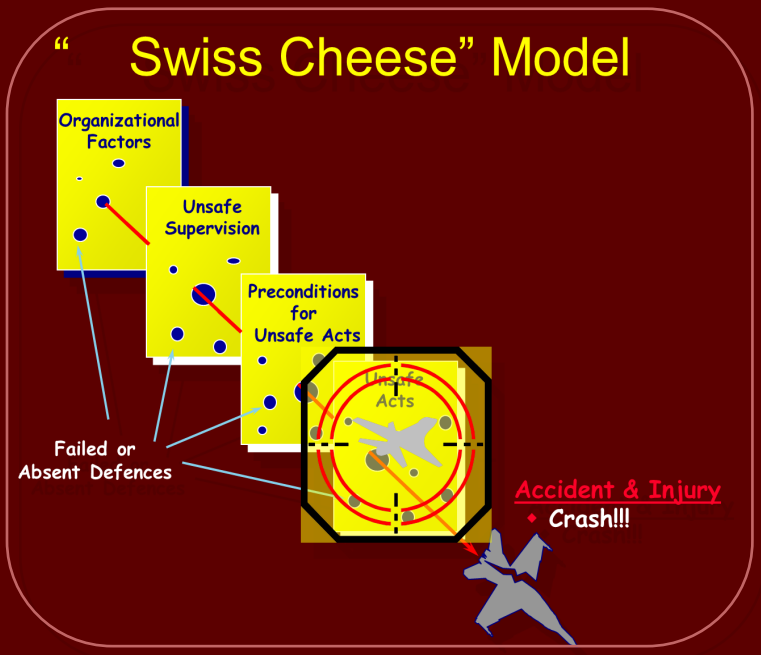
Regulations require that a pilot allow at least 12 hours between the consumption of alcohol and piloting an airplane. In fact, more time is probably necessary. An excellent rule is to allow 24 hours between the last drink and take-off time.

An evaluation of the Australian Transport Safety Bureau's accident and incident database was conducted for all occurrences in which drugs or alcohol were recorded between 1 January 1975 and 31 March 2006. There were 36 drug and alcohol-related events (31 accidents and five incidents). The majority of these occurrences were related to alcohol (22 occurrences).

Given this broad analysis on the effects of alcohol on the human body it should not be too hard to see why alcohol should be avoided for aviation professionals. Alcohol can have many negative effects on the human body, and these when combined with a flight-deck / maintenance scenario have the potential to cause great harm.

As aviation safety professionals, we must demonstrate our high standards and the ethical qualities expected in the performance of our duties. It is our duty to educate ourselves on the effects of alcohol.

As individual, we should also be aware of the long term health risks associated with excessive use of various stimulates. Our customers and families expect the best from us.



Open exchange of safety information

We welcome contributions from individuals who would like to share information relating to any Safety issues affecting Air Niugini.

We encourage sharing of information with fellow workers because the open exchange of safety information continuously improve aviation safety.

Major Contributors

1. ***Roger Hughes (President, Decoding Human Factors Inc.) - Complacency Revisited***
2. ***Captain David Innes (ANG Acting Safety Systems Manager) - The Operations Occurrence Report: A Refresher***
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