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Here's a **summary of the Aviation Safety Investigation Insights session:**

## Presenter

Keir Mobbs – Safety Investigator at Jetstar

- 30+ years in aviation (RAF, commercial airlines, aerospace).
- Leads technical safety investigations and Qantas Group standards.

## Purpose

Explain **why and how investigations are conducted**, share examples, and highlight systemic improvements.

## Key Points

### **1. Why Investigate?**

- Prevent recurrence of incidents.
- Demonstrate robust Safety Management System (SMS).
- Regulatory compliance.
- Identify systemic issues, not individual blame.
- Support **just culture**: focus on learning, not punishment.

### **2. Examples of Incidents**

- **UK Case (2024):** Cabin manager fell and broke bones when stairs were moved prematurely during boarding.
- **Darwin & Melbourne Cases:** Stairs removed before doors closed; near-miss hazards.
- **Engineering Case (Sydney):** Elevated work platform toppled; high-risk event investigated.

### **3. Investigation Process**

- Triggered by:
  - High-risk classification.
  - Consequence level  $\geq 5$  (e.g., serious injury).
  - Executive directive or ATSB involvement.

- Most investigations focus on **everyday hazards** to prevent escalation.
- Methods:
  - Collect data: reports, interviews, photos, flight data, CCTV (where possible).
  - Ask “Why?” repeatedly to identify root causes.
  - Use **Bow Tie Analysis**:
    - Hazard in center.
    - Left: preventive controls.
    - Right: mitigation measures.

#### 4. Challenges

- Memory distortion over time; interviews must be timely.
- Crew trauma considerations during interviews.
- Social media videos: helpful for evidence but raise privacy and psychosocial concerns.

#### 5. Findings & Trends

- From 2020–2023, **regulatory compliance issues** accounted for 23% of cabin crew-related findings.
- Other areas:
  - Injury/illness response improvements (e.g., free-flow oxygen, multilingual medical kits).
  - Closing gaps between training and real-world practice.
- Emphasis on **systemic fixes** over individual blame.

#### 6. Future Focus

- Enhance **crew resilience and stress management**.
- Address fatigue education and emotional regulation.
- Improve turbulence response and passenger interaction strategies.
- Promote **just culture awareness**, especially in regions where punitive approaches persist.

### Key Takeaways

- Investigations aim to **learn and improve**, not assign blame.
- Collaboration across departments is essential (cabin, flight ops, engineering, ground).

- Continuous feedback and scenario-based training help bridge gaps between SOPs and real-world operations.

# AVIATION SAFETY INVESTIGATION INSIGHTS



## WHY INVESTIGATE?

- Prevent recurrence
- Demonstrate robust SMS
- Regulatory compliance
- Focus on systemic issues, blame individual



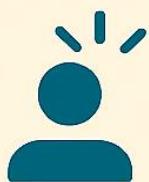
## EXAMPLES OF INCIDENTS

- Stairs moved prematurely during boarding
- Stairs removed before doors closed
- Work platform toppled



## INVESTIGATION PROCESS

• Data collection: Bow Tie Analysis, reports, interviews, photos, flight data	Method: hazard in center	preventive controls
		mitigation measures



## CHALLENGES

- Memory distortion over time
- Crew trauma



## FINDINGS & TRENDS

- Regulatory compliance issues
- Bridging gaps between training and practice

## FUTURE FOCUS

- Crew resilience and stress management
- Turbulence response

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