Abstract:

The aim of this assignment is to seek and improve the knowledge of Organisational Behaviour, and various reasons to organizational behavioral issues that believed were evident in the organisations and how they might have developed. We will be discussing how and why like these organizations were wrong or has not been guided seriously and also what other actions could be done in order not to an incident occur. Although the troubles which have been made by the organisations, leaders and managers that did not act and decide responsibly or ignored the problems which presented itself.

Introduction:

The Hawker Siddeley nimrod was a military Aircraft which has been made in the United Kingdom. It was designed as Royal Air Force maritime patrol aircraft. Nimrod has been originally created by “De Havilland” successor, which is an aircraft company and it is a group of British manufacturing companies engaged to Aircraft production, now part of BAE System. It served from early 1969 to march 2011 to play an important role in Defence. On 2nd of September 2006, in Afghanistan, the RAF Nimrod XV230 was lost when it suffered a disastrous mid-air fire, leading to the total loss of the aircraft and the death of all 14 crews on board. There were several matters that caused the incident. The main issue was from fuel and ignition which considered two of the physical causes. These all troubles were because of incapability of an organisation in neglecting or wrong decision making, Mistakes that mainly caused by different organisations culture, behaviour, structure, leadership and management lack of knowledge and communication which in this case was mostly because of regulations and legislations that has been ignored. All three organisations (BAE, IPT and QINETIQ) failed somehow in Nimrod Safety Case and they needed trilateral relationship in order to avoid the incident. Aircraft age, Defence Establishment and Industry was inevitably complex sophisticated, incestuous, and elliptical. It is also a very necessary and valuable relationship, not least because of the need to design, develop, build, test and maintain increasingly high-technology and high-cost weaponry. The story of the loss of Nimrod XV230 and the NSC should be a catalyst to a careful re-examination of the various relationships at all levels, in order quickly to rebuild trust in the short term and in the longer term to develop joint values and new ways of working together to achieve common outcomes. To be far more discriminating in the future as to what is, and is not, outsourced in Industry. Also cost and budget cut in order to change out-of-service old equipment was another issue that might take into consideration.

Analysis:

* **Characters and their tasks.**

**British aerospace systems:**

Nimrod XV230 which crashed badly on September 2006 was made by BAE systems. Before that sad incident the BAE systems with Ministry of Defense Nimrod IPT made the nimrod safety case to identify the ’serious design flaws’ that was present on Nimrod between 2001 and 2005.

The table below represents the main characters involved in BAE systems.

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| --- |
| * Richard Oldfield: * Nimrod review’s leader * Did not fully show up the hidden risks present on the Nimrod * As a leader, did not support position with full responsibility |
| * Chris Lowe * Chief airworthiness engineer. * The one behind “poor planning, poor management and poor execution” of the project. |
| * Eric Prince * The manager of the flight systems and avionics. * Played main role in the safety review. |

Table 1

**Nimrod integrated position team(IPT)**

Nimrod IPT was in charge of the planning of the Nimrod safety case (Third Phase). The table below shows the main characters involved in Nimrod IPT(Haddon-Cave2009).

|  |
| --- |
| * Frank Walsh * The safety review manager. * Worked as primary point of contact to the team at BAE Systems tasked with planning of the safety review. |
| * George Baber * MOD integrated project team leader. * In the Nimrod review, Mr Haddon-Cave allege George Baber of “fundamentals failure of leadership”. |
| * Wing Commander Michael Eagles * Chief of air vehicle. * Responsible for the production of the safety review and it was found that Wing Commander Michael Eagles passed on the project to a civilian worker. |

Table 2

**Qinetiq**

Qinetiq was the independent adviser to the Nirmod Safety Case with also the responsible of signing off or approving the Nimrod Safety Case.

The table below shows the main characters involved in Qinteq (Haddon-Cave2009)

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| --- |
| * Colin Blagrove * Technical assurance manager to the Nimrod Safety Review. * Carried the responsibility of signing or approval, unless it has been appropriate to do so and failed in his specific task in accordance with the Nimrod report. |
| * Martyn Mahy * Nimrod review task manager for Qinetiq. * Mr Haddon-Cave Criticized for having to do his work in certain areas such as consent to sign-off on the Nimrod safety case “without seeing or reading documents”. |

Table 3

* **Key Organisational Issues**

The nimrod’s incurable crash has been reviewed for several times.

The organisation and maintenance of the aircraft were the key aspects of its failure. The military was attempting to conceal its mistakes for numerous years. They tried to hide their malaise and disrespect for military producers. Several warning signs were not addressed, and this results in the huge failure of the aircraft.(Opinion)

There was a difficulty to analyse the nimrod’s failure due to that most of the wreckage was hunted by locals in the area, there was not much left to analyse. The flight logs and black box were claimed by a ground force that made it to the crash location. However the revolutionaries were attacking them continuously and finally forced to retreat. By the time they were able to come back in force to recover and analyse the wreckage, most of it was gone. Therefore the military was left with very little to analyse.

An independent investigator Charles Haddon-Cave QC mentioned in his report, it was clear that “had been a "systemic breach" of the Military Covenant - the nation's duty of care to the Armed Forces.” (Charles Gall, 29th October 2009, Daily record). Charles Haddon then carried on to explain that there had been safety report before the incurable crash, though "lamentable job" which was "riddled with errors” (Charles Haddon-Cave QC, Nimrod report). Lastly he added, "In my view, XV230 was lost because of a systemic breach of the Military Covenant brought about by significant failures on the part of all those involved. “This must not be allowed to happen again." (Charles Haddon-Cave QC, Nimrod report). (why)

From this report, it is obvious that there was significant malaise to proper service of the aircrafts. The ageing fleet had many issues that directed at it. The RAF officers and managers of the fleet has received from the confidential airworthiness report team that there were, “almost 60 "airworthiness concerns" and "airworthiness hazards" (Brian Brady, 11 SEPTEMBER 2011, The Independent).

Afterward none of these issues were addressed. In a safety assessment of the 25 Nimrods in service the review declared that "low manning levels, declining experience, failing morale and perceived overstretch" had directly caused the downfall of the Nimrod fleet. (Brian Brady, 11 SEPTEMBER 2011, the Independent). This shows how despite several clear notices to the MOD, there was no action taken to correctly service these ageing, out of date and failing aircraft.

Nothing was done despite of all these warning reports that the aircraft was not suitable for flight. It is now emerging that “RAF chiefs at the time dismissed the report's warnings”. (Brian Brady, 11 SEPTEMBER 2011, The Independent)

One of the fathers of the sufferers is still trying to seek legal action. He mentions that “I was aware of the failings of the Nimrods, but I did not know that they had been put so clearly in a report eight years before the XV230 went down”. (Graham Knight, father of lost serviceman). Charles Haddon-Cave QC confirms that, “Nart concerns and warnings were not sufficiently heeded in the... years leading up to the XV230 accident.” Charles Haddon-Cave QC, claims that this was most likely the reason for the failure of the Nimrod.

▪ Discussion:

* **Possible Outcomes and Consequences**

Three main organisastions were deeply criticized by the report , (BEA systems, Nimrod IPT and Qinetiq) , All three organizations failed somehow in Nimrod Safety Case and they needed trilateral relationship in order to avoid the incident. the review also included Ministry of Defence and the Royal Air Force to the list to take responsibility for incident, Besides the individual mistakes by the key role personnel , the lack of organisation played a major role in the tragedy.

The report show many of the important lessons to learn from them, but unfortunately these lessons are not new, espically in terms of organzational causes, and share with a lot of famous incidents previously for example ( The explosion of the challenger and the colobmbia space shuttles)

The main similarities which have included organizational issues comprehend (Haddon C and Cave QC 2009):

\*Implementing of ‘business’ principles.

\* Organisational disorder and rapid changes

\* Perfect place culture

\* Normalisation of deviance

\* Cuts in resources and manpower.

It is obvious that most of the points Haddon-Cave represented regarding the rapid changes are mostly caused by a financial crisis. These issues result in controversial decisions which compromise the future of the organization in order to minimize the expenses, by cutting down the quality of the service. For this reason it is difficult to think that in this context lessons has been learnt. This is not because of the organisational behaviour, but generally because of the individual behaviour of key rule personnel.

The report outcome has urged countries like Britain and Australia to take a step in the field of safety of engineering systems .For instance the Royal Academy of Engineering (RAE) in the UK was among participants by releasing researches and documents that support the new safety approach recommended by the Nimrod report.

One of Haddon-Cave recommendation that was embraced the RAE in the UK , is that a single professional body should be formed for Safety Experts to set professional and ethical standards, RAE turned the recommendation into practice by finding a way for the different institutions to work in cooperation and share vital information. (Altinisik H, 2010)

Moreover, the Royal New Zealand Navy did not hesitate on making similar approach towards avoiding future incidents. Implementing the safety rules recommended by Nimrod report and growing emphases on guidelines such as (Holmes.b) :

-“Training needs to deliver fully competent people”

- “Safety Cases are not a tick box paper exercise”

- “There are safety implications to address if changing

- “approach e.g. from ‘function’ to ‘project”

An extra positive result of the report is the significant change in the Australian defence material organization (DMO) which took place over the last two decades. As a result of the heavy bureaucracy system major changes were implemented by The DMO in terms of structure and culture. It was very essential to replace the management of main military services by a trained civilian force in order to catch up with most western militaries and build an efficient in addition to a professional force.( Air Cdre E. J. Bushell, 2011)

Unfortunately, as a result of rapid of changes, organisational disorder and the misconception of running the DMO organisation like a ‘simple’ business, it went through heavy downsizing and de-skilling.( Air Cdre E. J. Bushell, 2011)

The Nimrod review findings and the internal deterioration of the organisational structure shared similar ideas, which led the Australian Senate and the Department of Defence to realize the potential of disaster and recommended to implement the Haddon-Cave review as a model for the future. (Air Cdre E. J. Bushell, 2011)

It is impossible to go back on time and avoid this disaster. Respectively, the accident left a better experience for us to learn from and established a solid foundation to assist large organisations around the world by improving their organisational behaviour.

▪ Conclusion

In conclusion, there were many causes for the loss of XV230, There were physical causes like ignition source, probable fuel sources, responsibility for design flaws and previous incidents. Also there were organisational causes which are our main concern in this assignment. The organisational causes played a major in the loss of XV230. It adversely affected the ability of the Nimrod IPT to do its job. the oversight to which it was subject, also the culture within which it operated.

The key aspects of the failure lie beyond the organisation and the maintenance of the aircraft. There were numerous warning signs that were not addressed as the military tried to cover up its mistakes and hide their malaise and disregard for military procedures.

There were three main organisations (BEA Systems, Nimrod IPT and QinetiQ) that had a failure of leadership, culture and priorities. These three organisations were directly involved in the accident as well as criticism towards the Ministry of Defence and the Royal Air Force. Most of the lessons which were learnt regarding the organisational causes are not new and share major similarities with iconic accident cases.

The Nimrod report had many positive outcomes in many countries like UK, New-Zealand and Australia. One of positive outcome was from the Royal Academy of Engineering (RAE) which released an official document supporting the new professional approach of safety of engineering systems. The Nimrod Review provides clear tools and recommendations which helped large originations to improve their organisational behaviour, safety culture and many other recommendations which have been list below.

▪ Recommendation

The lessons to the learned from the loss of Nimrod XV230 are profound and wide-ranging, many of the lessons to be learned are not new. The organisational causes of the loss of the aircraft echo other major accident cases.

The Nimrod Report made some recommendations in eight key areas:

1 - A new set of Principles: It's very important to identify the right principles and make sure that always to be guided by them.

2 - A new military Airworthiness Regime: To build a new military airworthiness regime which is effective, relevant, and understood which addresses risk to life and drives new attitudes, behaviours and new safety culture.

3 - A new approach to safety Cases: Make the best practice for safety cases for the future, which are to be brought in-house and re-name it to "Risk Cases".

4 - A new attitude to aged Aircraft: Address the generic problems that associated with aged and legacy aircraft.

5 - A new personnel Strategy: Address the current weaknesses in the area of personnel.

6 - A new Industry Strategy: Address the flaws in the current bilateral and triangular relationships between the MOD, BAE Systems, and QientiQ.

7 - A new Procurement Strategy: Bernard Gray's report on procurement is published without delay and appropriate action taken as matter of urgency.

8 - A new Safety Culture: Making a new safety culture that comprising a reporting culture, a just culture, a flexible culture, a learning culture and questioning culture.