case study

Air Transport Service Harm Crisis: The case of Helios Airways tragedy

By Zisis Maditinos and Christos Vassiliadis

Introduction

Crisis is a concept that has attracted considerable attention across a diverse range of academic literature. According to Smith (2005), this work has also generated a significant body of theory that draws on multiple disciplines, particularly around the processes of crisis generation. As far as the service sector is concerned, this work has not gained the attention it deserves, despite its obvious relevance to the management of service sector organizations. Instead, literature has focused on the processes of "service recovery". This focus may have led it to ignore the significant body of work within the crisis literature on the processes of crisis incubation.

Crisis management is a continuous process of recognizing and responding to factors associated with a potential or actual crisis and its resolution. Therefore, crisis management deals with the anatomy of a crisis by looking at some symptoms, and recommending methods of prevention and intervention. A basic component of crisis management is communication. Developing effective communication strategies helps to avoid or deal more effectively with the unexpected bad publicity. During a crisis, it is usually the publicity that can sink the organization, not the damage from the crisis itself.

In service organizations that are involved in "high risk" service sectors, such as airline industry, health care services etc, further research and better understanding of the incubation process is absolutely necessary. In these high risk service organizations, when accidents happen, they usually result to serious harms, even to human casualties. These accidents obviously trigger organizational crises that may involve and affect several stakeholders and mainly the host organization, whose continuity is sometimes seriously unsettled. These crises are the outcome of a failure interaction among human, technological and organizational factors (Ash and Ross, 2004, Smith, 2005, Peters and Pikkemaat, 2005). When organizational pathologies related to these factors are combined - sometimes in addition to external pathologies (supervising authorities, governmental bodies etc) - any possible mistake can trigger an organizational crisis with unpredictable consequences.

The case of the Helios Airways flight HCY522 crash during August 2005, in the Attica area, Greece, which led to the death of 121 people, is used in this paper to illustrate how the failure interaction of the factors referred above can cost the existence of the organization itself. Moreover, the company's reaction to this unexpected crisis is assessed in order to offer useful conclusions for service organizations' managers.

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Breif Literature Review

Service Harm Crises

There are several reasons that trigger organizational crises. One of these reasons is due to the harm that a product or a service can cause to users or consumers. In the first case we have a product harm crisis while in the second case there is a service harm crisis. In these two types of crises, people who consume the product or the service are harmed due to problems or failures that are linked to the consumption of this product or service.

In the existing relevant literature there is not any special definition for the term service harm crisis. Siomkos and Maditinos (2002) first used it in a paper describing the case of Express Samina Shipwreck (a shipwreck in Greece with more than 80 victims, September 2000). Searching for the term "service harm crisis" in Google search engine (during December 2013), it gives back very few results (approximately 21), most of them relative to the above referred paper. In contrast, searching for "product harm crisis" term, Google gives back 175 results (in the same period).

Service harm crises can be defined as complex situations wherein the consumption or the use of a service can cause harm (damage or even death) to the user or consumer (Maditinos et al., 2010). They can cause serious problems to the responsible organization resulting in vast financial costs (e.g. for the compensation of the victims), negative effects on sales, destruction of its corporate image, even its existence and business continuity. They are mainly man made crises, as they are triggered basically by human errors. There are of course some cases caused by natural disasters: for example a thunderstorm can cause the crash of an airplane, which constitutes a service harm crisis. But such types of crises can be avoided if people involved in the service provision take the necessary measures (i.e. the pilot lands the plane in the nearest airport, before it enters the storm). They can usually be considered both immediate and emerging crises. When no warning signals exist, service harm crises are immediate. For example the plane hijacks during 9/11 were an immediate crisis for the airline companies whose planes were hijacked, as there were not any warning signals for

this tragedy. But, when crisis preconditions are obvious, such as systems failures, shortage of resources and small scale accidents, then the service harm crisis is an emerging crisis which can be avoided if certain actions are undertaken. Furthermore, service harm crises can be considered both natural accidents and abnormal accidents. The Express Samina shipwreck in Greece was a "normal accident" because some people didn't do their work properly and thus system failed to deliver safe services to the customers. In contrast, the 9/11 airplane crashes in WTC is an abnormal accident as it is considered to be the result of deliberate evil action (terrorism).

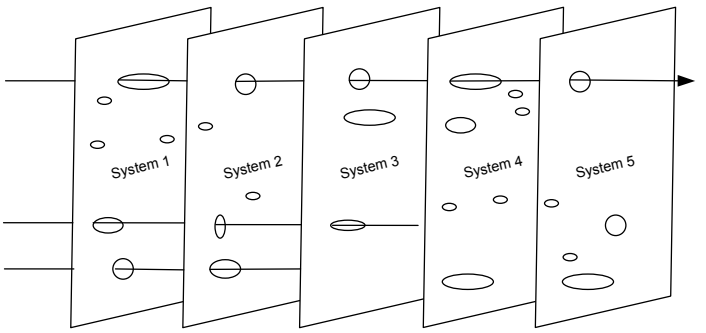
The importance of the interaction between the human operator and machines and the subsequent impact of organizational factors on this relationship has long been recognized in academic literature (Smith, 2000). Failure process is a complex dynamic process. A series of major accidents and disasters in recent years have pointed the dominant role of latent error within the chain of causality for such events. Ash & Ross (2004) have provided a useful approach for organizational crises using the "lens of epidemiology". According to them, over time, researchers in the field of epidemiology have found that there may be no specific event, condition, or characteristic that is sufficient itself to produce a disease. Disease is the result of many factors, none with the exclusive ability to cause all forms or examples of it. When multiple factors combine to create a crisis (as is generally the case), we refer to them as causal components. Causal components can be separated by time; one may have occurred years before the others, its residual effects nevertheless influencing outcomes.

Even though the final result is the only one attended to by the general population, crises are the result of a series of events that occur over time. In his book Human Error, Reason (1990) used an effective analogy to explain how one small problem or error can be compounded by subsequent errors. He described how layers of precautions can be aligned in precisely the right way to produce dramatic results. Because of its obvious similarity to the dairy product, this model is named the "Swiss cheese effect." Slices of Swiss cheese can be thought of as subsystems in an organization, with the holes representing errors. In this sense, error could represent any level of incompleteness (omission or commission) that causes the intended safety system to be less than complete. When a number of subsystems line up, there is generally enough redundancy to prevent serious crises. However, sometimes the holes in the cheese might line up and let error move through the entire system.

Figure 1 shows five separate systems, which are part of a bigger system, as slices of Swiss cheese. All of these subsystems have "holes" that represent the errors that occur. The arrow passing through all the holes shows the precise alignment of the errors. What is most important is that they are seemingly preventable. Major catastrophes do not occur by an isolated slip or mistake. In almost every case, they are the result of a larger error chain—rare circumstances combined to create a situation that proves disastrous. A cascade of events seems to form a combination that unleashes calamity.

Figure 1

The Swiss Cheese Effect



Source: Reason (1990)

Crisis management and communication

In general, crisis management is a continuous process of recognizing and responding to factors associated with a potential or actual crisis and its resolution (Ray, 1999). Further, Kash and Darling (1998) define crisis management as a series of functions or processes to identify, study and forecast crisis issues, and set forth specific ways that would enable an organization to prevent or cope with a crisis. The basic tenet in crisis management is that crises can be managed much more effectively if the company prepares for them. Therefore, crisis management deals with the anatomy of a crisis by looking at some symptoms, and recommending methods of prevention and intervention.

According to Stocker (1997), when confronted with a crisis, the first response to a crisis can be very important. Even though a crisis is on a much larger scale, the rules of complaint handling and the "4 R's" still apply:

- **Regret**: stakeholders want the organization to say that it is sorry that a crisis happened. Not that it is guilty, or even responsible, just that it regrets the event. This is very hard for some overprotective lawyers, who will caution that "these very words will come back to bite us in court." First, the real costs are not in the courtroom, and second, crisis research is clear: if the organization does not express regret, nobody will listen to anything else it says. An organization cannot skip the first R and jump to the second.
- **Resolution**: The organization should state, if appropriate, what it will do to resolve the issue. For example it will put safety caps on the medicine, buy double-hull ships, and test the chips before they are shipped, or, if it is not the company's fault, it will do nothing.

- **Reform**: The third step is to ensure, if possible, that it will not happen again.
- **Restitution**: Everybody wants something. This does not refer to legal judgments, but product coupons when the product returns to shelves, or free phone calls in return for outrages. The formula works.

During a crisis, it is usually the publicity that can sink the organization, not the damage from the crisis itself. Therefore, developing effective communication strategies helps to avoid this unexpected bad publicity. Effective communication strategies can be implemented to moderate the crisis. A communication strategy needs to be chosen from among alternative communication strategies based on the specific circumstances. That is, strategic communication focuses on the design of the message. Ray (1999) argues that organizations essentially have five different options when communicating during crisis: to deny responsibility, to hedge responsibility, to ingratiate the organization with its stakeholders, to make amends, and to elicit sympathy.

• **Deny responsibility.** Organizations may choose to deny any association with or responsibility for the cause of an event. Four tactics serve to deny responsibility: directly deny, expand denial, redirect blame, and aggression. Direct denial is a simple statement denying any accountability for the event. Expansion of denial goes further by explaining why the organization is not responsible for the event. An organization may redirect blame to another source as a method for denying responsibility. In situations where an accuser wrongly places blame, an organization may choose more aggressive tactics, such as confronting or attacking the accuser (Ray, 1999). Coombs (1995) adds to the above discussion stating that refutation strategies seek to eliminate the crisis. According to Coombs (1995), the most aggressive refutation strategy is intimidation. Intimidation is most often the threat of legal action against those who say an organization is experiencing a crisis. If an organization uses strategies of refutation the leaders must be absolutely sure they are correct in stating that a crisis does not exist.

• **Hedge responsibility.** A more viable alternative may be to hedge or evade responsibility for the event. Hedging responsibility allows the organization to distance itself from the crisis, or "duck" responsibility. Four tactics function to dodge responsibility: excuses, scapegoating, pleading ignorance, and refuting evidence. An organization may offer excuses, which explain extenuating circumstances or justify some action. Scapegoating enables the organization to place primary responsibility on another. An organization may plead ignorance by stating there was a lack of significant information about the situation. Or the organization may be in a position to refute or argue conflicting evidence to reduce responsibility (Ray, 1999). Coombs (1995) states that an organization can excuse the crisis by denial of intention, ("we didn't mean to hurt anyone") or by denying violation, ("no laws were broken here"). Furthermore, Coombs (1995) states that justification is an avoidance strategy that seeks to minimize the damage associated with the crisis. Organizations can minimize a crisis by denying the seriousness of injury, or claiming the victim deserved what happened, e.g. "it is tragic that someone was killed in a Ford, but they didn't have their seatbelt on".

• **Ingratiation**. The ingratiation strategy is designed to win stakeholders' support for the organization and reduce negative feelings toward the organization. One ingratiation tactic is to accentuate the positive. The organization must identify and reinforce positive aspects of the organization. A second tactic is to create identification between the organization and its stakeholders. Organizations attempt to become identified with symbols, values, or institutions, which have a strong base of public acceptance. A third tactic is to acknowledge others positively. Positively acknowledging another generally gains approval from the acknowledged recipient, and may possibly leave a positive impression on other stakeholders (Ray, 1999). Referring to ingratiation strategies, Coombs (1995) states that attachment strategies seek to gain public approval for the organization during a crisis. This is done by bolstering the organization's attributes, "our organization adds $1 billion to the local economy," or transcendence, "the soldiers were killed in the defense of freedom," or by praising others, "the heroic efforts of those that helped clean this oil spill cannot be overstated".

• **Make amends.** Organizations may choose to make amends in an effort to win forgiveness for the event. This is done in three ways: apologize, remunerate, and right the wrong. An apology expresses regret over the event and requests forgiveness. Organizations may remunerate victims with money or other services in an effort to reduce negative feelings toward the organization. Finally, by righting the wrong the organization demonstrates concern and regret by correcting the problem. Necessary changes are made to prevent the recurrence of the event (Ray, 1999). Forgiveness strategies attempt to win forgiveness of the public and to create acceptance for the crises. Negative feelings may be lessened if an organization takes positive actions to help the victims of a crisis. The airline industry is particularly adept at this following a crash (Coombs, 1995).

• **Elicit sympathy.** "A final strategic option is to elicit sympathy. This approach portrays the organization as an innocent victim. Sympathetic stakeholders tend to be less critical and the organization is likely to be placed in a positive light" (Ray, 1999). Repentance is a forgiveness strategy that simply asks for forgiveness. If an organization apologizes for the crisis, the negatives associated with the crisis should be lessened as people accept the apology and forgive the organization for its misdeeds. Rectification is a forgiveness strategy that normally follows repentance. Rectification involves taking action to prevent recurrence of the crisis in the future (Coombs, 1995).

The Case of Helios Flight HCY522 Tragedy

About Helios Airways Company

Helios Airways was founded in 1999. It was the first private owned airline company in Cyprus with its headquarters in Larnaca. In November 2004, the company was bought by Libra Holidays, a big tour operator in Cyprus (Wikipedia, 2009) and operated scheduled and charter flights from Larnaca and Paphos. It carried about 250.000 passengers annually (Dahman, 2008).

The company faced a serious incident of aircraft malfunction one more time before the 2005 crash incident of flight HCY522 in Athens area, Greece. It was on 20 December 2004, when a Helios Airways Boeing 737 form Warsaw suffered a loss of cabin pressure. Three passengers were rushed to hospital when the plane landed in Larnaca, Cyprus (Dahman, 2008). However, as the first innovative no-frills airline in the region with an excellent reputation, passengers did not sue the Airways for the hazard of cabin pressure experience, and as a result the total safety culture of the company was not questioned. In addition, the issue remained unidentified, as the media also did not pick up on the problem. The company remained a reputable airline as it continued to carry around 250.000 passengers annually.

The Fatal Crash Incident

In August 14th 2005, the company came to the international headline news. A Boeing 737-31S on the flight HCY522, flying from Larnaca to Prague via Athens was crashed in Attica suburbs. The aircraft had 115 passengers and 6 crew staff on board, all of whom died.

The aircraft departed at 09:07 a.m. from Larnaca Airport. Its destination was Prague, via an interim station in Athens International Airport. At 10:37 a.m., it entered the Athens FIR but it could not communicate with the control tower of Athens Airport. Several communication efforts followed but none was successful. As a result, the responsible emergency plan was activated and the Greek National Defense Council scrambled two air fighters, F-16, in order to find out what was going on. At 11:18 a.m., the F-16 pilots got in visual contact with the Helios aircraft. They saw that the co-pilot was unconscious, the pilot was missing from his position, and the oxygen provision system was activated. The plane was driven by the automatic pilot system. At 11:48 a.m. the F-16 pilots saw someone who was trying to regain the control of the aircraft. At 11:50 a.m. the plane was out of fuel and the tragedy was inevitable. Fifteen minutes later it crashed in Grammatiko area, North Attica. None of the passengers or the flight crew survived (AAIASB, 2006).

According to CNA (2005) an emergency meeting was conducted at Larnaca Airport, chaired by Cyprus President Tassos Papadopoulos, after news came in about a crash of a Helios aircraft. Helios Airways senior management was also at an emergency meeting. At that stage, there had been no official announcement from the company. Relatives of the passengers and crew of the fatal flight of the Boeing 737 were gathering at Helios Airways headquarters in Larnaca trying to find out as much information about their relatives as they could. Nikos Anastasiades, spokesman for Helios Airways, informed relatives of the victims about the fatal flight. The entire statement was the following: "A Helios Airways aircraft heading for Athens and Prague, with 115 passengers and six crew on board, crashed north of Athens around 12:20 [on Sunday, 14 August 2005]. Rescue teams are at the scene of the crash. All options as to the cause of the crash are being investigated. The government has set up a crisis management centre at Larnaca Airport to help the relatives of the passengers and the crew. Our thoughts are with the families of the passengers and the crew and we are doing everything possible to give them all necessary information of this tragic accident." Anastasiades did not take any questions. In Greece, rescue efforts were coordinated by the Ministry of National Defense and the Transport Minister, Anastasios Neratzis, headed to the scene of the crash. Both "black boxes" belonging to the fatal Boeing had been recovered and they were sent to a special centre in Paris for examination. Helios Airways representative George Dimitriou, accompanied by his lawyer in Athens completed a testimony over the plane crash. The representative in Athens of the Helios Airways testified at the Athens Police Headquarters on Monday in relation to the Helios Airways plane crash. The representative said in his testimony that he learnt of the air crash from a relative who communicated with him by phone and briefed him regarding what he had heard on television. Later, as he was said to have stated, he went to the company's office to learn exactly what had happened.

On 15 August 2005 a spokesman for Helios Airways announced that their fleet had been grounded since a Boeing 737 crashed. The Airways hired aircraft from other airlines (Austria and Egypt) to carry its passengers to their destinations. Helios Airways' Sunday flights into Cyprus were carried out as normal. Andreas Drakos, Executive Director of Helios Airways said that the aircraft that crashed on Sunday in Athens was airworthy and had undergone the necessary checks before take-off. He said the Airways would give an initial sum of € 20.000 to the family of each passenger killed during the crash.

In January 2006, Helios Airways changed its name to Ajet Aviation, continuing to be owned at 100% by Libra Holidays. This act obviously aimed to improve the company's ruined image due to the accident. In the end of October 2006, Ajet Aviation announced that it would cease all flights within three months. The company announced that it would stop flights for "financial reasons", adding that the move was a direct consequence of the 2005 tragedy. Industry experts argued that the adverse publicity stemming from Helios airplane crash had hit business and made it commercially impossible for the firm to continue operating flights. The company stopped totally its flight operations by the end of 2006. With this decision, the high expectations of the company's owners

were totally crashed, like the fatal plane was (Wikipedia, 2009).

The accident also affected other stakeholders. Families of the dead passengers filed a lawsuit against Boeing on 24 July 2007 for manufacturing defects. The families claimed 76 million euros in compensation from Boeing (AFX News, 2007). On 23 December 2008, five Helios Airways officials were charged with manslaughter and of causing death by recklessness / negligence. Relatives of the deceased filed a class action suit against the Cypriot Government – specifically the Department of Civil Aviation – for negligence that led to the air disaster. They claimed that the DCA was turning a blind eye to airlines' loose enforcement of regulations, and that in general the department cut corners when it came to flight safety (Wikipedia, 2009).

The investigation results

Soon after the accident the Greek government ordered the establishment of an Air Accident Investigation and Aviation Safety Board (AAIASB). The AAIASB had to investigate and find out why that tragedy had happened. Its final report was submitted in November 2006 and was based on data from the accident site, the readout of the flight recorders, the testimonies and documents gathered, and the examination of parts and systems of the aircraft.

This report gives a strong evidence for the theory presented briefly above about the failure interaction. More specifically, the AAIASB reported that there were direct and latent causes, as well as some other factors that contributed to the accident (AAIASB, 2006).

The direct causes were the following:

- Non-recognition that the cabin pressurization mode selector was in the MAN (manual) position during the performance of the: a) pre-flight procedure, b) before start checklist and c) after takeoff checklist.
- Non-identification of the warnings and the reasons for the activation of the warnings (cabin altitude warning horn, passenger oxygen masks deployment indication, Master Caution), and continuation of the climb.
- Incapacitation of the flight crew due to hypoxia, resulting in continuation of the flight via the flight management computer and the autopilot, depletion of the fuel and engine flameout, and impact of the aircraft with the ground.

As far as latent causes are concerned, they can be summarized as following:

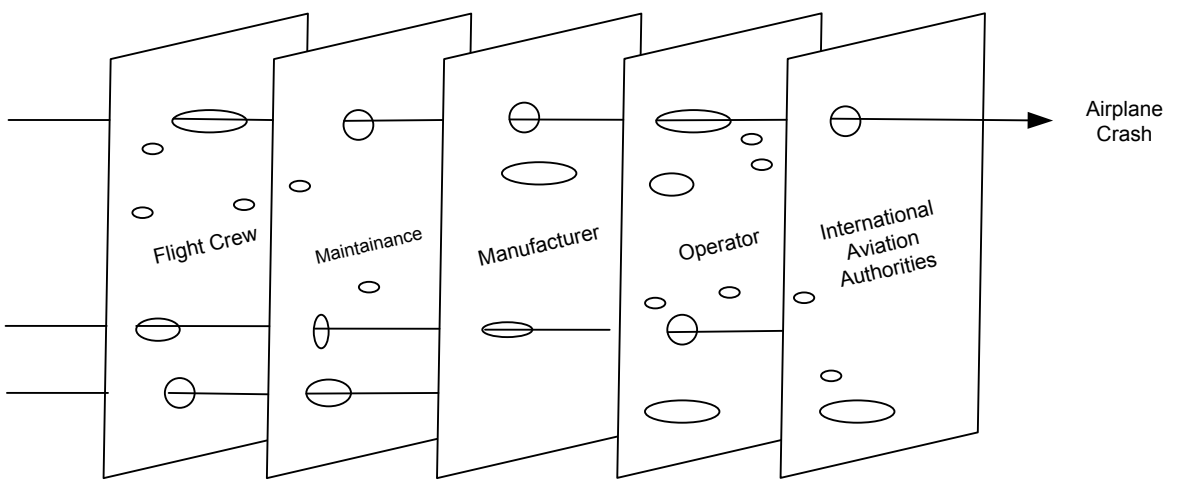
- The Operator's deficiencies in organization, quality management and safety culture, documented diachronically as findings in numerous audits.
- The Regulatory Authority's diachronic inadequate execution of its oversight responsibilities to ensure the safety of operations of the airlines under its supervision and its inadequate responses to findings of deficiencies documented in numerous audits.
- Inadequate application of Crew Resource Management (CRM) principles by the flight crew.
- Ineffectiveness and inadequacy of measures taken by the manufacturer in response to previous pressurization incidents in the particular type of aircraft, both with regard to modifications to aircraft systems as well as to guidance to the crews.

Finally factors that contributed to the accident

- Omission of returning the pressurization mode selector to AUTO after unscheduled maintenance on the aircraft.
- Lack of specific procedures (on an international basis) for cabin crew procedures to address the situation of loss of pressurization, passenger oxygen masks deployment, and continuation

Figure 2

The Swiss cheese effect in Helios Flight HCY255 Crash



of the aircraft ascent (climb).

- Ineffectiveness of international aviation authorities to enforce implementation of corrective action plans after relevant audits.

The model of Swiss Cheese effect was confirmed absolutely in this case. There was a failure interaction among several internal and external factors. The figure 2 presents this failure interaction. The five cheese slices represent five subsystems that were engaged in every flight operation. The holes in every slice represent failures or mistakes existed or made within every subsystem. The outcome of the combination of these failures – mistakes was the accident, which cost 121 human lives and the "life" of the company itself.

Assessing Helios Airwarys Reaction to Crisis

Assessing the 4 R's implementation

As previously discussed in literature review, it is imperative for a business to maintain a proactive relationship as opposed to a retroactive one. To sustain such an affiliation, it is vital to apply the 4R's. Helios Airways applied the 4R's as following (Dahman, 2008):

- Regret: Helios Airways did not boldly state that they were sorry such a tragic incident took place. This does not necessarily mean that Helios Airways had to state that they are guilty, or even responsible, just that they regret the event.
- Resolution: Helios Airways did not state what they would do to resolve this issue. In other words, they did not express their exact plans and strategies regarding this crisis.
- Reform: The third step that should have been communicated but not done was that of Helios Airways ensuring that the pressurization problem will not happen again.
- Restitution: Helios Airways could not have used restitution due to the fact that it is the lives of humans which had been lost. No amount of money can compensate for the loss of a loved one. Nonetheless, Helios Airways could have distributed coupons to the victims' families and availed them with free airline tickets to certain destinations for funeral plans and memorial service preparations.

So, the main conclusion is that Helios Airways did not apply any of the 4R. This ascertainment supports the conclusion that the company was totally unprepared to handle such difficult situations.

Assessing the communication strategy

The study indicates that an airline company is not supposed to use only one strategy of communication at a time. Rather it could use a mix of strategies depending on the circumstances. That is, an airline can use a mix of denying responsibility, hedging responsibility, ingratiation, making amends, or eliciting sympathy. Due to this, this paper discusses the different strategies that Helios Airways used to different degrees with the proposed strategy that Helios Airways should have used (Dahman, 2008).

Deny responsibility. Out of the four strategies of denial, (direct deny, expand denial, redirect blame, and aggression) Helios Airways chose to redirect the blame to Boeing after much had been said about the negligence of Helios Airways regarding the crash rather than what was missing from Boeing, the aircraft manufacturer. Though Helios Airways was correct in using the strategy of redirecting blame, it was supposed to enforce it immediately as the main strategic alternative to defend itself from the highly negative publicity. That is, Helios Airways was supposed to redirect the blame to Boeing, the aircraft manufacturer, for the failure of putting the right information on how to identify and correct warning signals of the Boeing 737 aircraft.

Hedge responsibility. Four strategies are involved in hedging or evading responsibility of the crash. These are: making excuses, scapegoating, pleading ignorance, and refuting evidence. Helios Airways did not explicitly make excuses for the extenuating circumstances or scapegoat others on time. Instead, they insisted that their aircrafts were airworthy and that they felt deep sorrow for the victims' families. The Airways should have clearly expressed that they are seeking forgiveness and would do everything to compensate the public. Helios Airways was supposed to clearly notify the media that it was Boeing's failure to provide appropriate signals with appropriate manuals.

Ingratiation. Ingratiation strategies are designed to win stakeholders' support for the Airways and reduce negative feelings toward the organization. The only aspects discussed openly after the crash were the arguments on whether the aircrafts were airworthy and the technicians were to blame. One ingratiation tactic that Helios Airways could have applied was to identify and reinforce positive aspects of itself. However, there were no discussions, neither from the media, nor from Helios Airways itself, which used to be one of the most efficient no-frills Airways transporting around 250.000 passengers every year. Never was there mention of the fact that Helios Airways was once tourists' choice to visit Cyprus. A second strategy that was supposed to be followed was to create identification between the Airways and its stakeholders. Helios Airways did not have any symbols, values, or institutions which had a strong base of public acceptance. In other words, no one tried to identify Helios Airways as one of the most charitable or community-supporting airlines. There was no sense of patriotism from the Cypriot citizens for the failure of one of their successful airlines. A third proposed strategy that should have been implemented was to acknowledge others positively. Helios Airways seems not to have supported any other institutions, such as, universities, old age homes, or other children's fund institutions. Doing so would have helped in attaining support from the beneficiaries. As a result, it could have had a positive impression on the stakeholders who would have spoken on behalf of Helios Airways.

Make amends. Helios Airways tried to make amends in an effort to win forgiveness for the crash on 14 August 2005. Helios Airways

remunerated the victims' families with an initial € 20.000 in an effort to reduce negative feelings towards the Airways. Finally, by righting the wrong, the Airways tried to demonstrate concern and regret by sending the aircrafts for a further check-ups by SAS (Sweden Based Scandinavian Air Systems). That is, Helios Airways tried to show that necessary changes were made to prevent the recurrence of the crash. Helios Airways was supposed to firstly apologize and show regret directly after the event, thus requesting forgiveness. With regard to the settlement of the € 20.000, Helios Airways was supposed to show that no amount of money can compensate for a lost life. Although Helios Airways did in fact send their aircrafts for further checkups, they did not ensure that the public, which includes the victims' families, was aware of this fact. Helios Airways could have done so by distributing this information to all forms of media.

Elicit sympathy. Helios Airways was not able to use this strategy, which involves showing that it is an innocent victim. As a result, the stakeholders were unsympathetic and more critical, and they placed Helios Airways in a negative light. Helios Airways could have promised to give the victims' families, and anyone else who may have been affected by the accident, what they deserved. They should also have communicated regularly with the stakeholders. One way to express their deepest sorrows and condolences would have been to send members of staff to the funerals and memorial services of the deceased. Basically, Helios airways should have admitted its mistakes and try to prove it is a victim of those mistakes.

Conclusions

Pearson (2002) identifies the obvious: there is no way to ensure that an organization will escape crises. Especially in high risk industries such airlines, passenger coastal shipping, health care services etc, when accidents happen, they usually result to serious harms, even to people deaths. So, it is necessary for these companies to develop all the required mechanisms and measures (scanning processes, cross checking etc) in order to eliminate or minimize the possibilities for potential crises. However, as there is no way for an organization to ensure that it will escape crises, crisis preparation and communication should be of high concern for every organization's leadership and management. There is no doubt that both preparation and communication are complicated processes, and despite the progress that has been achieved in terms of formulating crises' aspects and impacts, there are several unsuccessful crisis management cases that come to publicity on a constant basis.

The case of Helios Airways flight HCY 522 crash was an indicative service harm crisis case. It can be considered as a man made, emerging crisis as the AAIASB report revealed. Moreover, it can be seen as a normal accident due to a series of human errors and omissions, which interacted among each other. While the root cause of the crash is held to be a result of human error, there is clearly a number of mitigating factors that need to be considered when assessing causality.

Although Helios Airways was operating in a high risk industry, the company proved to be totally unprepared in managing crises. It did not apply elementary rules of crisis management. The communication effort was incomplete and as a result the company failed to rescue its destroyed image due to the plane crash. Moreover, this failure to manage the crisis effectively led the company to cease its operations permanently.

The main conclusion of this case study is that in high risk service industries, such as airlines, it is necessary for the managers to pay extreme attention to the preconditions that can result to potential failures and furthermore, to organizational crises. They have to undertake all the necessary actions in order to avert these potential crises or minimize their effects if they finally happen. This "scanning" process could be assisted by models that help the organization to estimate the degree of the existence of such dangerous issues. Further research should focus on the development of such models.

Discussion Questions

- What were the actual reasons of the Helios Airways accident?
- How was the Swiss cheese effect confirmed in this case?
- What should the company do to apply effectively the 4Rs?
- How can such service harm crises be prevented?
- What should a service organization do in order to prevent its continuity from such situations?
- Which are the better communication strategy tactics to be followed in such situations?
- If you were a tourism/hospitality organization's manager, what could you learn from this case study?

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