

# Investigating safety culture



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**If you see this in a rail depot, does it help your investigation?**



# What is safety culture?

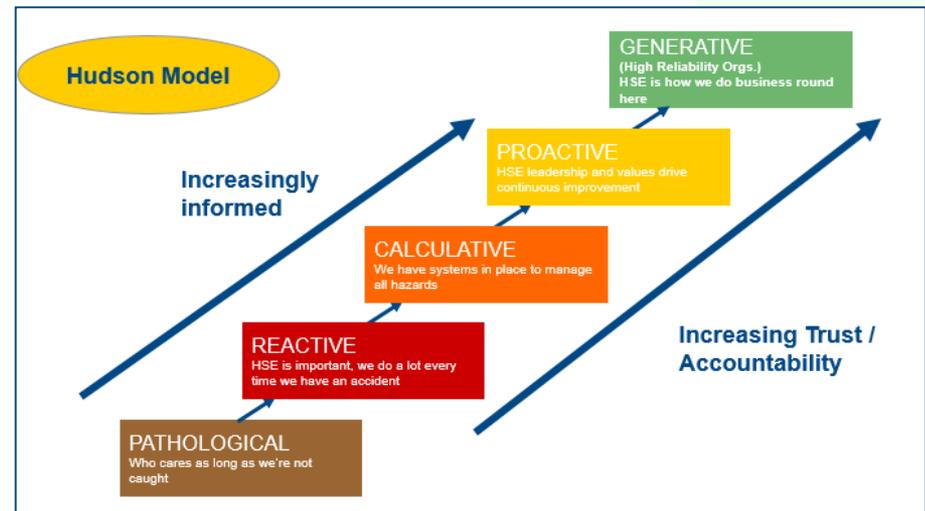
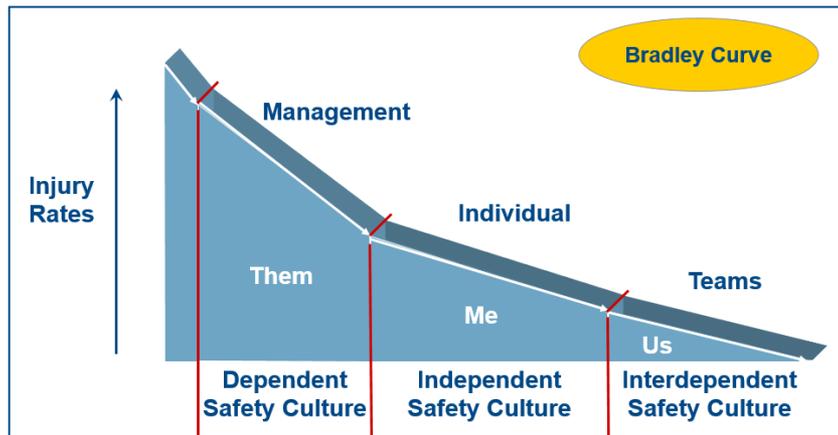
“The safety culture of an organisation is the product of the individual and group **values, attitudes, perceptions, competencies** and patterns of **behaviour** that determine the commitment to, and the style and proficiency of, an organisation’s safety management”

**These simple explanations are sometimes the most useful!**

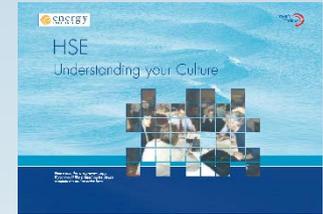
**The way we  
do things  
around here!**

**What happens  
when management  
goes home!**

# There are many ways of representing safety culture – the Bradley Curve is easy to explain while the Hudson Model is based on published research



# Using the Hudson model – examples of how the culture feels personally for management



PATHOLOGICAL	REACTIVE	CALCULATIVE	PROACTIVE	GENERATIVE
<p>I accept that injuries are unavoidable in this kind of work</p> <p><i>I believe I have done my job when I have told everyone to work safely</i></p> <p>I walk on when I see something dangerous as that's the supervisor's job</p> <p><i>When we have an accident I find out who is to blame and get rid of them</i></p> <p>I think that meeting the legal requirements is good enough</p>	<p>I have to take safety seriously as my bonus is partly tied to the accident rate</p> <p>I visit work sites when they are having serious problems</p> <p><i>I believe HSE is best managed by HSE specialists</i></p> <p>I send warning letters when people are found behaving carelessly</p> <p><i>I feel comfortable if we have bought a reliable safety program</i></p>	<p>I say I take HSE seriously as I know this is expected of me</p> <p><i>I like to have accident investigations closed out</i></p> <p>I avoid selecting contractors with a bad HSE record, if possible</p> <p><i>I think all accidents could be prevented if people only do what they are told</i></p> <p>I believe pre-qualification ensures that all our contractors are safe enough</p>	<p>I find HSE interesting and feel competent to manage it</p> <p><i>I try to have the best HSE performance among my peers</i></p> <p>I follow up action items personally after incidents and hazard reports</p> <p><i>I agree that management bears responsibility for system failings that cause incidents</i></p> <p>I look for other ways than incidents to measure success of our HSE activities</p>	<p>I am always on the lookout for new ways to manage HSE</p> <p><i>I will not allow business decisions to be taken without considering HSE</i></p> <p>I trust my supervisors and workforce to tell me if there are problems</p> <p><i>I create the conditions for my staff to solve the problems they encounter</i></p> <p>I am aware that not every solution will work first time and seek to learn why</p>

▶ Practical characteristics are mapped in the brochure “Understanding your Culture”

**So if I go back to the photograph at the start of this section, it can be described as a Broken Window – and is evidence**

## Broken Windows Theory

- If a window is broken and left unrepaired, people walking by will conclude that no one cares and no one is in charge
- Soon more windows will be broken, and a sense of anarchy will spread
- In a city, relatively minor problems (such as graffiti and public order) are the equivalent of “broken windows” – invitations to more serious crimes



# What are the 'broken windows' (related to safety) you find during your investigation?

## Broken Windows

- What are the 'broken windows' you find during the investigation?
  - Appearance and housekeeping?
  - Asset condition
  - Processes and procedures
- Who is responsible for identifying and tackling these 'broken windows'?
- How is this monitored?



# .....beyond the broken windows

- “Safety is not found in a single person, device or department of an organisation instead it is created and sometimes broken in systems not individuals” (Dekker)
- So ‘broken windows’ only one manifestation of risk
- Deepwater Horizon – focus on low personal injury rates obscured the bigger picture
- Organisational values and beliefs, control of hazards at source and complexity of the system are important

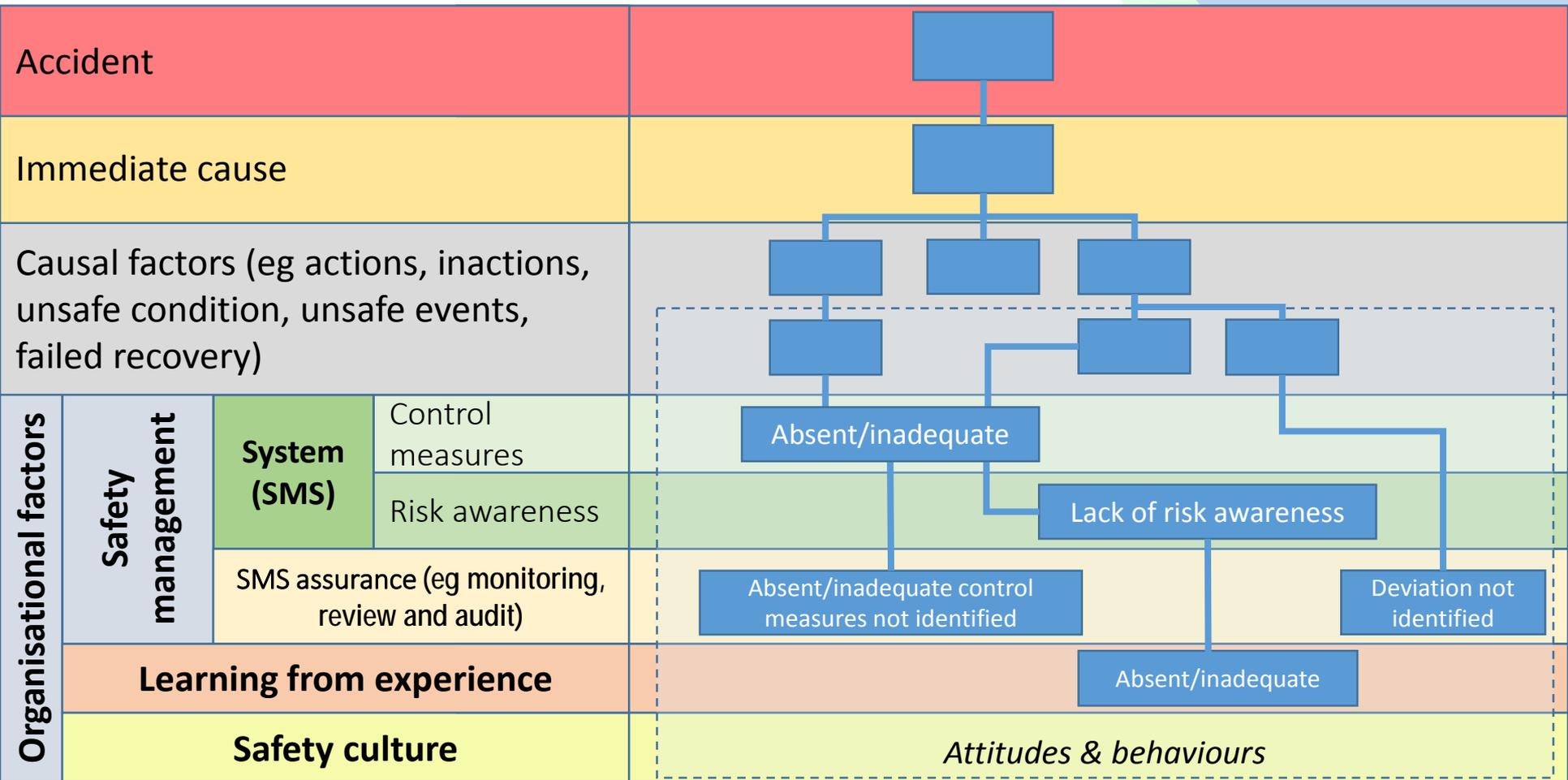




# How can we investigate safety culture?

- If it is difficult to define and measure it will be difficult to investigate!
- Serious non-compliances may be a clue
- RAIB investigation remits normally include management/organisational issues
- This has the potential to 'capture' safety culture, but...
- ...may not always be obvious and may be indirect
- Persistent questioning of why certain causal factors are present helps uncover cultural issues

# Understanding organisational factors



# Evidence of safety culture issues

- The RAIB often finds evidence of safety culture issues when investigating organisational factors
- An organisation's safety culture is often revealed by:
  - Interviews
    - questioning of actions, assumptions and their influences
  - Documentation and its tone
    - internal/external safety audits,
    - briefings or newsletters,
    - internal investigations
  - Questionnaires
    - exceptionally!

Accident Error Design  
Time Human Environm  
People Warning  
Investigation How  
Report Work



# Potential traps



- Beware of subjectivity
- A bad outcome is not always evidence of poor safety culture
- Treat uncorroborated witness evidence and post-accident staff surveys with care
- Areas of uncertainty should be clearly identified

# Safety culture and SMS



- SMS and safety culture are not interchangeable
- However, research suggests a positive link between a developed SMS and good safety performance
- Deficiencies in the SMS may indicate issues with the wider organisational culture

# Addressing safety culture in recommendations

- Recommendations to address safety culture issues should be carefully targeted at specific areas of concern, for example:
  - lack of reporting
  - not learning from experience
- Local or company wide focus?

# Conclusions

- There are many definitions of safety culture but no single agreed definition. It is not a management system it is a concept!
- Investigation findings with regard to safety culture should be based on solid evidence, rather than subjective judgements
- Cultural factors can exist at the level of the individual or the wider organisational level
- Examination of organisational factors by means of systematic causal analysis is the best way of revealing the underlying attitudes and behaviours