# THE INTERPLAY OF SAFETY AND ORGANISATIONAL CULTURE

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# SESSION OVERVIEW

1. OLD VIEW/NEW VIEW – THEORIES
2. SAFETY SYSTEMS AND CULTURE
3. BRIEFLY DEFINE SAFETY AND CULTURE
4. SAFETY CULTURE VS CULTURE OF SAFETY
5. CREATING A CULTURE OF SAFETY

# CONTEMPORARY SAFETY THEORY

## OLD VIEW

- SAFETY IS THE ABSENCE OF SOMETHING NEGATIVE
- FOCUS ON WHAT WENT WRONG
- PROCESSES ARE DEVELOPED FOR WORKERS TO FOLLOW – NO IMPROVISATION – WORK AS IMAGINED
- REACTIVE
- PEOPLE ARE A LIABILITY
- **SYSTEMS THEORY**
- SYSTEM FOCUSSED
- CAUSE AND EFFECT LINEAR APPROACH
- OVER PRESCRIBED – INSTRUCTIONS FOR EVERY CIRCUMSTANCE

## NEW VIEW

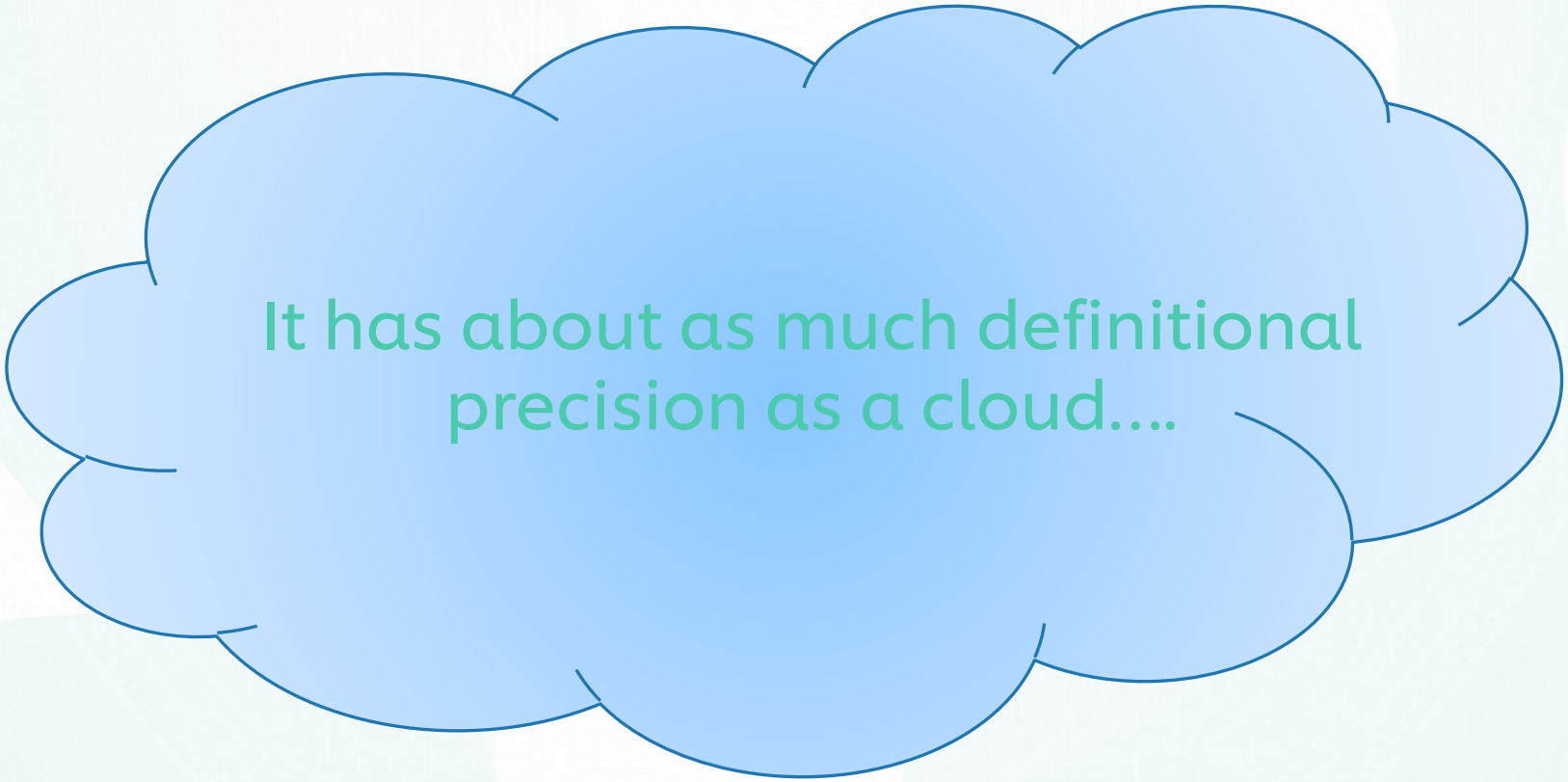
- SAFETY IS THE PRESENCE OF SOMETHING POSITIVE
- FOCUS ON WHAT GOES RIGHT
- WORKERS WILL FIND MORE EFFICIENT AND BETTER WAYS OF GETTING WORK DONE – WORKS AS DONE
- PROACTIVE
- TRUST THE WORKERS
- **CULTURE AND CLIMATE THEORY**
- HUMAN FOCUSSED
- COMPLEX HUMAN SYSTEMS AND FACTORS
- ENOUGH DOCUMENTATION/TOOLS TO MANAGE RISK EFFECTIVELY

# LIMITATIONS OF SYSTEMS

*EVIDENCE WAS GIVEN THAT OIMS WAS A WORLD-CLASS SYSTEM AND COMPLIED WITH WORLD'S BEST PRACTICE. WHILST THIS MAY BE TRUE OF THE EXPECTATIONS AND GUIDELINES UPON WHICH THE SYSTEM WAS BASED, THE SAME CANNOT BE SAID OF THE OPERATION OF THE SYSTEM IN PRACTICE. EVEN THE BEST MANAGEMENT SYSTEM IS DEFECTIVE IF IT IS NOT EFFECTIVELY IMPLEMENTED.*

*ESSO'S OIMS, TOGETHER WITH ALL THE SUPPORTING MANUALS, COMPRISED A COMPLEX MANAGEMENT SYSTEM. IT WAS REPETITIVE, CIRCULAR, AND CONTAINED UNNECESSARY CROSS-REFERENCING. MUCH OF ITS LANGUAGE WAS IMPENETRABLE. THE COMMISSION GAINED THE DISTINCT IMPRESSION THAT THERE WAS A TENDENCY FOR THE ADMINISTRATION OF OIMS TO TAKE ON A LIFE OF ITS OWN, DIVORCED FROM OPERATIONS IN THE FIELD. INDEED IT SEEMED THAT CONCENTRATION UPON THE DEVELOPMENT AND MAINTENANCE OF THE SYSTEM DIVERTED ATTENTION AWAY FROM WHAT WAS ACTUALLY HAPPENING IN THE PRACTICAL FUNCTIONING OF THE PLANT...*

# THE TROUBLE WITH CULTURE...



# CULTURE OF SAFETY – A JOURNEY, NOT A DESTINATION

# CULTURE: TWO ASPECTS

- SOMETHING AN ORGANISATION **IS**: SHARED VALUES AND BELIEFS.
- SOMETHING AN ORGANISATION **HAS**: STRUCTURES, PRACTICES, SYSTEMS.
- VALUES AND BELIEFS ARE A PRODUCT OF "HOW WE DO THINGS AROUND HERE"
- ONLY WAY TO CHANGE VALUES AND BELIEFS IS TO CHANGE PRACTICES.

## WHAT IS SAFETY CULTURE THEN?

"THAT ASSEMBLY OF CHARACTERISTICS AND ATTITUDES IN ORGANISATIONS AND INDIVIDUALS WHICH ESTABLISHES THAT, AS AN OVERRIDING PRIORITY, SAFETY ISSUES RECEIVE THE ATTENTION WARRANTED BY THEIR SIGNIFICANCE."

(INSAG'S (1986) 'SUMMARY REPORT ON THE POST-ACCIDENT REVIEW MEETING ON THE CHERNOBYL ACCIDENT')

# WHAT IS A CULTURE OF SAFETY

1. **INFORMED** - MANAGERS KNOW WHAT IS REALLY GOING ON AND WORKFORCE IS WILLING TO REPORT THEIR OWN ERRORS AND NEAR MISSES.

2. **WARY** - READY FOR THE UNEXPECTED.

3. **JUST** - A 'NO BLAME' CULTURE BUT WITH A CLEAR LINE BETWEEN THE ACCEPTABLE AND UNACCEPTABLE.

## CREATING A CULTURE OF SAFETY – INFORMED AND LEARNING

- DEPENDS ON WHERE YOU ARE STARTING FROM
- START AT THE TOP
- DECLUTTER
- ANALYSE
- EASE OF REPORTING
- BETTER LEADERS: CURIOUS, EMPATHIC, CONFIDENT, COURAGEOUS

## CREATING A CULTURE OF SAFETY – WARY

- PLANNING IS IMPORTANT, BUT:
- YOUR REMAINING PROBLEMS ARISE FROM WHAT YOU NEVER THOUGHT OF OR CONSIDERED, SO:
  - CONSTRUCT SYSTEMS THAT CAN COPE WITH THE UNEXPECTED.
  - PRACTICE CHRONIC UNEASE.

## CREATING A CULTURE OF SAFETY – JUST

- GET RID OF THE IDEA THAT BLAME IS A USEFUL CONCEPT (THIS IS HARD TO DO).
- DEFINE CLEAR LINES BETWEEN ACCEPTABLE AND UNACCEPTABLE.
- HAVE THOSE INVOLVED DRAW UP THE GUIDELINES.

# JUST CULTURE DECISION TREE

| Description | Did the team member go above and beyond the call of duty? | Were all procedures and instructions followed? | Did the team member think they were doing things the right way? | If completing the same task, would others have acted in the same manner? | If the procedure was a barrier to getting the job done, did the team member do it differently without reassessing the job? | Did the team member think there was some benefit for the company by doing the job a different way? | Did the team member vary from the procedure to make it easier for themself? | Did the team member intentionally not follow the procedure without thinking or caring about the consequences? |
|---|---|---|---|---|---|---|---|---|
| | YES / NO → | YES / NO → | YES / NO → | YES / NO → | YES / NO → | YES / NO → | YES / NO → | YES |
| Behaviour Type | Exceptional behaviour | Expected Behaviour | Unintentional Error (Slip, lapse or mistake) | Routine Violation | Situational Violation | Optimizing Violation | Personal Optimising Violation | Reckless Violation |
| Work Team | Appropriate recognition or reward in line with Company practices and authorities at the discretion of the line manager. This could include: praise, public recognition, award, positive PDR. | Encouragement and recognition from the line manager. | Skills development and coaching in the use of correct procedures. | Coach team members on importance of understanding and following correct procedures, for example not taking short cuts. | Coach the team member on speaking up when procedures cannot be followed and delaying the job until it can be completed properly. | Coach the team member on balancing work and time pressure with company values. Consider disciplinary measures where appropriate e.g. first warning. | Consider formal disciplinary action in accordance with the Transfield Services House Rules and/or relevant workplace agreement. | Formal disciplinary action to be taken in accordance with the Transfield Services House Rules and/or relevant workplace agreement. |
| | Did the supervisor/ manager also exhibit exceptional behaviour? | Does the supervisor/ manager lead by example by complying with procedures and instructions? | Did the supervisor/ manager fail to supervise work to ensure the task is completed in the required manner? | Was the supervisor/ manager allowing non-compliant (poor) work practices to develop without correction? | Did the supervisor/ manager know the procedure was a barrier to getting the job done and do nothing? | Did the supervisor/ manager permit shortcuts, for the sake of getting an outcome? | Did the supervisor/ manager overlook this behaviour on this or previous occasions? | Did the supervisor/ manager condone the actions of the team member? |
| | YES | YES | YES | YES | YES | YES | YES | YES |
| Supervisor/ Manager | If the behaviour is displayed by the whole team appropriate recognition / reward is at the discretion of the line manager. This could include: praise, public recognition, award, positive PDR. | Encouragement and recognition if the whole team is working this way. | Consider coaching in error identification and management. | Coaching on monitoring and enforcing procedures. Performance appraisal may be affected for not demonstrating leadership skills. | Coaching on the importance of monitoring and enforcing procedures. Performance appraisal is affected for not demonstrating HSE commitment. | Performance appraisal is affected for allowing a non-compliant work practices to develop. Coaching for implementing leadership skills. Consider disciplinary action. | Performance appraisal is affected as appropriate. Consider disciplinary action. | Coaching on how to recognise and deal with such behaviour earlier. Consider disciplinary action. |

## CONCLUSION

- SAFE ORGANISATIONS MAKE MONEY WHERE OTHERS DON'T DARE.
- SAFETY CULTURES HAVE INCREASED TRUST (AND LOWER COSTS):
- WITH MORE ADVANCED CULTURES, THE WORKLOAD CAN BE REDUCED WITH THE SAME OR BETTER PERFORMANCE.
- SMALLER BUSINESSES CAN IMPLEMENT SYSTEMS AND IMPROVE THEIR CULTURE MORE EASILY THAN LARGE ONES.

# THANK YOU