HUMAN FACTORS

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BRIEFING NOTE No. 9

Safety culture

Any group of people develops shared attitudes, beliefs, and ways of behaving. These form a 'culture'. In a safe organisation, the pattern of shared assumptions puts safety high in its priorities. Source: Reference 1.

Why safety culture?

The International Maritime Organisation (IMO) developed the International Safety Management (ISM) Code and strongly promotes safety culture via the adoption of this code. "Effective implementation of the ISM Code should lead to a move away from a culture of 'unthinking' compliance with external rules towards a culture of 'thinking' self-regulation of safety – the development of a 'safety culture'. The safety culture involves moving to a culture of self-regulation, with every individual – from the top to the bottom – feeling responsible for actions taken to improve safety and performance."
Source: IMO http://www.imo.org/

The workforce may feel that their company has a good safety culture, without necessarily being able to explain why they think so. This is because, although safety culture is a powerful influence on safety performance, culture itself is not directly visible. If colleagues and managers generally show a positive attitude to safety in what they say and how they act, this would be evidence of a good safety culture. Having a good safety management system that employees believe in, and especially if they participated in building it, is also a sign that the company has a good safety culture.

How is your company's safety culture?

Answering 'Yes' to the following questions is an indicator of a good safety culture. However, if the answer to any of the following questions is 'No', then you should take action!	Yes	No
1. Do managers generally involve the workforce in discussions about safety related matters and consult them before introducing new safety procedures or systems?		
2. Does the company listen and try to solve problems raised by the people closest to the hazards?		
3. Do managers visit site regularly and do things the workforce would regard as helpful when they're there?		
4. If there is an incident or accident, does the organisation seem interested in solving the problem rather than finding out whose fault it was?		
5. Are incidents always investigated and given the right level of attention according to how serious they were rather than being 'covered up'?		
6. Does the company actively look outside itself and keep up to date on information and new ideas in safety?		
7. Do operators avoid risks and behave as if they are genuinely concerned about their own safety or that of other people?		
8. Do people seem aware of the hazards in their work or how to control them?		
9. Do management and safety reps generally trust and respect each other?		
10. Are people who blatantly break rules generally found out and made accountable?		

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A just culture

One problem in trying to improve a safety culture is that employees might fear being blamed for accidents or incidents they were involved in and so avoid giving the company information on what really happened. In the long run, a company will make more and better improvements by gathering information on such occurrences than by taking action against an individual. Many companies now adopt a 'just culture' where a company takes a fairer and balanced approach to blame. The company has to make it clear how it defines acceptable vs. unacceptable behaviour. Typically, any blatant disregard for safety (e.g. horseplay) is not acceptable. Note that a just culture is not a 'blame free' culture. Open discussion and honesty is preferable but organisations lacking a trusting and open culture may consider using confidential/anonymous incident reporting in order to gather information on safety issues as an interim measure.

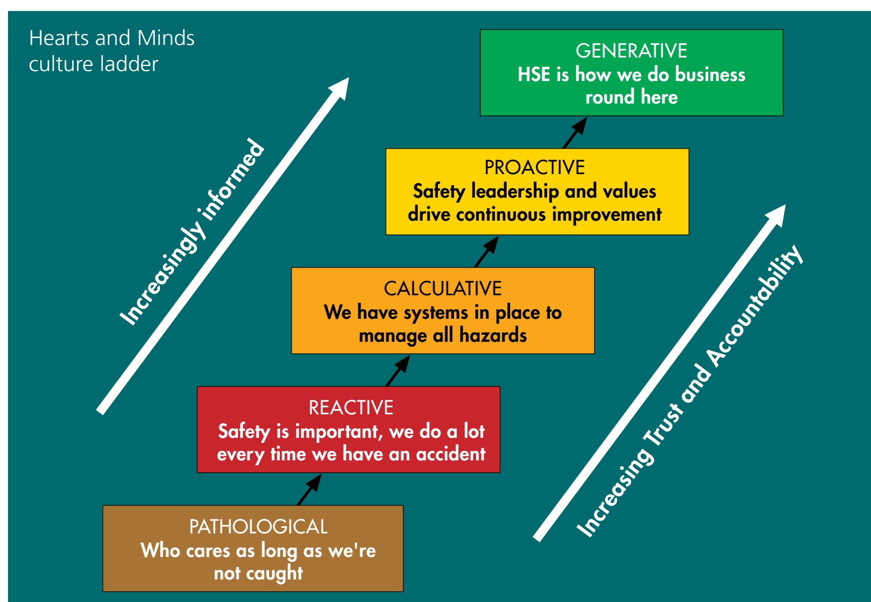
Local and national cultural differences and safety

Safety culture in an organisation can differ between sites, departments and even between shift teams. This means that cultural issues within an organisation may need to be dealt with at a local level and non-locally produced solutions may be met with resistance.

According to the International Labour Office, "All safety and health considerations are affected by commonly held beliefs, values, attitudes and behaviour that may be strongly influenced by national culture." This means that, where teams consisting of different nationalities work together, cultural differences can impact health and safety as a result of differences in language, customs and practices, ways of working and views on appropriate safety behaviours. Source of quote: International Labour Conference, 93rd Session, 2005.

What should my company do about it?

The culture in a company is strongly influenced by management attitudes and behaviours (the management culture), and also by the management systems in place. A culture cannot be changed quickly, but management can fairly easily find out if there is a problem in their company culture, and therefore if there is a need for change. Various questionnaire and interview-based methods are available for measuring a company's safety culture and indicating where changes should be made. Companies should gauge the maturity level of their culture (see below) and strive to move towards the next highest level as it is difficult or impossible to skip levels.



How would you describe your company's safety culture?

An OGP workshop developed a five level description of company safety cultures from worst to best (Reference 3). This is similar to the safety culture maturity concept developed in an HSE study, and which appears in the Shell Hearts and Minds *Understanding your culture* tool. The five levels are described as:

- Generative: safety is integral to everything we do.
- Proactive: people try to avoid problems occurring and exist in a constant state of safety awareness.
- Calculative: management systems are used to encourage and monitor safe working.
- Reactive: improvements are only made following a serious incident.
- Pathological: no-one knows or cares about safety.

Where does your company fit on this scale?

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Management responsibility

HSE's *Successful health and safety management* (HSG 65) describes the four main activities necessary to form a good safety culture as: control, cooperation, communication and competence. Management's responsibility, then, is to ensure that these activities are carried out, and to continually improve the means of carrying them out.

Control and cooperation

In a good safety culture, management will:

- Develop practical safety policies and standards to measure safety achievements.
- Provide employees with clear job descriptions that emphasise safety responsibilities.
- Review individuals against health and safety objectives and reward or correct as necessary.
- Adopt a democratic style – consult employees and encourage them to participate in decision-making about safety.
- Support a 'just' culture.
- Show their visible commitment to safety by making site visits and discussing issues.
- Clearly promote safety over production issues.
- Have a good safety management system.
- Generally aim for excellence in management.
- Have contingency plans.
- Be flexible (prepared to change) when faced with new situations and problems.
- Learn from mistakes.
- Encourage a team spirit and trust between employees and management.
- Have a good relationship with regulators.

Communications and competence

Management will also:

- Listen to concerns and ideas raised by employees.
- Actively seek out information and ideas from outside the company and from different business units about safety issues and new methods and initiatives.
- Ensure that communications within the organisation are relevant and effective (not too much or too little).
- Provide communications in the most appropriate form, for example: bulletins, letters, notices, meetings, presentations, shift logs and face-to-face discussions.
- Give employees information on health and safety policy and procedures, lessons from incidents and feedback on performance.
- Provide good information to those outside the organisation: regulators, trade associations, others in the industry and the public.
- Select, train and assess employees to ensure that they are competent in their work and in health and safety matters.
- Provide competent safety reps and safety advisers.
- Ensure that there are sufficient numbers of employees to carry out all foreseeable tasks, including fault recovery and emergency tasks.

CASE STUDY 1

The 'Baker Report' on the BP Texas City accident provided a number of findings/ recommendations to improve company safety performance. The report authors said "a positive safety culture is important for good safety performance. [Without] a healthy safety culture, even the best safety management system will be largely ineffective in ensuring and sustaining excellent process safety performance" (Reference 2). The report suggested five main failings of BP's safety culture:

- Poor process safety leadership.
- Lack of a positive, trusting open environment.
- Lack of resources required for process safety performance.
- Lack of process safety consideration in management decision making.
- Lack of process safety culture.

The Baker Report showed how important safety culture is to running a safe organisation and how it includes a wide range of issues. BP committed to acting on all of the Baker Report recommendations.

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Measuring performance

Below is a sample of performance indicators that could potentially be used to monitor how effectively safety culture is being managed, divided into leading indicators (showing that a problem may occur in future) and lagging indicators (showing that there is currently a problem). See Briefing note 17 *Performance indicators* for more information on using performance indicators.

Leading indicators	Lagging indicators
Results from HSE safety climate surveys (or other safety culture/ climate surveys or external audits). Leadership: • Measure of visibility of senior executives in the workplace (number of site visits, etc.). • Number of safety tours undertaken by managers and middle managers. • Number of task observations undertaken by leaders (behavioural safety measure). Number of incidents/accidents reported upwards (and in a timely fashion) through the reporting chain. Effectiveness of incident/accident investigation process, including circulation of reports, and effectiveness of interventions.	Number of observations of poor safety culture from application of behavioural safety methods. Number of remedial actions required following safety culture audits. Number of reported near-misses (should not be zero). Percentage of incidents/accidents that are repeat incidents/ accidents (measure of how well the organisation is learning from incident/accident investigations). Breaches of company policy.

CASE STUDY 2

Management at Associated Octel made changes at one of their sites to address what they saw as a lack of accountability of all working there. They accepted that changing the culture of the site would not be a rapid process and could take three to five years. Changes included: managers and supervisors reporting in person to the Manufacturing Director on injuries and accidents; close monitoring of remedial actions following accidents; positive encouragement for workforce to report issues; workforce has authority to refuse to work if they feel unsafe; direct channels of communication to senior managers (to increase trust and openness). Benefits have included: 40 % reduction in production costs; improved equipment reliability; reduced lost time incidents (35 in 1996 to zero in 2002 and 2003); reduced insurance claims (50 in 1997 to zero in 2002); improved morale shown by reduced absenteeism; and 50 % reduction in injury rates.

Source: HSE Business benefits of health and safety – case studies http://www.hse.gov.uk/business/casestudy.htm.

References

1. HSE, (1993), *Organising for safety*, 3rd report of ACSNI study group on human factors.
2. Baker, J. (2007), *The report of the BP US refineries independent safety review panel*, BP.
3. International Association of Oil and Gas Producers (OGP) http://info.ogp.org.uk/HF/.

Further reading

- HSE (2000), *Successful health and safety management*, HSG65, HSE Books.
- Groeneweg, J. (1998), *Controlling the controllable*, Fourth Edition, DSWO Press.
- Reason, J. (1997), *Managing the risks of organizational accidents*, Ashgate Publishing.
- HSE (2002), *Safety culture: A review of the literature*, HSL/2002/25.
- HSE (2003), Human factors briefing note No.7, *Safety culture* http://www.hse.gov.uk/humanfactors/comah/.
- Hearts and Minds Toolkit, *Understanding your culture*, http://www.eimicrosites.org/heartsandminds.

For background information on this resource pack, please see Briefing note 1 *Introduction*.

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