Managing rail staff fatigue

11. Appendix B: Features of a positive safety culture

11.1 Culture can be best understood as 'the way we do things around here'. An organisation's culture will influence human behaviour and human performance at work. Poor safety culture has contributed to many major incidents and personal injuries. Success normally comes from good leadership, good worker involvement and good communications.

11.2 Creating a positive safety culture in an organisation is not a quick, one-off activity, but requires the sustained, consistent implementation of risk management principles in a comprehensive health and safety management system.

11.3 ORR uses the Risk Management Maturity Model (RM3) to understand the culture in the organisations it regulates. ORR will look at the issues involved in culture in a number of the RM3 assessment criteria including, but not limited to: SP Health and safety policy, leadership and board governance; OC: Organising for control and communication. Seven attributes of an integrated health and safety culture are identified.

11.4 Features of a positive safety culture include a reporting, just, flexible and learning culture; these terms are referred to in this guidance and are explained below.

A reporting culture

11.5 In a reporting culture, people are encouraged and willing to lookout for, and routinely report, errors, near misses, unsafe conditions and behaviours and any other safety concerns. With regards to fatigue, a culture of reporting should be encouraged, underpinned by simple fair processes that are easy to access and that staff are briefed on. Effective reporting systems for incidents, near-misses and concerns regarding fatigue should be easy to use, and give rapid, useful, and accessible

feedback to potential reporters.

11.6 Fatigue should not be treated as sickness or as being subject to attendance at work processes. Mutual trust is essential. This means that staff are confident that reporting fatigue will not result in negative consequences (such as being punished or losing pay) and will be followed up and acted upon by the organisation. The behaviour of front-line staff themselves is also important, whereby they do not criticise or demean colleagues who report experiencing fatigue, or alertness and/or attention issues.

A just culture

11.7 A 'just' culture treats people such that the majority believe justice will usually be dispensed – the system is seen as fair. In a 'just' culture, the company line is more clearly drawn between a 'blame' culture (where fear prevents open risk communication) and a 'no-blame' culture (where sloppy practices and negligence tend to creep in). Such a culture can increase psychological safety, where staff feel more able and comfortable to talk about safety issues such as losing alertness, attention, being fatigued or distracted (RSSB's website provides further information). It is important to gain agreement and trust from staff on fair disciplinary systems; formalising acceptable and unacceptable behaviours in policies and procedures creates transparency and sets expectations.

11.8 When considering the culpability of an individual for an unsafe behaviour, it can be helpful to consider the 'Substitution test' - would a well-motivated, equally competent, and comparably qualified individual in the same circumstances, without the benefit of hindsight, have behaved differently? If not, blaming the individual may divert attention from underlying organisational weaknesses.

A flexible culture

11.9 In a flexible culture, decisions are made by the people best equipped to make them, irrespective of their position or grade. For example, those suffering from fatigue may be best placed to identify it and self-report. The identity of decision makers is decided on the basis of functional skill. Although control is usually centralised by means of adherence to well-tried Standard Operating Procedures, a flexible culture recognises that blind rigidity in following 'rules' carries risk, because it is impossible to devise rules covering every situation. Unexpected or fast-

developing circumstances are best controlled by staff closer to, and more familiar with, a changing situation.

11.10 A flexible culture recognises that first-line supervisors' competence is critical since they are placed in control at critical times when the value of their experience and judgement is vital. First-line supervisors will often be those responsible for determining whether staff are too fatigued to work and hence, their competence, specifically in understanding fatigue and its risks, will be key in effective decision-making. This requires a common understanding of decision premises and assumptions, so that decentralised control is consistent with overall central expectations.

11.11 Diverse work groups are encouraged, to bring more perspectives and a greater total span of experience, insight and flexibility than a homogenous group.

11.12 All rules are kept under constant review, and modified where experience shows improvement is needed, following a modification process which involves rule users throughout, to ensure that rules are practicable and will actually control risk.

A learning culture

11.13 In a learning culture the organisation facilitates staff learning and continuously transforms itself, with individual and organisational learning seen as critical to the organisation's survival and development. Good competence management systems (see ORR's Developing and maintaining staff competence Railway Safety Publication 1, 2016) are a prerequisite. There is a recognition that the organisation doesn't operate in a static environment - new processes, pressures and incidents arise, and reports generated by a reporting culture are only useful if the organisation learns from them.

11.14 Incidents and failures are seen as valuable opportunities to improve operations, learn lessons and rectify flaws in the safety management system. This includes in depth analysis of underlying causes and learning from accidents, incidents and near misses.

11.15 The lessons learnt from investigations should be communicated widely and recommendations implemented swiftly. A learning culture propagates information about improvements in risk control upwards, downwards and across management structures. Processes exist to encourage staff participation, and staff involvement leads to increased competence and confidence amongst individuals in their ability to change outcomes. This in turn increases their

motivation to participate further. Involving staff is recognised as key.

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