

SAFETY CULTURE & LEADERSHIP IMPROVEMENT



MODERN DAY ALCHEMY

DR. MARK FLEMING
SAINT MARY'S UNIVERSITY
MARK.FLEMING@SMU.CA

Outline

- **Background**
- **Safety culture and leadership review**
 - Integrated model of safety culture
- **Cultural causes of offshore disasters**
- **Safety culture improvement**
- **Lessons from alchemy**
- ***i SCIN***

Piper Alpha



DEPARTMENT OF ENERGY

The Public Inquiry into the Piper Alpha Disaster

The Hon Lord Cullen



Ubiquitous cause of accidents

Coast Guard slams exploded Gulf rig's owner for '**poor safety culture**'

Government panel blasts lack of '**safety culture**' in nuclear accident

LACK of a "health and safety" culture at Macclesfield Borough Council and an outdated water system at the Leisure Centre have been blamed

A recent consultant's report found that the city's *injury* rate for the last few years is three times ... I suspect that a **poor safety culture** is to blame

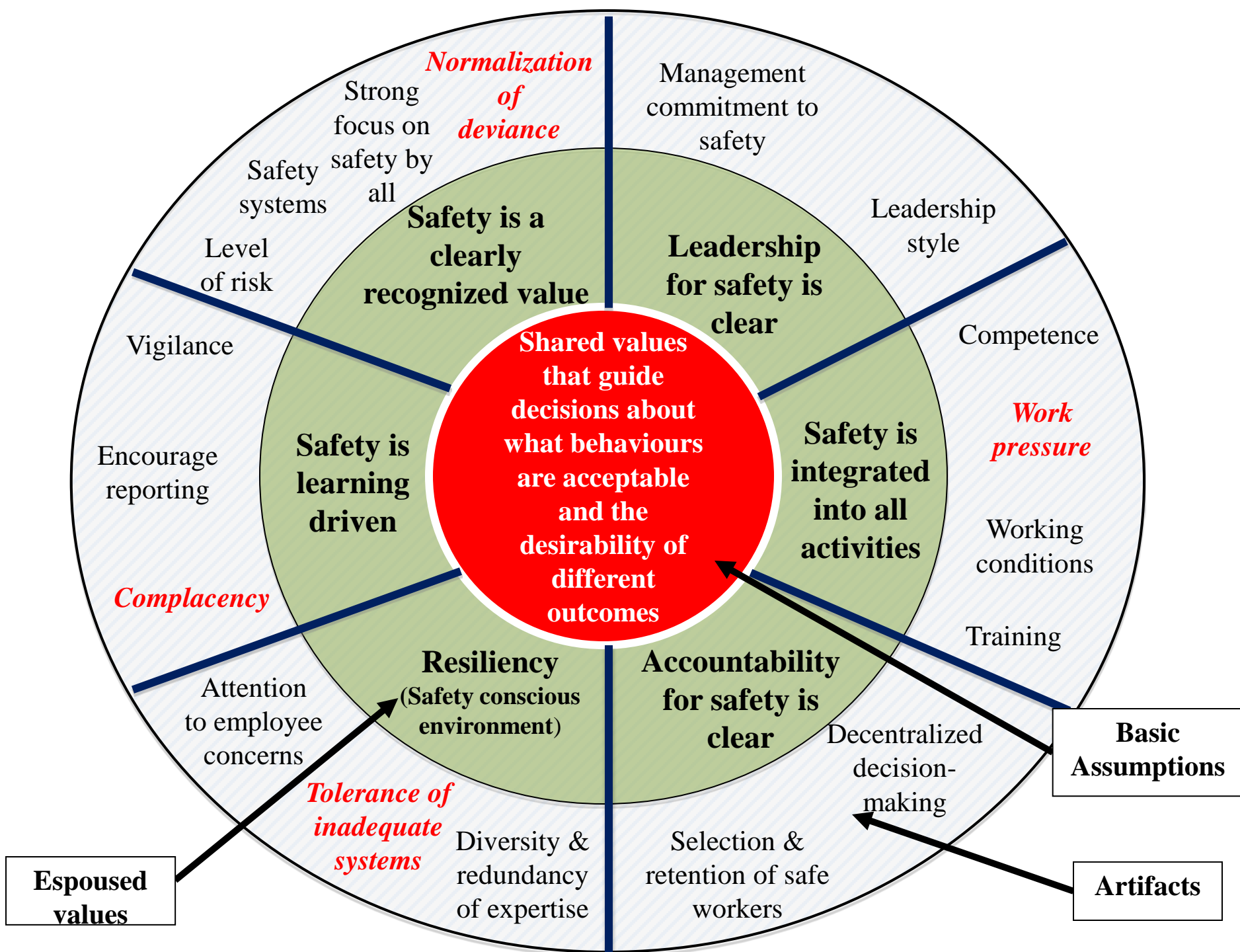
Hospital's **poor safety culture** blamed for deaths of stomach patients

Report on Fatal Plane *Crash Blames Safety Culture* ...

The report points to the airline's **poor safety culture** as responsible for many of the failures.

Safety culture review

- **create a comprehensive framework**
 - theory underpinning safety culture
 - main components of safety culture
 - attributes of a positive safety culture
- **evidence of a relationship between safety culture and safety outcomes**
- **ways to assess or measure safety culture,**
- **improvement strategies**



Safety culture and disasters

- Reviewed 17 offshore disasters to identify cultural causal factors
- 14 disasters contained cultural causes
 - Tolerance of inadequate systems and resources (identified 10 times)
 - Normalization of deviance, (identified 9 times)
 - Complacency, (identified 8 times)
 - Work pressure/ cost (identified 4 times)

Disaster prevention

- **Do not view safety culture as an optional extra**
- **Do not tolerate self deception**
- **Adopt a systematic approach to safety culture improvement**

Systems approach



Safety culture improvement system



Safety culture vision

- **Similar to general health and safety policy**
- **States the desire to continuously strive to improve the safety culture in pursuit of perfection**
- **May include a definition of a positive (ideal) safety culture**

Responsibilities

- **Defines responsibility and accountability for key groups in creating and maintaining a positive safety culture**
 - **Managers**
 - **Supervisors**
 - **Contractor management**
 - **Non managerial staff**
- **Presents a safety culture framework**

Plans and actions

- **Review current practices (e.g. using safety culture improvement tool)**
- **Sets short and long term safety culture improvement objectives**
- **Specifies processes to promote a positive safety culture**
- **Links with other aspects of the SMS (e.g. training, incident reporting)**

Sample: Commitment to safety

Managers Visiting the Worksite	Select level
Managers do not visit worksite to specifically discuss safety	0
Managers visit worksite regularly to discuss safety as specified by a formal policy/ program (e.g. STOP)	1
There is a formal manager worksite visit program that specifies the number of visits to be conducted by each manager and tracks completion.	2
There is a comprehensive program that specifies how to perform a worksite visit, trains managers how to conduct a visit, evaluates managers to ensure they are competent and tracks frequency of visits and close out of actions.	3
There is a comprehensive program described above plus the quality of the managers' visits is evaluated by workers and anonymous feedback is provided.	4

Assessment

➤ Episodic (biannual)

- Multi method safety culture assessment (e.g. questionnaire, interviews, document review)

➤ Continuous

– Safety culture metrics

- Capturing the markers left by safety culture on daily operations (e.g. the quality of safety reports)

Audit

- **Assessing the implementation of safety culture improvement processes:**
 - Compliance with specified plan (e.g. leadership training plan)
- **Assessing the effectiveness of the processes**
 - Extent to which process met desired objective (e.g. change leader behavior)

Review and refine

➤ Review

- Safety culture assessment
- Audit
- Other safety performance information (e.g. incident reviews)
- External (e.g. research, other organisations)

➤ Refine safety culture management system

Where alchemists went wrong

- **Alchemy was an applied science rather than philosophical**
- **Alchemists were not critical of their own theories**
- **They interpreted their data to fit with their theories**
- **It was difficult to disprove some of their theories**

Modern day alchemy?

Similarities

- Importance of safety culture accepted without question
- Poorly defined
- Difficult to test causal relationship between culture and disaster
- Applied vs academic

Differences

- Much of the research is subject to peer review
- Evidence supporting parts of the causal relationship
- Research using different frameworks reaching similar conclusions (e.g. HRO's)

What can we learn from Alchemy?

- **Do not accept the importance of safety culture as a given, but based on the evidence**
- **If new evidence emerges then be willing to change**
- **Continue to examine causal relationship between culture and outcomes**
- **Even if current theories are wrong we have identified an important dimension of safety**

Conclusions

- **We need to be more critical about safety culture**
- **Regulators have an important role in promoting a positive safety culture**
- **Our understanding of safety culture is changing quickly**
- **The offshore industry can learn from other domains**

International Safety Culture Improvement Network

- **Cross-industry collaborative (offshore, nuclear, construction and healthcare)**
 - Create a repository of safety culture documents
 - Capture best practice
 - Develop safety culture metrics
- **If interested in joining then send me an email**

It won't happen to me....

When anyone asks me how I can best describe my experiences of nearly forty years at sea, I merely say uneventful. I have never been in an accident of any sort worth speaking about....I never saw a wreck and have never been wrecked, nor was I ever in any predicament that threatened to end in disaster of any sort."

**Edward J. Smith
(Captain of the Titanic)**



Safety culture improvement system

