EUROPEAN UNION AGENCY FOR RAILWAYS

Making the railway system
work better for society.

COR - Just Culture and Liability

COMMON OCCURRENCE REPORTING PROGRAMME

Document Type: Technical document

Document ID: ERA-PRG-004-5

Origin: ERA

Activity Based Item: 5.1.2 Activity 1 - Harmonized Approach to Safety (WP2016)

Department: Railway Sytems

Unit: Safety and Operations

	Elaborated by	*Validated by*	*Approved by*
Name	Kim Drews	Krzysztof Zubilewicz	Bart Accou
Position	Project Officer	Project Officer	Head of Unit
Date	30/08/2019	03/09/2019	03/09/2019
Signature	*(signed)*	*(signed)*	*(signed)*

Document History

Version	*Date*	*Comments*
Version 1.0	20/11/2018	First version for external consultations
Version 2.0	28/08/2019	Second version after external consultations

1. Table of content

1.1. List of Tables

2. References, definitions and abbreviations

2.1. Reference documents

[Ref. N°]	*Title*	*Reference*
[1]	COR project plan	Project Plan ERA-PRG—004
[2]	Project Plan Developing a common approach to Safety Culture	ERA-REP-158_PPL
[3]	Directive (EU) 2016/798 of the European Parliament and of the Council of 11 May 2016 on railway safety (recast)	2016/798
[4]	Regulation (EU) 2016/796 of the European Parliament and of the Council of 11 May 2016 on the European Union Agency for Railways and repealing Regulation (EC) N° 881/2004	2016/796
[5]	Commission Delegated Regulation (EU) No 2018/762 of 8 March 2018 on establishing common safety methods on safety management system requirements pursuant to Directive (EU) 2016/798 of the European Parliament and of the Council and repealing Commission Regulations (EU) No 1158/2010 and (EU) No 1169/2010	2018/762

2.2. Standard Terms and Abbreviations

The general terms and abbreviations used in the present document can be found in a standard dictionary. Furthermore, a glossary of railway terms that focuses primarily on safety and interoperability terminology, but also on other areas that the Agency can use in its day-to-day activities as well as in its Workgroups for the development of future publications, is available on the Agency website.

2.3. Specific Terms and Abbreviations

Table 1 : Table of Terms

Term	*Definition*
Agency	The European Union Agency for Railways such as established by the Regulation (EU) No 2016/796 of the European Parliament and of the Council of 11 May 2016.
ERA Safety culture understanding (not definition)	Safety culture refers to the interaction between the requirements of the **safety management system**, how people **make sense** of them, based on their attitudes, values and beliefs and what they actually do, as seen in **decisions and behaviors**. A positive safety culture is characterised by a collective commitment by leaders and individuals to always act safely, in particular when confronted with competing goals.
Just culture	A culture in which front-line operators and others are not punished for actions, omissions or decisions taken by them which are commensurate with their experience and training, but where gross negligence, wilful violations and destructive acts are not tolerated. (*Source: Definition of just culture: REGULATION (EU) No 376/2014, art. 2(12)*
Occurrence	In this paper, occurrence means any safety-related event which endangers or which, if not corrected or addressed, could endanger a train or any rolling stock, its passengers, staff or any other person, and includes in particular an accident and incident.
Risk	The frequency of occurrence of accidents and incidents resulting in harm (caused by a hazard) and the degree of severity of that harm. (Art.3.(1) of Regulation (EU) 402/2013 – CSM for risk assessment)

Table 2 : Table of Abbreviations

Abbreviation	*Meaning*
COR	Common Occurrence Reporting
CSM	Common Safety Method
ECM	Entity in charge of maintenance
IM	Infrastructure Manager
NSA	National Safety Authority
NIB	National Investigation Body
RSD	Railway Safety Directive – Directive (EU) 2016/798
RU	Railway Undertaking
SMS	Safety Management System

3. Purpose of the document

This paper forms part of the Agency's Common Occurrence Reporting project and builds on previous consultation papers on "Designing the common occurrences and taxonomy"[1], "Legislation"[2], "Phasing"[3], "Roles, use of data, governance and confidentiality for COR Safety Management Data"[4] and "COR – System Proposal"[5]

The purpose of this document and the comments to it, is to clarify why culture is important, how a just culture affects organisational thinking on safety, and in particular, how a just culture can influence the use and potential success of a shared reporting system.

It is also the purpose to reflect on, possible responsibility/liability issues that might concern or arise with the introduction of a COR system and to clarify if the just culture approach might conflict with national legislation.

These considerations will be valuable in deciding if and how, a future COR can be designed and built to fit the purpose of cultivating a learning environment and enhance risk-based decision making in the best possible way.

4. Scope and objective

The paper will touch on a large part upon the actors within the socio-technical railway system and their interaction. In particular the main stakeholders, being the operational companies and the authorities and subsequent the judicial systems possible effect on reporting.

Aviation legislation is an example on how a harmonised legal framework can support safety reporting and learning. Regulation 376/2014 on the reporting, analysis and follow-up of occurrences might give some inspiration and points for discussion and therefore we will refer to this regulation in several sections.

The different national approaches and terminologies for example "Liability based on fault and strict liability" as explained in the DLA Piper 2010 study makes the investigation on liability under different national legislation regimes a massive undertaking. Therefore this paper does not outline to what extent existing national legislation underpins or undermines just culture. The paper will deal with several topics that relates

[1] Paper on designing the common occurrences and taxonomy - ERA-PRG-004-TD-002
[2] Paper on phasing the COR safety management data collection - ERA-PRG-004-TD-004
[3] Paper on legislation – ERA-PRG-004-TD-001
[4] Paper on Roles, use of data, governance, and confidentiality for COR Safety management Data
[5] COR - System Proposal

to possible liability issues under national law and will also ask for feedback on possible concerns and how the development of a COR system can handle such issues in the best possible way.

The authorities of the Member States may need to address how their national legislation will influence railway stakeholders in developing a positive safety culture and a just culture within their organisations. This issue bears on their responsibility to both ensure that the national legal framework supports effective risk management and to promote the development of a positive safety culture and just culture by the operational stakeholders.

Nor is it a part of the paper to explore the construction of the financial setup of the national bodies responsible for overseeing safety on a Member State level. The way that NSAs are funded, for example, partly from the fines levied on railway organisations for various non-compliances, can have a negative impact on the NSAs behaviour towards the organisations they regulate and on the organisations reactions to NSA supervision.

Such arrangements might create unfortunate incentives on the part of organisations to conceal safety violations to avoid fines and perhaps on the NSA to fine organisations unproportionately for relatively minor incidents.

On the other hand, if there are incentives within the system where reporting safety issues gives a discount account against a fine, there might be incentives in a positive direction. In either event whilst these influences exist within the system the Agency at this stage has no visibility of them and therefore this paper does not consider these issues.

However these are important topics that will be further illuminated in the paper and might be discussed in the COR workshops.

The Agency welcomes your feedback on how national legislation and/or the financial construction of the NSA underpins or undermines just culture. Your feedback will be helpful for the work we are doing in the Safety Culture project.

The objectives of this paper are:

- *to explain why culture is important for safety and how it relates to COR*
- *to provide a common understanding of the term just culture within railways*
- *to explore how just culture affects organisational safety thinking, and how the different actors within the railway system potentially affect the culture in external organisations.*
- *to reveal possible concerns for all stakeholders regarding the use of COR and/or a just culture*
- *to consider possible conflicts between just culture, national law, the judiciary and reporting practice if and when they conflict.*

5. Introduction to safety culture

This section is meant to give a brief explanation of the term “safety culture”, how this relates to just culture and how a positive safety culture will benefit the use of COR, safety and the railways as an sector.

Sustainable safety performance requires the alignment of structural SMS and behavioural aspects within an organisation.

Institut pour une culture de sécurité industrielle (ICSI) explains safety culture and organisational culture in the following way;

The safety culture is a set of ways of doing and thinking that is widely shared by the emploees of an organisation when it comes to controlling the most significant risks associated with its activities.

All lasting human groups develop their own culture. This encompasses the shared experience of ways of doing (common language, ways of greeting each other or of dressing…) and ways of thinking (philosophical principles, views on what is and isn't acceptable in terms of behaviour, and so on). Of course, companies are made up of diverse groups of individuals. But like all human groups, organisations – companies, trade unions, government bodies, non-governmental organisations… – create their own culture. This is called an organisational culture, and it includes:

• ways of doing that are shared and repeated: organisational structure, rules and procedures, technical choices, patterns of behaviour… This is the visible part.

• common ways of thinking: knowledge, beliefs, what is considered implicitly obvious, attitude towards authority and debates… This is the invisible part; it is more difficult to perceive and the most complex to change.

"The safety culture reflects the influence that the organisational culture has on matters relating to risk management. "[6]

In other words, the safety culture is closely linked to the SMS. The safety culture has a strong influence on how the SMS is lived and how the organisation acts and behave accordingly on a daily operational basis. A poor safety culture can in fact undermine the SMS to the extent that the control of risk is weak which in turn will lead to a greater likelihood of accidents and incidents.The understanding of safety culture developed and used by the Agency is in line with the ICSI explanation and also integrates the daily operational conflicts of multiple business priorities:

Safety culture refers to the interaction between the requirements of the safety management system, how people make sense of them, based on their attitudes, values and beliefs and what they actually do, as seen in decisions and behaviors. A positive safety culture is characterised by a collective commitment by leaders and individuals to always act safely, in particular when confronted with competing goals.

5.1. Why safety culture

Safety is the essential precondition for successful rail business in Europe and a positive safety culture is essential for improving rail safety in Europe.

The success of positive safety culture in other high-hazard industries has convinced leaders of the European rail sector, as well as European law-makers, to embrace this philosophy across the continent, thereby creating a harmonised market for rail safety management and reporting.

A positive safety culture provides the operational stakeholders with more than the traditional mitigation measures; An organisation creating an atmosphere of trust and openness, with the main purpose of organisational learning, where staff experiences a fair treatment and a positive development origining from reporting, will receive more early warnings and will therefore be in a better position to manage risks.

Of course this implies that the organisations are ready and competent to interpret correctly the safety management data by identifying the right measures and providing willingness to implement also major changes if there is a need for them.

[6] https://www.icsi-eu.org/documents/208/icsi_essentials_01_safety_culture_an.pdf

As ICSI explains more detailed; *The safety culture approach makes it possible to avoid attributing observed behaviours to individuals only, as this line of reasoning rapidly reaches its limits when it comes to prevention. It aims to understand which of the organisation's characteristics have a positive or negative influence on the way employees perceive safety. These characteristics can include, for example, procedure clarity, communication with management, shared vigilance, contractor relations, the reporting and handling of incidents, the policy with regards to recognition/sanctions (ICSI)*

The recognised importance of culture is understood in the Recast Railway Safety Directive, where Recital 10 [1] calls upon the Member State as follows:

Member States should promote a culture of mutual trust, confidence and learning in which the staff of railway undertakings and infrastructure managers are encouraged to contribute to the development of safety while confidentiality is ensured.

And further in article 9 (2):

Through the safety management system, infrastructure managers and railway undertakings shall promote a culture of mutual trust, confidence and learning in which staff are encouraged to contribute to the development of safety while ensuring confidentiality.

Finally, the lack of a positive safety culture is widely known to be a contributing factor in many cathastrophic accidents:

'Poor Safety Culture' has been identified among the causes of numerous high-profile accidents, such as the fire at King's Cross underground station (Fennell, 1998); the sinking of the Herald of Free Enterprise passenger ferry (Sheen, 1987), the passenger train crash at Clapham Junction (Hidden, 1989), the disasters of the Space Shuttles Challenger (Rogers, 1986) and Columbia (Gehman, 2003), the Überlingen mid-air collision accident (Ruitenberg, 2005), and the BP oil refinery accident (Baker et al., 2005).[7]

6. Just culture and COR

6.1. What is just culture and how does it influence reporting

Just culture is an essential element of a broader safety culture and is a strong enabler for a sound reporting culture.

Just culture is meant to encourage learning by creating the trust necesseary to have open and honest information sharing (e.g. reporting) about safety-related problems and concerns without fearing punishment or a blaming attitude. It is essential to build the understanding of the value of shared safety-related information, and to value discussions on such information, to uncover risks and their mitigations in the pursuit of improving the overall safety of railways and not at least to learn abouth when things go good, and why everything workt out fine. Building a questioning attitude and a flow of information to constantly learn about workplace reality relies on the belief that the information will be used to improve system performance and not to punish or blame individuals, teams, managers or even organisations. As a side effect, an open dialogue will also lead to other possible workplace improvements which can improve efficiency.

Hence, a just culture is directly connected with a healthy reporting and safety culture of an organisation.

By not punishing the negligent acts of professionals (the so-called 'honest mistakes') safety is strengthened through the reinforcement of a positive culture based on an environment of trust, free reporting of safety occurrences, analysis and dissemination of 'lessons learned' for the benefit of safety. [8]

[7] http://www.skybrary.aero/bookshelf/books/564.pdf

[8] http://www.skybrary.aero/index.php/Hindsight_18 Just Culture vs. Criminalization.

However there is a limit; just culture is not a “no-blame” or “immunity” culture, which is reflected in the just culture definition stemming from aviation regulation 376/2014:

"Just Culture" is a culture in which front-line operators and others are not punished for actions, omissions or decisions taken by them which are commensurate with their experience and training, but where gross negligence, wilful violations and destructive acts are not tolerated. [9]

A good just culture is fragile and needs to be nurtured, as it relies heavily on trust in how the system handles shared information. Like a good reputation, trust takes time to build, but is easy to lose. What is perceived as unjust blame or punishment of individuals may ruin the organisations occurrence reporting, as nobody wants to report themselves or others if it is considered a risk to themselves or colleagues.Ultimately no-one wants to incriminate themselves especially if they see that the consequence is likely to be severe. This is not only the case inside the operational company but also when sharing between organisations across the sector.

6.2. Just culture in the socio-technical system (information sharing across organisations)

Just culture goes beyond the operational organisation. Any corporate just culture is influenced and can be affected by external organisations. This could for example be the case in the operational companies relation with contractors, where possible fear of loosing contracs due to safety related issues, might be an incentive to hide known problems that could have been solved if they were discussed. Another example could be, where authorities (or the judiciary) enforces, or is expected to enforce, what is perceived as “unjust” punishment or a blaming attitude on an organisation or individuals. Such an unjust behaviour has the ability to ruin the operational organisation’s incentive to report and share information and thereby the ability for the system as a whole to learn about safety.

In other words, it is not enough to establish a just culture in your own “silo”. There is a need for an enhanced cooperation and coordination between stakeholders in the railway system to facilitate and underpin reporting and learning and thereby improve safety at company level, national level and European level. Without this there is a danger that unfortunate incentives within the system will affect safety at all levels within the railway system.

To do this, a climate of trust across operational actors and authorities is needed. Stakeholders need to be confident that open discussions and information sharing is not misused, but is treated with the common objective of helping each other in achieving a higher level of safety. Of course this needs to be done with integrity and respect to the different obligations and responsibilities but with the purpose and attitude of seeking win-win transactions.

As recited in aviation regulation 376/2014:

(36)In addition, the civil aviation system should promote a ‘safety culture’ facilitating the spontaneous reporting of occurrences and thereby advancing the principle of a ‘just culture’. ‘Just culture’ is an essential element of a broader ‘safety culture’, which forms the basis of a robust safety management system. An environment embracing ‘safety culture’ principles should not prevent action being taken where necessary to maintain or improve the level of aviation safety.

It is also worth mentioning here the possible side effects following the level of trust in the sociotechnical system. In resent years, the correlation between trust and economic performance have been a topic within economic science. Relying on the following quotes, it is reasonable to assume that an appropriate level of

[9] https://eur-lex.europa.eu/legal-content/EN/TXT/?qid=1507624635655&uri=CELEX:32014R0376

trust and the subsequent information sharing in the railway sociotechnical system will lead to positive financial outcomes:

Trust is a fundamental element of social capital – a key contributor to sustaining well-being outcomes, including economic development.[10]

Sociologists and anthropologists (like Richerson and Boyd, 2005) have accumulated a wealth of (positive) *field evidence on the impact of culture on economic behavior.*[11]

Tabellini (2005) documents that both GDP (Gross Domestic Product) per capita and growth are higher in those regions that exhibit higher levels of the "good" cultural values like trust, beliefs in individual effort, generalized morality and low obedience. This evidence strongly suggests that "better" cultural values do have a large economic payoff.[12]

Several empirical papers show that the level of trust of a community affects economic performance (Knack and Keefer, 1996; Knack and Zak, 2001).[12]

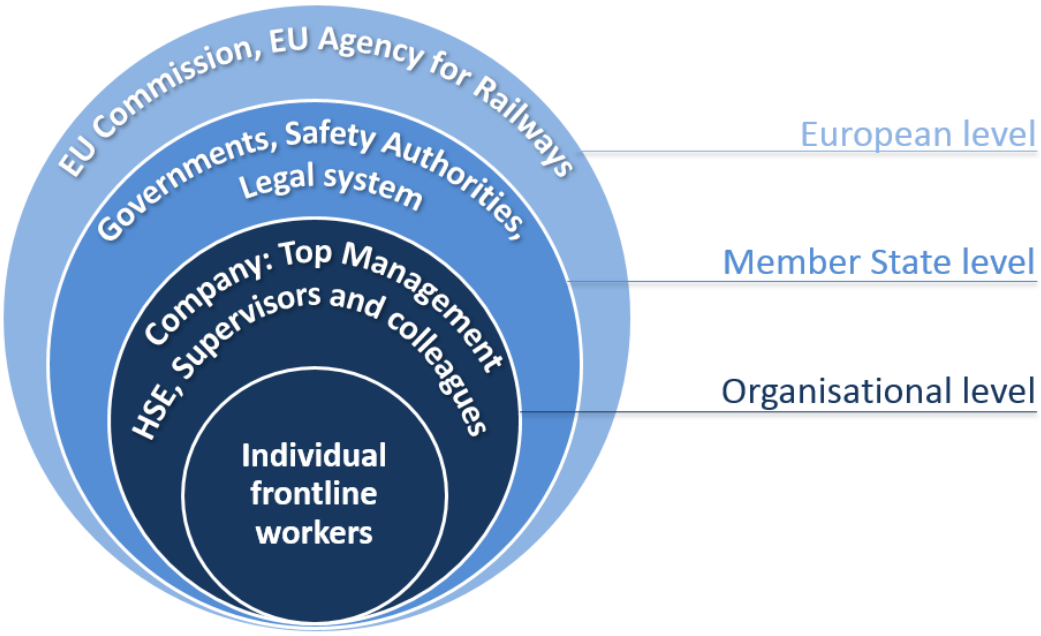

Fig. 1 The implementation of just culture is key to improve information sharing and safety learning across the system actors.

6.3. How can COR underpin Just culture and reporting

COR can contribute to the building of a just culture by developing and supporting an open and transparent reporting culture where everybody reports. A harmonised legal framework can reinforce a common terminology and understanding supported by a common IT tool and taxonomy. The publically available outputs give an opportunity for shared learnings and benchmarking.

COR will also support the introduction and/or further development of National occurrence reporting, which is an opportunity to (further) develop a sound and just reporting culture. e.g. through supervision.

[10] https://ourworldindata.org/trust#what-is-the-relationship-between-trust-and-gdp
[11] Does culture affect economic outcomes?

The success of a COR system relies heavily on the reporting culture within the organisations providing data to the system. Reporting systems and culture are iterative – effective reporting systems underline the importance of safety improvement and thereby boost safety culture, and safety culture encourages reporting of safety concerns.

As the reporting culture across Member States varies, it is essential to foresee that time and resources are needed to achieve a common reporting culture across Member States. This is not only about when and what to report, but also about understanding the taxonomy used and acknowledge the importance of valid data. Otherwise different inputs might to some extent undermine the intention of the system by mixing apples and oranges.

In general for reporting systems and structures and also for the COR, if it at some point will be used directly by operational companies for reporting, certain basic characteristics needs to be considered in the design and in the use. Amongst others:

- *easy to access and to do the reporting, IT-systems, rules, standards and procedures underpin reporting, avoiding double reporting;*
- *possible to do the reporting instantly, perhaps even by voice recording and pictures from a mobile*
- *reporters get feedback. What is happening with their reports, who analyzes the reports, which authority/entity is responsible and what actions are taken;*
- *staff know and trust that the organisation is using reports to improve safety;*
- *it is possible to be confidential to ensure reports wont't be used inappropriately, and reporters won't be blamed for reporting themselves or others;*
- *staff is encouraged to report to contribute to the learning and development of safety;*
- *reported occurrences are investigated promptly and thoroughly by independent competent staff;*
- *staff have some knowledge about the minimum level that they are expected to report about.*

The agency welcomes additional points that should be considered.

6.4. General concerns regarding COR and sharing of information

Stakeholders have expressed concern about the potential legal risks of information sharing. Whilst it is important not to lose sight of the relative priority of different business risks (safety, legal, commercial, moral), tools and processes will need to be designed in a way that supports full legal compliance. Legal systems vary significantly across Member States and it is likely that neither the Agency nor the European Commission will have the ability to influence application of national laws in this area.

We would like to have all your inputs to these concerns, to explore and discuss how they might be handled.

Below are some of the concerns that we will explore in more details in the following sections regarding just culture of the involved stakeholders.

- companies might not be willing to report occurrences because they will be afraid that it might be used against them. This could be between companies in contractual relations, or by the NSA in supervision (additional inspections/audits) or (re-)certification, administrative actions (fines), additional massive workloads (to produce reports etc. without creating value). Ultimately they might also fear the judiciary (any form of prosecution) or for competitive reasons towards other sector companies.

- NSA / MS might not be willing to report to an EU wide system because of political reasons (comparing safety levels, media attention, political oversight)

- why and when issharing of safety related data "critical" which is why it should not be shared at all

- another possible threat: media - misinterpretation of safety data is common in journalism with a tendency to focus on "bad stories" rather than "good stories" - "look how unsafe railways are", especially if developing

reporting systems contributes to a rise in noted occurence levels (more gets reported - more goes into statistics)

- what kind of information will be publicly available and therefor accessible for the media

For the reasons above all the concerns of the stakeholders regarding reporting in the COR system should be heard and addressed, it should also be considered if these and other concerns can be solved with a CSM on COR.

7. Just culture of operational actors

Who are the operational actors?; The RSD specificly declares that IMs and RUs "…shall promote a culture of mutual trust, confidence and learning…", however all operational actors (as defined in 798/2016 article 4.4) are just as important for maintaining or improving the level of safety on the railways and should be considered to be so, hence in this paper the operational actors are considered to be all operational actors.

The operational actors will be the main source of providing information to the COR about occurences, whether reporting directly in the COR system or indirectly at a national level, the information will origin from the operational actors.

More so with individual staff members as the main source of information. During operations, when staff do risk assessments on the spot, e.g. due to situations that are not covered in rules and procedures or due to conflicting goals like punctuality and safety, or from technical or human mistakes, this is where the majority of occurrences happen. It is also in this environment where a positive safety culture can have a direct and immediate influence on safety. Therefore, the value of a COR system is strongly dependent on the reporting culture within the operational actors, and their willingness to use the system and share data.

A good reporting culture at the organisational level is not built in a short time. Management need to address the importance of a positive safety culture and just culture for reporting, and act accordingly to develop the necessary trust and climate. This will often be across internal subcultures, over large geographical areas to staff working 24/7 and to contracting companies. Building a good safety culture in such conditions is not an easy task and requires ongoing actions.

Depending on the maturity level it might take time, resources and the right competences, not only to establish the trust between the different levels inside an organisation, but also to create a common understanding and a common language, to be able to benefit from the knowledge of own and shared safety related information.

As mentioned previously, a good reporting culture is fragile and can easily be destroyed. People need to feel that the system works for them. If reporters and those reported are trated in a fair transparent system and it is evident that reporting leads to organisationel learning then information will flow. If the system cannot be trusted and information is used in an inappropriate way, where reporters feeling that the system is not working for them or against them, they will stop using the system in the intended way and valuable information and safety learnings will be lost.

For the operational actors there is also a need to build trust and confidence with the external organisations who have an influence on reporting performance. This is not only to have a good and open relationship with the authorities, but for RUs and IMs, it is also an obligation to ensure that their contractors and other partners implement risk control measures (RSD (9)). A company's safety culture is reflected in the way risk control is managed, in general a positive safety culture would automatically entail that safety issues from contractors and other parties are reported and shared.

In the following, we imagine what good could look like in the operational context, this is not covering all aspects and we welcome comments giving more examples.

In the ideal climate, reporting makes sense for the operational staff because:

- *Staff have a questioning attitude and behaviour, which amongst other things are affected by the non-technical skill training and the inviting management behaviour and attitude.*
- *It makes sense to report, as Safety related information is acted upon and is used to improve system performance, (not just to re-train already experienced professionals).*
- *Staff are aware of major railway risks and their contribution to risk management*
- *Safety issues and learnings are shared across the organisation and outside the organisation with relevant stakeholders*
- *Confidential reporting is possible, clear communication about acceptable and unacceptable behaviour and consistent application are means to encourage staff to report and are helpful tools to build and maintain trust.*

How will an operational reporting culture like the above influence the data and value of COR and how can it be achieved?

From aviation regulation 376/2014:

(9) Various categories of staff working or otherwise engaged in civil aviation witness events which are of relevance to accident prevention. They should therefore have access to tools enabling them to report such events, and their protection should be guaranteed. In order to encourage staff to report ocurrences and enable them to appreciate more fully the positive impact which occurrence reporting has on air safety, they should be regularly informed about action taken under occurrence reporting systems.

7.1. Organisational just culture

A good safety culture is initiated, structured and driven by top management. It is supported and demonstrated in daily operations and decision making. The SMS is good for formalising safe operations, but even the best designed SMS with well defined risk assessments, rules and procedures needs constant development and will never be perfect and neither will human beings.

Priorities and conflicting goals is a daily operational reality. This means that staff need to prioritise between time, money, quality, resources, etc. - and safety. In such decisions safety needs to be the first consideration and ultimately have the highest priority, before operational efficiency.

Recognising and accepting that operations are done like this, makes it very important to have a safety culture, where the commitment to safe operations are valued and where staff is empowered and backed up by their management, to choose safety over production when needed. This should be done by all individuals including those of contractors, without fearing blame but with confidence that information will be used for learning. Likewise, it should be natural to report, not only when things went wrong, but also when operations succeded even though rules and procedures are not followed – or perhaps because rules and procedures was not followed! These are valuable learning opportunities to improve the system.

Using the human flexibility to ensure operations are done efficient and safe, also creates the possibility for mistakes. Human behaviour can range from honest mistakes on one side of the spectrum to gross negligence on the other; within this range organisational policy-making applies. Outside these boundaries e.g. for voluntary intent to damage intervention by the judicial system is called for.

Defining when an act is considered gross negligence, wilful violation or destructive is not an easy task and these limits might vary from organisation to organisation and from time to time. To manage expectations, it is important to define and communicate how these borders are understood and managed.

One example of a method, being used in operations today, to determin the character of an act, is to establish (as independent as possible) “panels or boards” with internal and/or external members representing the roles the organisation sees necessary. E.g. with representatives from staff, unions, safety experts, managers,

HR, etc. Such a board can act objective, transparent and independently, following known well disseminated relevant procedures and with the ability to decide if a certain act is due to systemic failure, "honest mistakes", unacceptable gros negligent behavior which needs to be disciplined or if the responsible individual ultimately should be prosecuted. Personal information about the involved individuals shall be kept confidential and thus this information will not be available to the board, in order to protect individuals from the abuse of power.

In reality, the decision of categorising a certain act as being disciplinary is often made by managers, however, managers are often not operational experts, safety experts or prosecutors, and the motive behind their decisions can be questionable, which can potentially destroy the trust between front line staff and management.

Therefore clear expectations about where the line must be drawn between acceptable and unacceptable behaviour, consistent communication of these expectations, fair and balanced investigative processes and responses to rule breaking and/or errors, provide organisations and their employees with the confidence about their rights and responsibilities and are means to foster trust in the organisation .

Consistently applied expectations and boundaries will also work as a protection of employees, in the way that power can not be misused by using the "opportunity" of an honest mistake go get rid of expensive or difficult employees. In essence, management must demonstrate the readiness to use safety information for the purpose of organisational learning, in a fair manner, to maintain a level of trust of the employees.

It is important to realise that these boundaries can be unclear. Apart from specific issues, such as violence or alcohol abuse, the boundaries are constantly moving as acceptance criteria are continuously re-negotiated. Even for seemingly obvious issues such as substance abuse, the action taken may vary substantially depending on the organisation's view on boundaries between individual and organisational responsibilities. The organisation may choose to discipline and punish substance abuse as an individual shortcoming or see this as an organisational responsibility and choose to rehabilitate and support an employee in difficult circumstances. However, it is important that the boundaries established within an organisation are created and communicated with all employees, and are consistently applied.[12]

Relevant sections from aviation regulation 376/2014:

(37) A 'just culture' should encourage individuals to report safety-related information. It should not, however, absolve individuals of their normal responsibilities. In this context, employees and contracted personnel should not be subject to any prejudice on the basis of information provided pursuant to this Regulation, except in cases of wilful misconduct or where there has been manifest, severe and serious disregard with respect to an obvious risk and profound failure of professional responsibility to take such care as is evidently required in the circumstances, causing foreseeable damage to a person or to property, or seriously compromising the level of aviation safety.

(42)Employees and contracted personnel should have the opportunity to report breaches of the principles delimiting their protection as established by this Regulation, and should not be penalised for so doing. Member States should define the consequences for those who infringe the principles of protection of the reporter and of other persons mentioned in occurrence reports and should adopt remedies or impose penalties as appropriate.

7.2. Just culture in the operational actors - concerns

Depending on how a COR system can be used, these are some of the concerns we see, however this is not an exhaustive list, so all inputs are welcome:

[12] http://www.ogp.org.uk/pubs/452.pdf

- *Are/will/can the operational companies be obliged to report using COR? According to National law?*
- *Are operational companies afraid of sharing safety related information with other companies for competive reasons?*
- *Are operational companies afraid of being blamed or disciplined by authorities for the shared safety information?*
- *Is it possible to create valuable lerning using a confidential/anonomous system?*
- *Is it possible according to national law to use a trusted body, and for the trusted body not to share information from safety investigations which potentially could harm the reporter or the reported e.g. in case of prosecution.*

8. Just culture of authorities

All authorities need to establish sound relationships with those they supervise, so that open communication and sharing of safety related isses is encouraged. This is where focusing on establishing robust safety culture within the sector can benefit not at least the NSAs. Organisations that understand their safety responsibilities, and are motivated to proactively fulfill them, will seek out the help and advice of authorities they trust. This is, however, a delicate balance to strike. Authorities need to avoid relationships that compromise the roles of regulator / regulatee, so that challenging decisions and discussions are possible, without fear of upsetting strong personal relationships. Similarly, although trust is important, authorities need to be willing and competent to challenge information provided by those they supervise. Whilst avoiding the risks of 'regulatory capture', a balance between enforced (hard) and negotiated (soft) styles of regulation has the greatest potential for achieving good safety performance.

When NSAs receive safety related information from the operational companies,it is important to seek an appropriate balance between the obligation to act and the benefit of safety. If the priority from the NSA first and foremost is to act (checking the box), to cover the NSA from any possible liability issues from having guilty knowledge, then it might be of harm for safety! If such actions is perceived as unproportionate or unfair and without the NSAs being willing to liaise with companies on safety matters in an open solution seeking manner, then it will nourish a behaivior of hiding and covering up issues that could have been solved in cooperation.

It might also be problematic to establish a sound information sharing if the authorities are partly self financed through fines and fees they can impose on the operational companies. Such a construction might be an incentive to misuse reported information for own benefit and will therefor lead to less information sharing and learning if it is not handled in a sound manner. On the other hand fines for not reporting or hiding relevant information could be used as an incentive to report.

Finally ERA and the Commission needs to be transparent and cautious with the use of data received by Member States, as the comparison of safety levels can lead to unwanted political pressure, political oversight and media attention which might harm the National authorities willingness to report and share all safety related information.

For the Agency, this is in particular relevant with the new role in authorisation and certification where the access and use of possible company or vehicle specific knowledge from COR, SAIT or other sources should be considered.

Relevant section from aviation regulation 376/2014:

(20)The objective of the exchange of information on occurrences should be the prevention of aviation accidents and incidents. It should not be used to attribute blame or liability or to establish benchmarks for safety performance.

8.1. Just culture of authorities - concerns

These are some of the concerns we see as possible discussion points, however this is not an exhaustive list, so all inputs are welcome. How can these concerns be solved within a COR system/ COR CSM:

- *If so, when is National legislation and the legal system (rules of engagement) forcing NSAs to act unproportionate to cover their own responsibility/liability, which can lead to operational companies wanting to hide known issues – and how can it be solved?*
- *Is there a lack of appropriate tools for the NSAs to act proportionate?*
- *Is a partly self financing construction an issue that should be discussed, and how can it be handled?*
- *what are the concerns from Member States regarding the Commission/ERA use of safety information and how can these concerns be solved within a COR system?*

The below from aviation regulation 376/2014, might serve as inspiration for the discussions.

(41) Staff of organisations, of the competent authorities of the Member States and of the Agency who are involved in the evaluation, processing or analysis of occurrences have a significant role to play in the identification of safety hazards and safety deficiencies. Experience shows that when occurrences are analysed with the benefit of hindsight following an accident, the analysis leads to the identification of risks and deficiencies that might otherwise not have been identified. It is possible, therefore, that the persons involved in the evaluation, processing or analysis of occurrences may fear potential consequences in terms of prosecution before judicial authorities. Without prejudice to national criminal law and the proper administration of justice, Member States should not institute proceedings against persons who, in the competent authorities of the Member States, are involved in the evaluation, processing or analysis of occurrences in respect of decisions taken as part of their duties which subsequently, and with the benefit of hindsight, prove to have been erroneous or ineffective but which, when they were taken and on the basis of the information available at that time, were proportional and appropriate.

9. Just culture and the judiciary

In the aftermath of serious incidents or accidents, cases might come to the attention of prosecutors - perhaps through occurrence reporting. This is an important role for democracy and the public demand for justice, but prosecutors are not experts on how the railway sector works, and they might not understand the complexity of the system behind a given function. However, they can play a major role, not only for any indivdual that might be prosecuted, but also for the incentive to report.

Let take an example, which is well known within air navigation services. A reported occurrence, not accident, leads to a criminal investigation for endangering the public. If such a criminal investigation ends where the individual is guilty for an “honest mistake/human error”, that could have happened to anybody else given the same conditions (systemic issue), and the judiciary do not consider the operational risk management responsabilities (798/2016 (7) and (18)), but just the “duty of care” of the individual due to having followed the relevant training provided by the employer. Then it will most likely be perceived as an unjust treatment by the individual and colleagues and will therefore damage the willingness to report. Nobody wants to report their errors if there is a risk for blame, punishment or perhaps even selfincrimination. Such an act from the judiciary will punish the individual, but will not necessary change anything in the operational environment, and will therefore not help the development of safety but it will undermine the future reporting.

With the experience from the just culture workshops with the judiciary, it is the Agency’s view that the above approach is a common way of perceiving failures for the legal systems – with some exeptions. Therefore it

might take time, and involve ministries at a national level, to establish a national just culture, which can help creating a balance between maintaining justice and improving safety for the benefit of the public.

If the judiciary looks beyond the human error and considers coporate responsibility in the complex system the individual is working within, they will be able to make fair and just decisions which can be an incentive to develop a safer system where the use of human abilities as the last safety barrier is minimised to the extent possible. A broader perspective from the judiciary will therefore not only be helpful for the individual being placed in a bad system, it also has the potential to improve learning and the development of safety.

In other words; human errors and honest mistakes is opportunities to improve the system, whereas gross negligence and wilful wiolations is an individual responsibility.

Eurocontrol states it like this:

"A person who breaks the law or breaches a regulation or company procedure through a deliberate act or gross negligence cannot expect immunity from prosecution. However, if the offence was unpremeditated and unintentional, and would not have come to light except for the report, he/she should be protected from punishment or prosecution." [13]

The connection between reporting and the juciary is supported by the aviation regulation 376/2014 in particular in the following recitals:

(38) In order to encourage reporting of occurrences, it should be appropriate to protect not only reporters, but also persons mentioned in the occurrence reports concerned. However, such protection should not exonerate those persons from their reporting obligations under this Regulation. In particular, in a situation where a person is mentioned in an occurrence report and has himself or herself th,e obligation to report that same occurrence, and intentionally fails to report it, then that person should lose his or her protection and face penalties in application of this Regulation.

(39) Without prejudice to national criminal law and the proper administration of justice, it is important to clearly demarcate the extent of the protection of the reporter and other persons mentioned in occurrence reports from prejudice or prosecution.

9.1. Just culture and the judiciary - concerns

- *Does your national criminal law prohibit the use of relevant safety investigation material e.g. interview statements, or do you have any national arrangements supporting the balance between justice and the development of safety? (Like it is often the case for media in the protection of sources)?*
- *Does your national criminal law allow the judiciary to access all safety investigation material in a legal investigation, and do you have specific examples where investigation statements have been used in convictions?*

10. Confidentiality, access and possible use of COR information

Confidentiality is a mean to protect the reporter and/or the reported and will also support the separation of a safety investigation and for example a legal investigation intended to place responsibility and guilt. It is also a request in the RSD recital 10 and article 9 stated as: "…. *contribute to the development of safety while ensuring confidentiality."*

The question is though, how can reporting be confidential and at the same time give basis for learning? If a reporting system is completely anonymous, then it won't be possible to do interviews or to follow up with

[13] https://www.skybrary.aero/index.php/Just_Culture

the involved people during the internal safety investigation, which means that the ability to learn and improve the system will be limited.

One normal way of handling the confidentiality is where the identity of the reporter is only known by a trusted body inside the organisation, often in the safety department dealing with occurrences, incidents and accidents.

However this practise raise the question, whether it is possible to keep such safety reports confidential or anomonous according to national criminal law, if authorities or the judiciary want to have acces to them at a later point in time. It also needs to be considered to which extent reported data is public data in the way that the needs to be shared if the public wishes to have access.

Another point of discussion that arises in the just culture workshops with national prosecutors is the judiciary's possible use of safety investigation information.

The RSD 798/2016 (38) states: *A safety investigation should be kept separate from any judicial inquiry into the same incident, and those conducting it should be granted access to evidence and witnesses.*

None the less, where the higher ranking national criminal code allows the judiciary, at a later point in time, to access and use information from internal or NIB safety investigations, it is possible for the reporter or the reported to give self incriminating statements during the safety investigation for the purpose of safety learning, believing the information is confidential.

Wether the information comes from internal safety investigations in the operational company or from NIB investigations, the possible outcome of the judiciary using, what should have been confidential information, gathered during safety investigations for the purpose of criminal proceedings is harmful for future reporting and safety learning.

The Agency welcomes your knowledge of cases within railways where reported occurrences have lead to judiciary investigation and/or where the judiciary have used information given during a safety investigation during a prosecution.

Relevant recitals from aviation regulation 376/2014:

(34) In order to ensure the confidence of employees or contracted personnel in the occurrence reporting system of the organisation, the information contained in occurrence reports should be protected appropriately and should not be used for purposes other than maintaining or improving aviation safety. The internal 'just culture' rules adopted by organisations pursuant to this Regulation should contribute in particular to the achievement of this objective. In addition, the limitation of the transmission of personal details, or of information allowing the identification of the reporter or of the other persons mentioned in occurrence reports, by a clear separation between the departments handling occurrence reports and the rest of the organisation, may be an efficient way to achieve this objective.

(35) A reporter or a person mentioned in occurrence reports should be adequately protected. In this context, occurrence reports should be disidentified and details relating to the identity of the reporter and of the persons mentioned in occurrence reports should not be entered into databases.

(40) In order to enhance the confidence of individuals in the system, the handling of occurrence reports should be organised in such a way as to appropriately safeguard the confidentiality of the identity of the reporter and other persons mentioned in occurrence reports with regard to fostering a 'just culture'. The aim, wherever possible, should be to enable an independent occurrence handling system to be established.

(43) Individuals may be discouraged from reporting occurrences by the fear of self-incrimination and the potential consequences in terms of prosecution before judicial authorities. The objectives of this

Regulation can be achieved without interfering unduly with the justice systems of the Member States. It is therefore appropriate to provide that unpremeditated or inadvertent infringements of the law that come to the attention of the authorities of the Members States solely through reporting pursuant to this Regulation should not be the subject of disciplinary, administrative or legal proceedings, unless where otherwise provided by applicable national criminal law. However, the rights of third parties to institute civil proceedings should not be covered by this prohibition and should be subject only to national law.

(44) Nevertheless, in the context of developing a 'just culture' environment, Member States should retain the option of extending the prohibition on using occurrence reports as evidence against reporters in administrative and disciplinary proceedings to civil or criminal proceedings.

(45) In addition, the cooperation between safety authorities and judicial authorities should be enhanced and formalised by means of advance arrangements between themselves which should respect the balance between the various public interests at stake and which should in particular cover, for example, access to and the use of occurrence reports contained in the national databases.

10.1. Confidentiality concerns

- *How can efficient and valuable confidential reporting be structured within the limits of national law?*
- *Who can have access to the information in a COR and to which extent can details from occurrence reporting be disclosed or confidential? This is a relevant question for example towards the judiciary and the duty to grant public access.*

11. Liability concerns

This paper has touched upon several topics linked to possible liability issues. However all liability issues that can affect the operational reporting should be considered in the development of the COR to aceive the best possible value of the system.

Therefore we ask you to raise and clarify all liability concerns where national legislation can undermine the development af a just culture and the intended use of the system.

12. Conclusions

Safety culture and just culture has shown that it can have a positive impact on improving safety performance, particularly if it is a part of a proactive SMS.

Likewise poor safety culture and just culture can contribute to the causes of high profile accidents as it focuses on blame at individual level rather than at a systematic preventive level, leading to organisational silence and therefore valuable lessons are not learned.

The creation of a positive safety culture and just culture is heavily affected by stakeholders from outside the organisation, therefore it is important to create awareness of that influence and to create a sound balance of trust between the different actors in the eco-system to achieve the best possible outcome.

Linking culture with COR will help to improve its capability to learn and improve. A positive safety culture and just culture will be a mean to instill mutual trust and confidence and mowe towards a risk based approach wich can focus on preventing accidents and with a likely positive effect on businessgoals such as efficiency.

There are many concerns to be discussed and we are fully aware that might not have captured all. This is not at least regarding possible conflicts with national law.