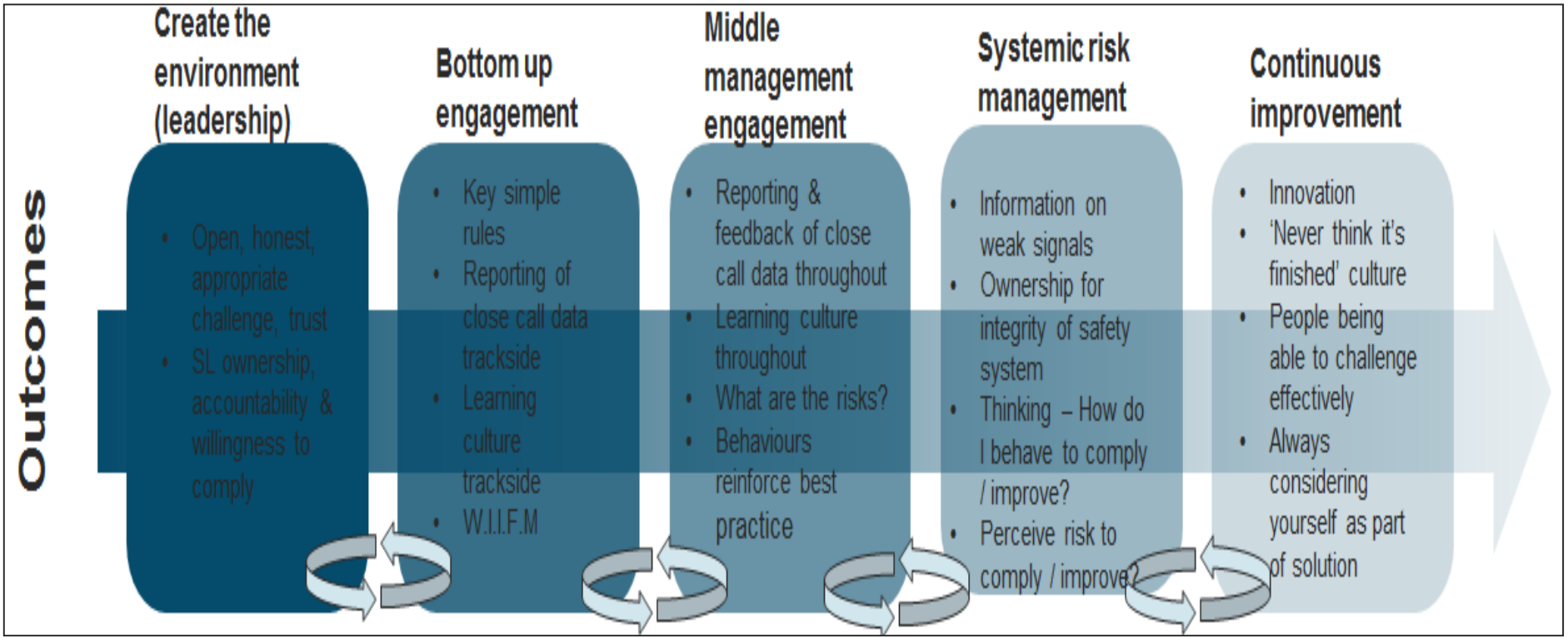
Developing safety culture in Network Rail

Lynn Chamberlain-Clark

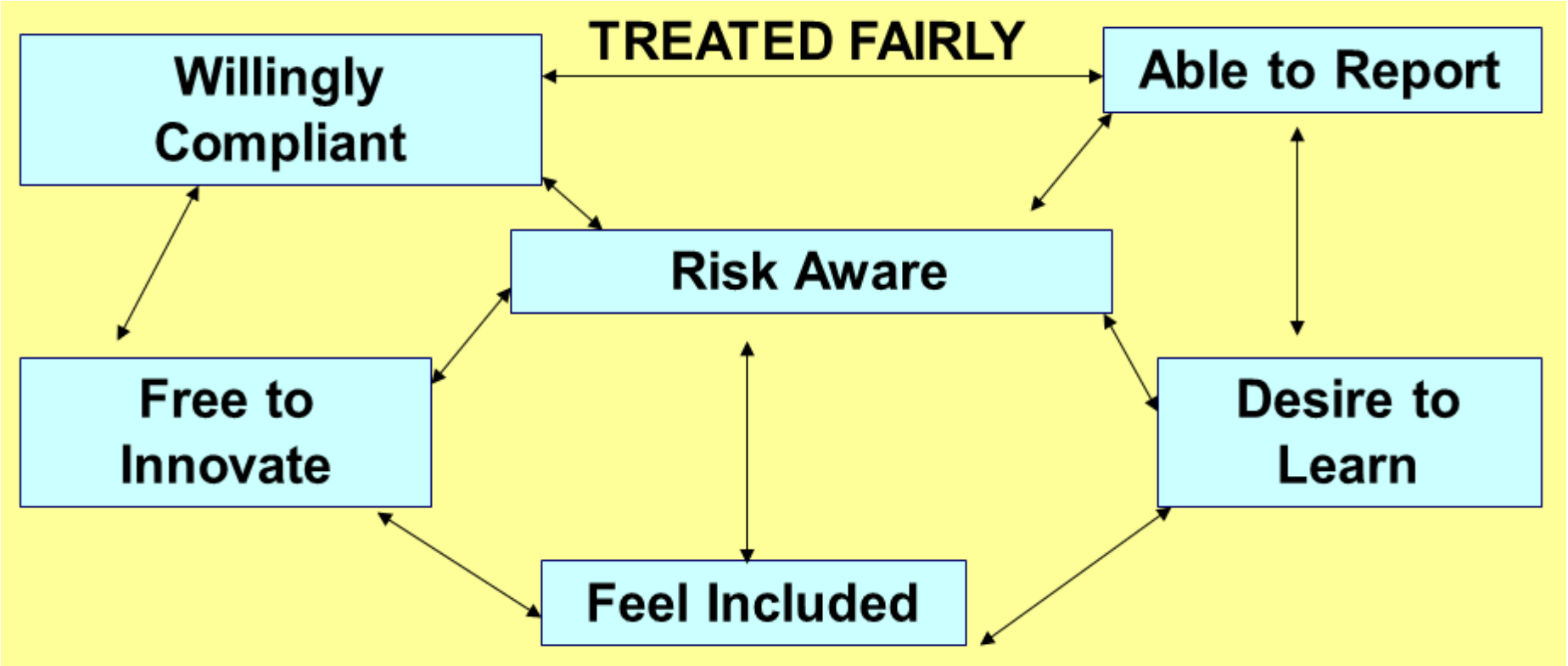
Principal health and Safety Change Specialist,

Network Rail, UK

The solution- designing a safety culture in NR



The solution: Building the skills



Creating the environment-vision and Leadership

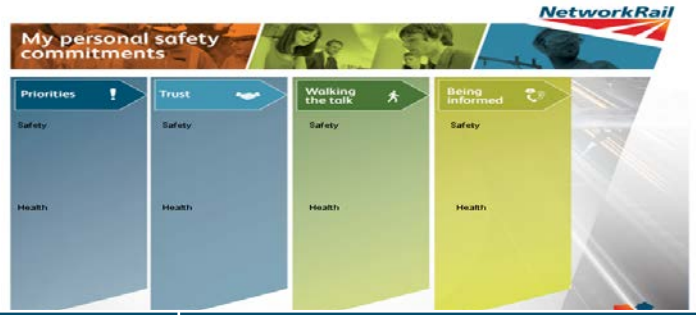
everyone home safe every day

Safety Vision

Safety commitment

Safety engagement training

Safety leadership experiential learning



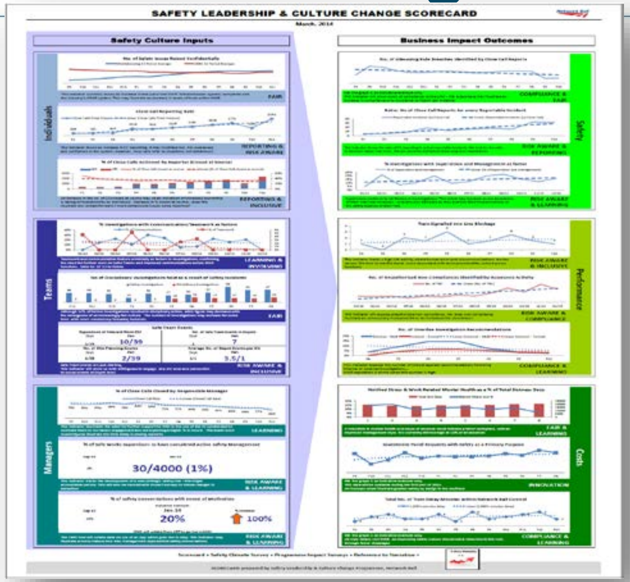
Verification	**To determine whether layers of protection are in place To check that they are effective To identify how they can be reinforced**
Education	**To learn about what is really happening To take the pulse of the organisation To understand the impact (unintended consequences) of leadership decisions**
	To show concern for individuals To promote safe behaviours (Lifesaving Rules) To inspire sustainable improvement

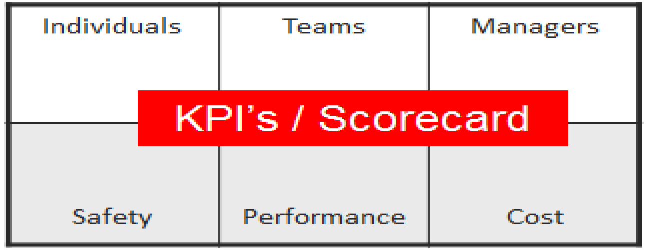
Building Trust for Safety

Creating the environment-measuring

Cultural Themes	1 Complaining *Why should we do anything?*	2 Reacting *We do something because others tell us to*	3 Directing *We need to get employees to follow the rules*	4 Devolving *Individuals take responsibility*	5 Involving *Everyone is involved in making this a safer place*
Compliant Culture	Any rules are a hindrance to be resisted or secretly ignored Blame culture; reporting safety issues creates problems; that wouldn't work here – it's the railway	Reactive, technical or procedural solutions in compliance with regulations Got to do it 'cos regulator says so; we don't have our own safety agenda	Simple rules, programmes & communications that all understand Develop competence & set own strategy beyond compliance	Safety rules & behavioural change gain widespread acceptance & promotion Staff empowered to make risk based decisions to comply with the rules	Everyone is committed first & foremost, to keeping the LSRs, encouraging and challenging fellow workers to do the same
Reporting Culture	Unspoken agreement at all levels of business that accidents & incidents are kept secret Nobody listens to us; them vs us mentality	Details of accidents and incidents are only revealed or reported when demanded or extreme cases We do as we are told to do	Improved systems for reporting are in place but still not widely used – employees cynical about fairness Some start of an understanding of the rules – making links between culture and safety	Increased reporting of Close Calls thro promotion locally by managers who ensure anonymity & feedback Starting to see and understand how my actions & behaviours affect others	We actively identify & report hazards, unsafe conditions & acts, close calls & assets of concern, without fear of retribution
Fair Culture	Accusation & punishment is rife. Employees are in fear of being 'found out' with automatic blame & dismissal the result Don't feel valued. "It's not fair", nothing in it for me. A fear and blame culture	An appearance of fairness which is largely rhetoric, with unofficial punishment & falling 'out of favour' Not trusted [illegible] 'common se[illegible] culture still [illegible]	Investigators / designated persons are re-trained in fair culture approaches, prominent comms about shift in culture [illegible]	Managers role model a fair approach to incidents & accidents. Widely recognized that there are multiple causes [illegible] embedded. Fair Culture [illegible]ked about so much; Wide [illegible]ing of unsafe acts	Everyone is trusted to work responsibly within clear, simple boundaries; where the consequences of being unsafe are clear & free of automatic blame
Risk Aware Culture	Safety is not seen as a key business risk. Danger 'comes with the territory' Why bother – nothing changes; we've always done it this way; our way works for us; someone else's problem	Senior/ mid[illegible] involved in s[illegible] incr. & they are 'held to account'. Safety messages are one-way, mostly warnings Rely on the rules to cover back Break rules to get the job done	[illegible] Frontline staff given permission to speak up but productivity is still effectively the top priority More engagement and incr. learning	[illegible] conversations about risk [illegible]rt of daily work life at all levels. Staff ideas more listened to & used Dynamic Risk Assessments occur; people question and challenge in active dialogue	We are aware of the risks we face, encouraging open discussions to identify ways of reducing risks; where looking after colleagues is part of great teamwork
Learning Culture	Accidents are seen as unavoidable so few lessons learnt I have nothing more to learn. Complacent - got away with unsafe practices in past: judge others after safety incidents!	Incident investigation is incident -specific so lessons not transferred. Responsibility for my learning sits elsewhere – any failure is someone else's fault. I rely on experts to tell me what to do	Reports & recommendations published after incidents but only serve to add /amend rules Lots of rules and targeted safety programmes enable role based learning and some sharing of learning	Senior managers buy-in to culture change - un-learning and questioning of assumptions More proactive; share & embed new learning in processes; coaching conversations at all levels	We provide and seek feedback in constructive conversations about safety, learning from mistakes & making changes to our business to stop repeat incidents
Inclusive Culture	Responsibility for H&S lies with 'them'. Frontline staff have their own informal safety agreements "Every man for himself". Lack of understanding of risks. Child to child or parent to child relationships	Managers at all levels are told to address safety, esp. after major incidents & go through a 'box-ticking' exercise Management vs staff. A 'tell' culture	Principally a 'tell' culture with opportunity to participate in surveys. Comms campaign encourages involvement Safety groups / committees develop to include culture theme	Frontline staff incr. involved in planning safety into work; management & T.U. reps work together. Less hierarchical; more 2 way dialogue / process	Everyone plays their role in delivering a safe environment, contributing ideas which are built into our safety vision & practice

We can estimate where we are NOW

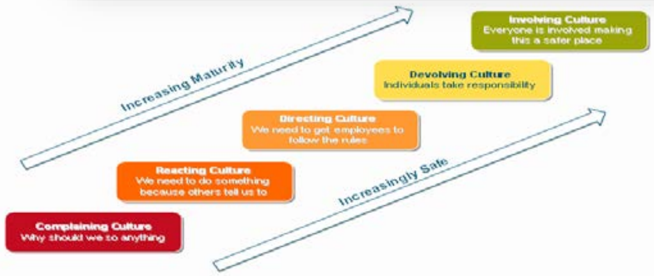




Behavioural Narrative

Balanced scorecard

Leading KPIs



Bottom-up engagement- talking about safety

Bottom up engagement- willing compliance

Working responsibly

- Always be sure the required plans and permits are in place, before you start a job or go on or near the line.
- Always use equipment that is fit for its intended purpose.
- Never undertake any job unless you have been trained and assessed as competent.
- Never work or drive while under the influence of drugs or alcohol.

Driving

- Never use a hand-held or hands-free phone, or programme any other mobile device, while driving.
- Always obey the speed limit and wear a seat belt.

Working with electricity

- Always test before applying earths or straps.
- Never assume equipment is isolated – always test before touch.

Working at height

- Always use a safety harness when working at height, unless other protection is in place.

Working with moving equipment

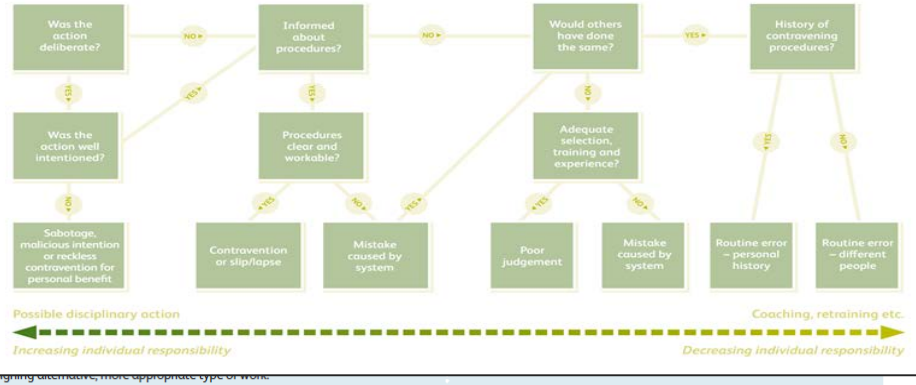
- Never enter the agreed exclusion zone, unless directed to by the person in charge.

Simplifying rules -10 Life saving rules

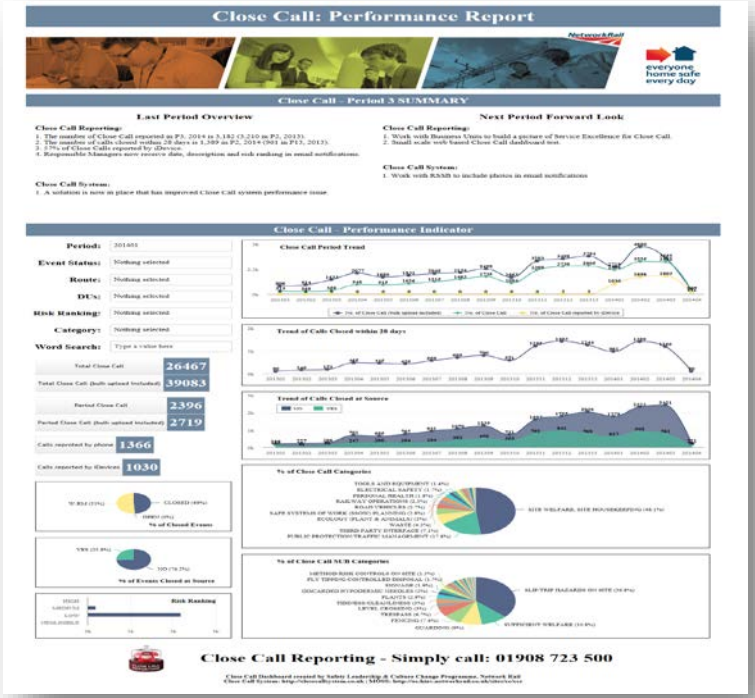
A fair process for any breaches

			Action relating to manager of individual/s
different people	It has become the accepted way of working.		
Mistake caused by system	The mistake was the result of inadequate information, training or support. Workload and equipment factors may also have contributed to this error.		
Contravention	The person committing the violation thought it was better for the company to do it that way or considered the job couldn't be done if the procedures were followed. The violation was committed to improve performance or to please the supervisor.		Coaching conversation on how to manage Rule-breaking. If this type of violation has occurred before, a formal discussion must be held to explain the implications of condoning a violation or not taking action, and to set the required performance standard. As part of such a discussion, the reason for condoning unacceptable behaviour must be investigated, which will
Routine error – personal history	It's not the first time that this type of error has been made by this person. Other people in similar situations do not make this error.		
Poor judgement	The person demonstrates poor risk awareness and/or understanding of the impact their actions have.	Assessment of fitness to work (abilities and suitability for this type of job). If appropriate, competence development and coaching. If not, consider assigning alternative, more appropriate type of work.	Coaching on fitness to work.
Slips and lapses	Actions did not proceed as planned, e.g. something was done the wrong way, done twice or a step was forgotten.	Coaching conversation on how to spot, report and prevent errors.	Coaching conversation on how to manage errors. Identify alternative work methods that make better use of reminders, checklists and other job aids.

This chart shows how we assess any rule breaks, establish why those rules were broken and respond fairly.



Middle management engagement- responsibility



Everyone part of analysing and improving safety – visualisation boards

Close call

Bow-ties

Middle managers- knowing their staff

Safety hour

Time to talk

Taking ownership

Identifying solutions

home safe plan

everyone home safe every day

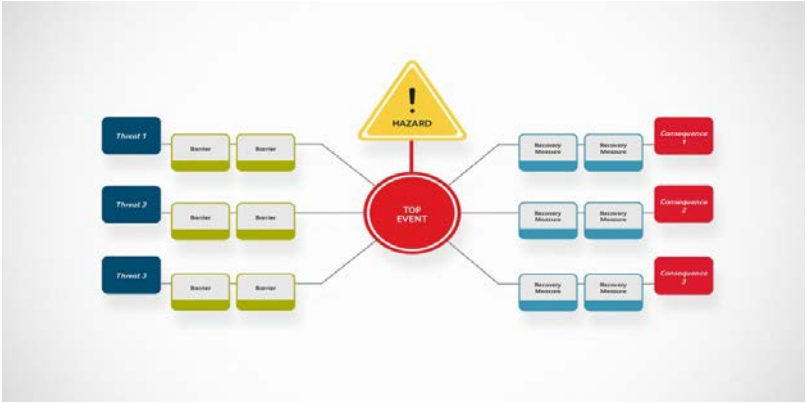
Opportunity

Systemic risk- the early barriers

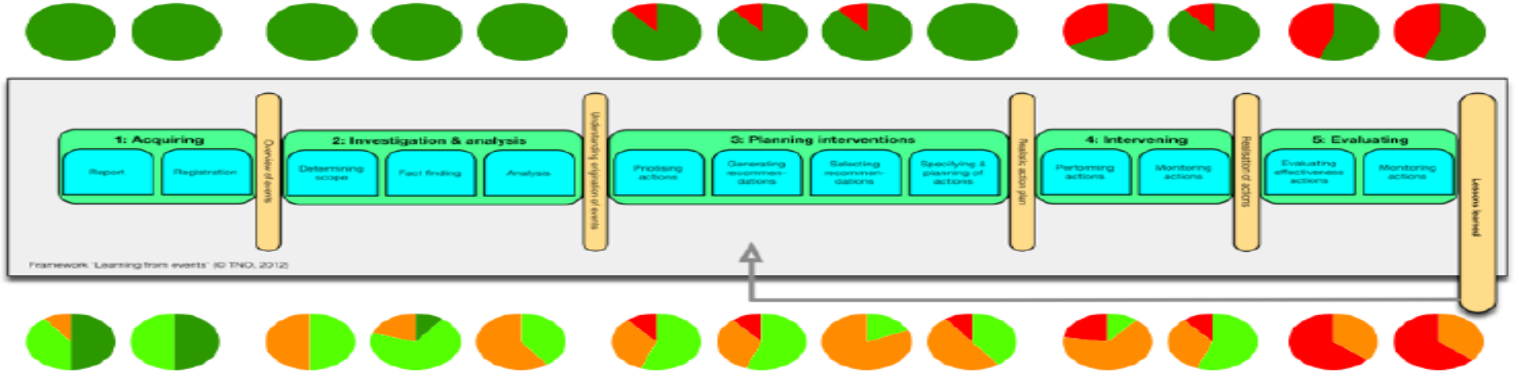
All stages of the process included in bow-ties and the people who work in these stages

Bespoke interventions help office based staff understand how their decision affect safety

Front-line sessions as part of competencies and awareness



Systemic risk- Learning from incidents



Safety Bulletin

A serious incident has taken place

everyone home safe every day

Smouldering head torch

Issued to: **All Network Rail line managers, safety professionals and Achilles registered contractors**

Ref: NRB 17/02

Date of issue: 23/02/2017

Location: IMDM Motherwell area, Scotland Route

Contact: Simon Constable, Head of Route Safety, Health & Environment, Scotland

Safety Advice

Action required following a serious incident

everyone home safe every day

Immediate quarantine of Manitou 160 ATJ Plus and 160 ATJ Plus RC based MEWPs

Issued to: All Network Rail line managers, safety professionals and RISQS registered contractors

Ref: NRA 17/01 Update 1

Date of issue: 08/03/2017

Location: Cowlairs, Scotland

Contact: Oluferni Okeya, Principle Engineer

Overview

At approximately 01:35 on 3 March 2017 a Rail Product ART 17 TH MEWP accessed at Cowlairs Road Rail Access Point to carry out Overhead Line Equipment installations as part of the Edinburgh to Glasgow Improvement Programme (EGIP).

Those specifically identified are:

- Rail Products UK/Manitou ART17T
- Rail Products UK/Manitou ART17T(H)
- Nedtec SkyRaller 400RR

Review of impact of learning

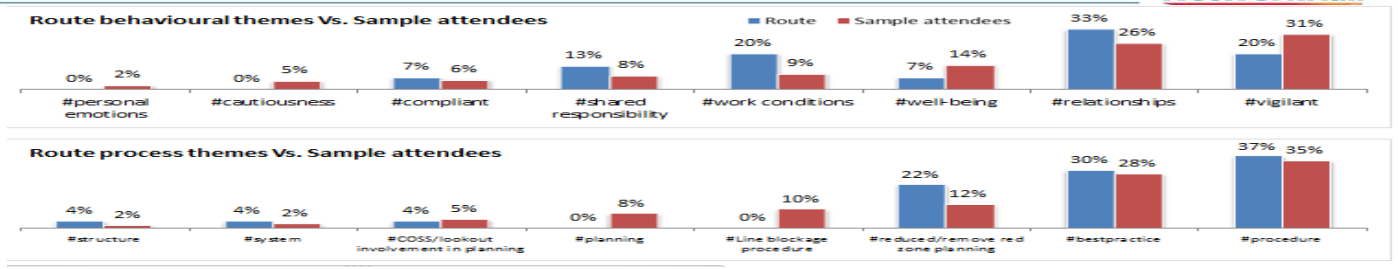
Quicker information

Open questions- create ownership of behavioural change

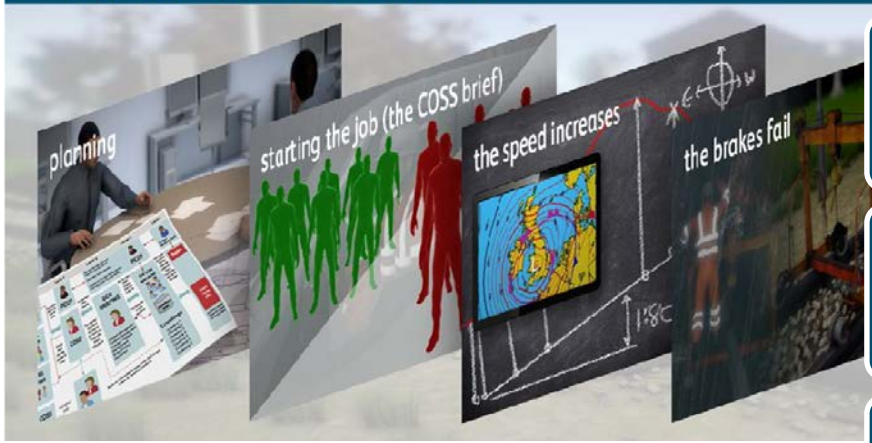
Continuous improvement – double loop learning

Learning:

- includes all staff
- is emotive
- Leads to personal commitments that are reviewed



Exploring the barriers



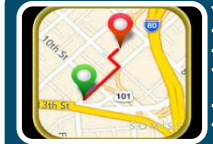
Vehicles

- Use of in car technology – fatigue camera's etc.
- What safety specification do we use when selecting vehicles?
- Comfort of users – Air conditioning, adjustable seats
- Vehicle familiarisation can be an issue when using hire cars and changing between vehicles
- Competence / experience of driving larger vehicles such as transit vans

Fatigue

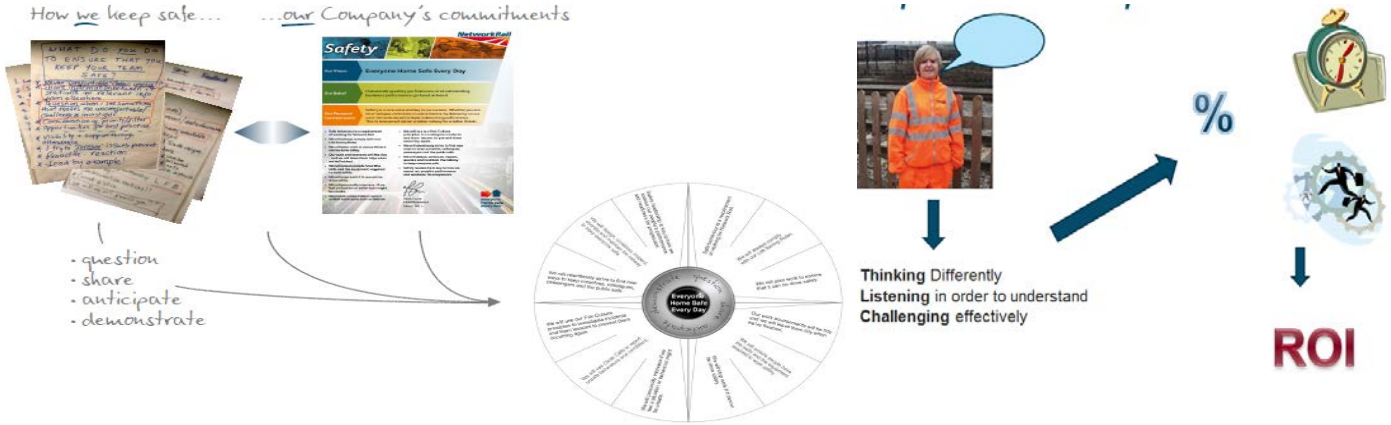
- Traveling distances required especially night shifts
- Consider the use of designated drivers
- Positioning of staff / depots v's work locations
- 12 hour shifts can increase fatigue, particularly night shifts
- Vacancy gap resulting in overtime and increased fatigue

Journeys



- People are required to travel long distances to and from work sites
- The use of journey planning should be considered
- Could we use technology to reduce the number of journeys undertaken such as video conferencing?
- Meeting locations should take into consideration travel distances for attendee's
- Network Rail should set driving time limits and break guidelines for drivers

Continuous improvement-ownership



LSR

11 → 10

Creating and understanding of need, expectations and outcomes for Behavioural change

Improving based on learning and feedback

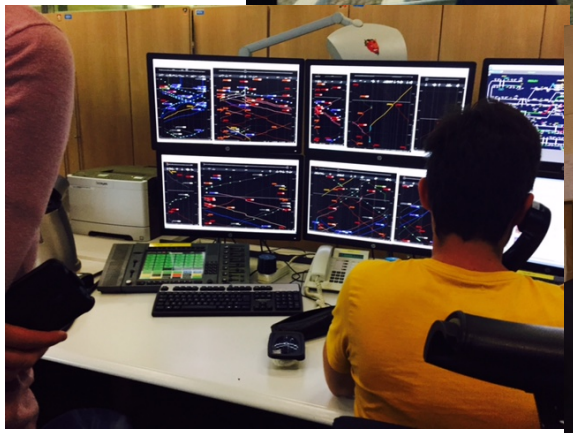
Number → Closure → Feedback

European Twinning

Challenges of national and organisational safety culture

KPIs – predictive learning seems more reliable in measuring safety culture

Ways of working with NSAs affects safety focus- how do they improve safety culture?



Any questions?