

Restoring frontline safety ownership

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SUMMARY

With a long and proud history of railway development, like many countries Britain has learned lessons in railway safety the hard way, progressively amending the Rule Book and standards regime in response to each serious accident. We think of the obvious like the requirement for automatic continuous braking after the 1889 disaster at Armagh in which 80 people died. But after nearly every event, we tinker with the rules, the processes or the competence arrangements. Almost always, that adds an extra layer of 'Swiss cheese' following Jim Reason's analogy. Rarely do we strip any out or stand back from the detail to take stock of the whole control framework.

The more we add to the rules, the more complex they become. Yet despite being comprehensive, how often have we heard: "it was perfectly safe if properly used"; how often have investigations found that the rules weren't followed? So more recently we've recognised that the more complex rules become, the less we can expect staff to understand and reliably follow them. And worse, where people do become habituated to following the rules, the more they're spoon-fed and the less they think for themselves to do what's right in a particular situation. And working safely can become a burden, done because the rules say so, not because of sound safety judgements on site.

I argue that the most effective risk management is achieved by competent people making sensible risk-based decisions in the right safety culture. But our system had become paper-heavy, disconnected from practical site decisions and impossible to fit every local circumstance. We recognised that standards cross-referenced each other in a complex web.

Introduction

In 2012, Network Rail set about a fundamental change to how we manage safety. One step was to move our safety leadership from a 'compliance' mindset, where we reached *towards* compliance and accepted bad things if they fell outside the boundaries of ensuring safety 'so far as is reasonably practicable'. In place, we created a team focused on safety as an integral part of sustainability, with a clear vision that everyone should go home safe every day. That's not most people, most days, but sustainable and consistent safety. Our strategy to transform safety is clear: we intend to eliminate fatalities and major injuries. And as part of tackling the precursors, we are also aiming to eliminate repeat-cause events.

Our strategy is underpinned by two critical enablers which recognised:

- we needed simplified rules that more clearly identify fewer absolute requirements, and to help competent people take risk-based decisions throughout their working day; and
- it is how people think and behave that will enable us to achieve our vision. We therefore committed to achieve a significantly improved safety culture.

Simplifying the rules

So, as one part of Network Rail's move to transform safety, we have taken a radical look at our standards regime. We had around 1000 company standards and three times as many non-compliances to those standards. By combining technical specifications with processes, competence and guidance all in one place, standards had grown to become more than most people could reliably recall and follow. And people took false comfort from obtaining a Temporary Non Compliance rather than actively owning risk controls. Our

centrist style had frozen risk controls in a regime that stifled innovation and currency. It no longer fitted a business becoming more devolved to Routes and other operational units.

Alongside the standards regime, our approach to checking employee competence had grown into a behemoth of some 500,000 individual competency tests every year. Too much focus was on ticking the boxes rather than really assessing competence in a risk-based context. And in turn the effect on parts of the external training sector targeting contractor staff competence drove opportunism and shortcuts with a disproportionate focus on achieving a ticket rather than truly assessing competence.

The standards regime was identified as a 'black swan' - a risk factor we didn't really understand, rather like those in the financial sector before the 2008 meltdown. We had become used to the 'railway way' of command and control through rules and standards, and lost some perspective of whether the control framework as a whole was effective. In my former role, I was too used to seeing a focus on standards to the exclusion of what legislation required, and little recognition that a blinkered approach solely on standards compliance would be disproportionate in some circumstances and insufficient in others. With increasing challenge to financial efficiency, blanket standards were recognised as a potential cost burden too.

Risk-based controls

We recognised the need to learn from elsewhere so explored risk management in over 20 organisations in industries such as oil, gas, aviation, mining and more. We found consistent themes that many of those others shared, but which were not so evident in our own arrangements:

- a sophisticated and systematic understanding of risk;
- a system of controls informed by that understanding;
- day-to-day decisions shaped by that understanding; and
- role-based guidance and training given to people taking those decisions

We settled on using the 'Bowtie' analytical technique, widely used in the petrochemical sector, to review our entire risk control framework. The analysis has enabled us to identify the most significant threats impacting safety, whether for safe infrastructure, operations or workforce activity. We have been able to recognise the most reliable risk controls, those which add little or no benefit and gaps where new controls were appropriate. Bowties more clearly distinguish between the controls that prevent loss events and those which mitigate the consequences, and helped achieve our broad strategic objective of managing risk through higher integrity controls.



Business Critical Rules and clear competence expectations

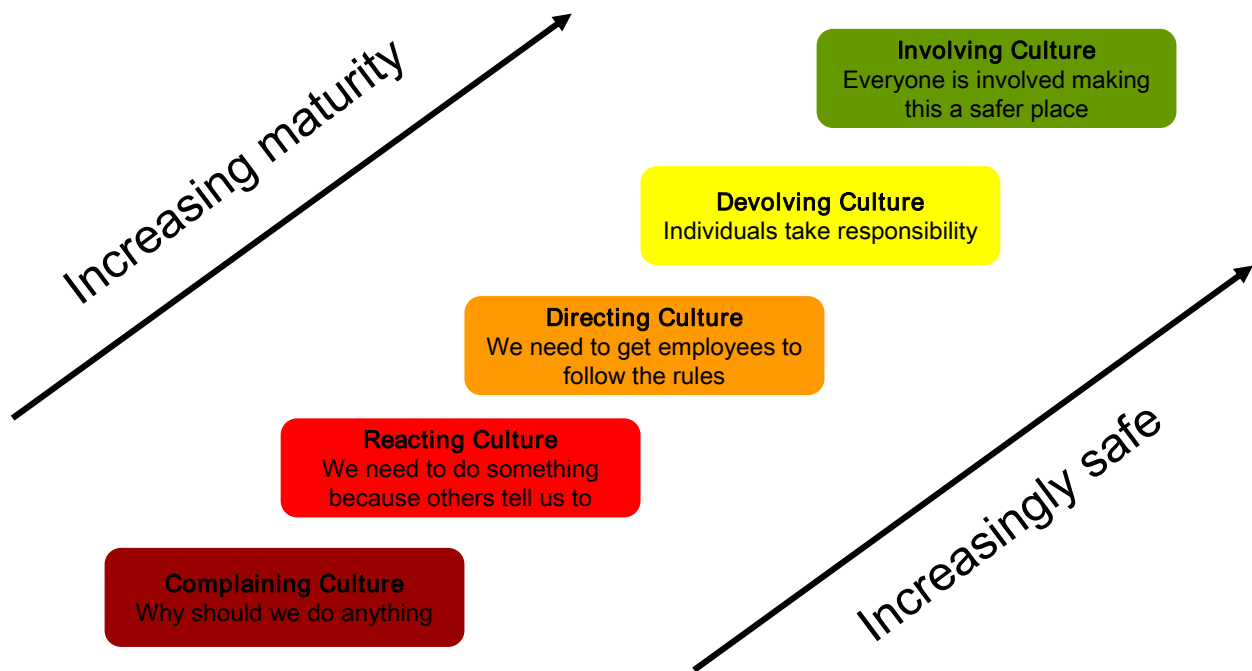
Our Bowtie analysis has enabled us to distil hundreds of 'standards' into a straightforward set of around 120 Business Critical Rules. Now we better understand what controls are business critical, we are developing clear role-based manuals and expectations for the skills and competence needed. And so the people in those roles have a fighting chance of knowing what's expected of them, what is critical to achieve and what has some latitude, and they are more properly accountable for decisions about safety.

Role based manuals provide a single place for a job holder to understand what they must do and guidance about the decisions for which they are accountable.

Maturing our safety culture

But that transformation cannot happen in a vacuum. It simply won't work to take away the comfort of a blanket of standards – being told what to do in every circumstance – and try to apply the new accountabilities in a management command culture where our workers still expect we will blame the little guy whenever something bad happens.

Our strategy describes a series of stages in culture change as we move from a complaining environment where people 'do' safety because they're told to, and without engagement or commitment on their part, towards an involving culture where everyone is part of the solution.



Lifesaving Rules

Once again, having looked outside the company and our industry, and drawing lessons from the oil industry particularly, we have distilled hundreds of clauses across dozens of standards into just 11 Lifesaving Rules. Rules that would have prevented almost all our workforce deaths and life changing injuries over the past 12 years. They are clear, succinct and apply to everyone.

The Lifesaving Rules

- Contact with trains**
Always have a valid safe system of work in place before going on or near the line.
- Working with moving equipment**
Never enter the agreed exclusion zone, unless directed to by the person in charge.
- Working with electricity**
Always have a valid permit to work where required.
- Always test before applying earths.**
- Never assume equipment is isolated – always test before touch.**
- Driving**
Always wear a seat belt while in a moving vehicle and always obey the speed limit.
- Never use a hand-held device or programme any hands-free device while you are driving a road vehicle.**
- Working at height**
Unless it is clear other protection is in place, never work at height without a safety harness.
- Taking responsibility**
Never undertake an activity unless you have been trained, assessed as competent and have the right equipment.
- Always use equipment for working at heights that is fit for purpose.**
- Never drive or work while under the influence of drugs or alcohol.**

Alongside those Lifesaving Rules, we have agreed with our Trades Unions principles for the consequences of breaching those rules. One of the unions has been particularly proactive, independently promoting the approach in a campaign about fair employment practice. Key to our culture shift, this framework examines the actions of the individual alongside their manager, their team and the local environment. Where someone deliberately flouts the rules, they can expect a harsh outcome. But where managers' actions or system failures are the real cause, the spotlight falls elsewhere. That is key to a fair culture. The chart at Annex 1 illustrates our decision tree for reaching a consistently fair conclusion to rule breaches

Safety conversations

Another critical part of our safety culture change programme has been to promote more effective safety conversations between managers and staff. Moving from a traditional command-style safety tour regime, commonly with a focus on finding unsafe conditions, conversations are now more often intended to be about conveying a message or listening to concerns and views from the frontline. By altering the emphasis, we are promoting engagement with those at the sharp end and demonstrating that everyone owns and needs to contribute to the culture change, including the senior manager doing the 'tour'. We've also helped those managers, whether in the frontline management chain or in a 'backroom' central function, to recognise their own part in achieving our vision.

Just as the White Star shipping group found to their peril in 1912, simply having posters indicating "Safety outweighing every other consideration" was no help for the Titanic when there was a transatlantic record to be won; so any claim that safety is a top priority must be demonstrated with deeds, not over-ridden by perceived or more stark messages about train punctuality ... implicitly encouraging safety shortcuts. Frontline staff need to believe they are *expected* to work safely at all times. That requires trust to be established. Our journey is as much about personal responsibility as it is about corporate action and if we are to ensure that everyone indeed goes home safe every day, then everyone has both a right and an obligation to be involved in achieving this vision.

Helping supervisors fulfil their role too

Our traditional focus for supervisor competence had again been on making sure they knew the rules, and very little on how to be an effective supervisor. We had been slow to develop supervisors' non-technical skills in, for example, communication, leadership and recognising risk-taking behaviour. We're putting that right with a training programme targeting up to 21,000 people who directly supervise trackworker safety – whether they work for us or our contractors. Helping those supervisors take better decisions, and giving them the skills and confidence to do the right thing for safety is critical.

Close calls

But it's not just the supervisors – everyone must take accountability for safety. Our strategy set out our objective to eliminate repeat-cause events. That requires action in relation to close calls just as much as serious events. So we have put huge effort into establishing close call reporting and investigation.

And again, where those close calls involve reports of Lifesaving Rule breaches, to apply the fair consequences model. So far, as we expected, a high proportion of the early close calls are about unsafe conditions – tactile inanimate things. We know we'll really have moved up the safety culture change steps when the balance shifts to reporting unsafe acts, and particularly people reporting when they recognise they did something wrong themselves. But most of all, those changes will signal that we have established the trust that is so fundamental.

Conclusion

Just as Akinori Yanagi so vividly illustrated at last year's conference when reporting on workers' actions after the 2011 Tsunami which devastated parts of the Japanese railway, having the most comprehensive manuals cannot provide all the answers. We absolutely need competent railway staff, trained and supported in an environment where they can take sensible risk-based decisions. With a clear vision and an ambitious safety strategy in place, Network Rail is changing the rules, roles and arrangements to up-skill and help frontline staff better protect themselves and their colleagues to achieve our vision of everyone going home safe, every day. And in so doing, we're helping restore frontline safety ownership.

Annex 1 – Our fair consequences model

