



# International Rail Safety Council

## Organisational culture and safety outcomes

**Lynn Chamberlain-Clark**

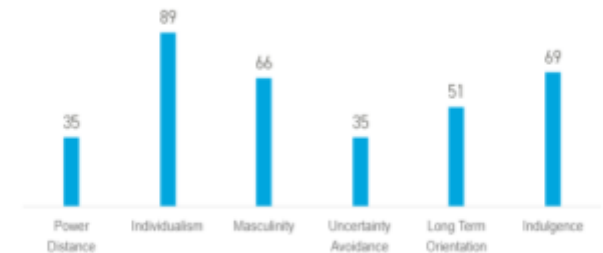
**Principal Health and Safety Change Specialist**

**Network Rail**

# External impacts on culture



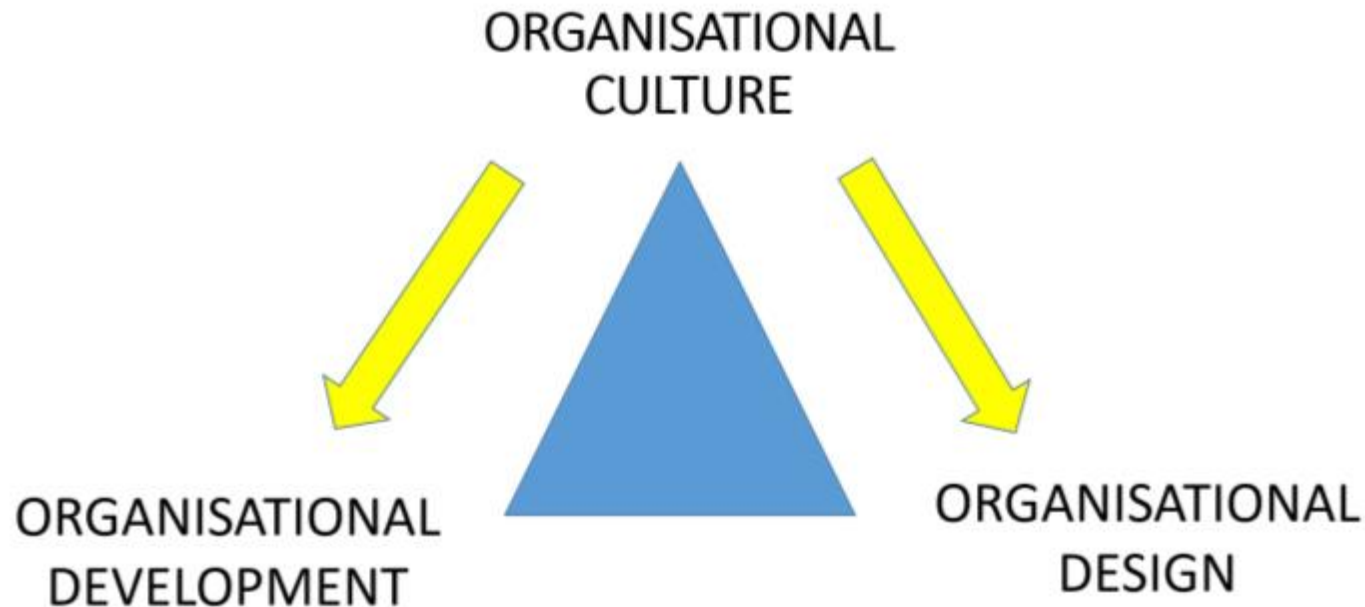
The safety culture of the organisation is affected by:  
National culture:



planning, collaboration, degree of risk taking and instant gratification- all of which can have a significant effect on safety

Organisational culture: see next slide

## *Internal factors affecting culture:*



**Organisational development:** Is a process of planned, systemic over-arching change designed to improve effectiveness. As such it includes interventions for processes, structure and culture.

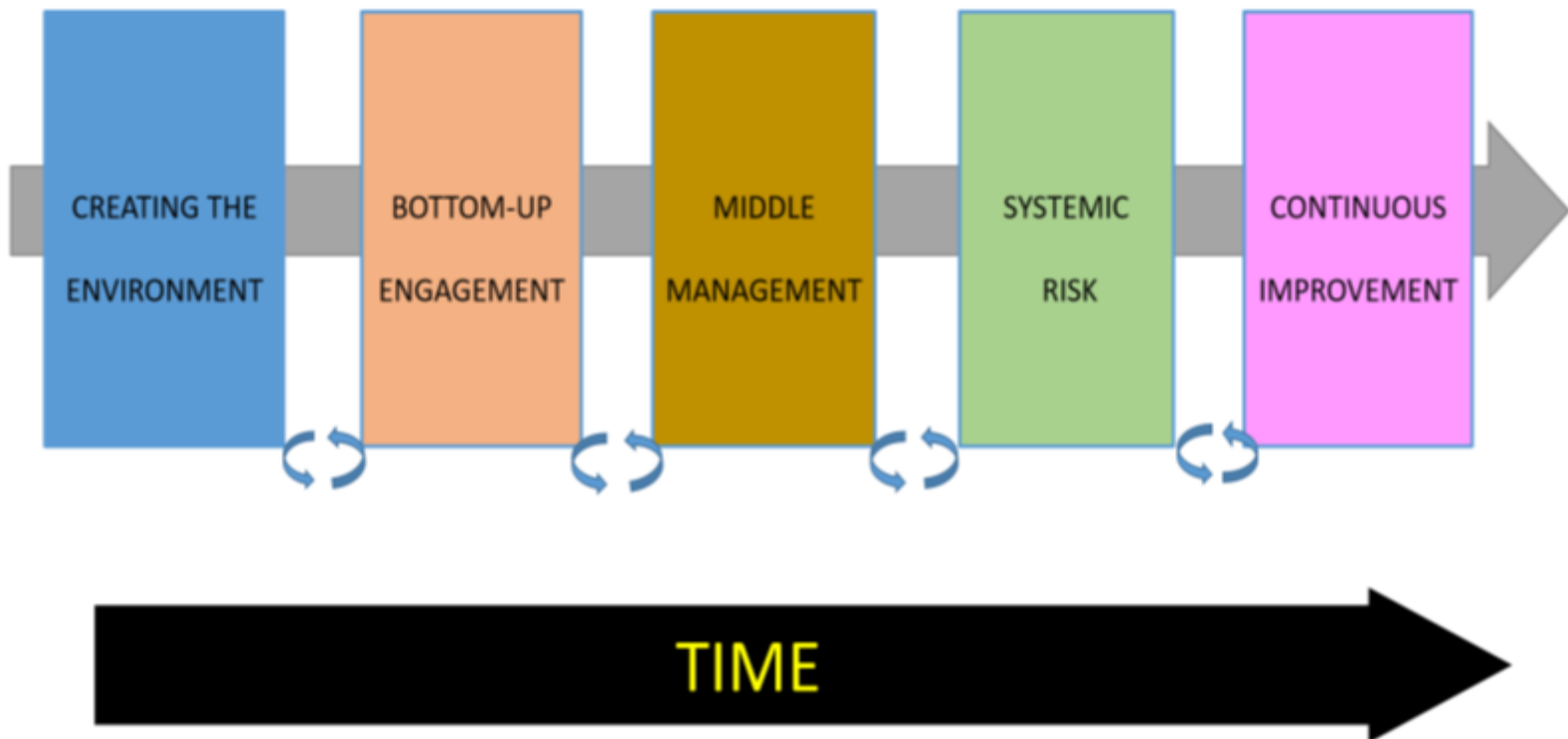
**Organisational Design:** Aligning the structure of the organisation with its objectives

## ***Creating a vision statement:***



**everyone  
home safe  
every day**

# Organisational Focus

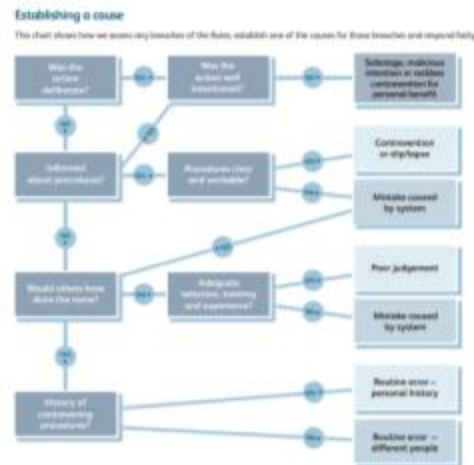


# Individual focus and change



# Changing 'safety culture'- leadership

Creating the environment



## Defining safety leadership behaviours

- How to deliver the vision
- Defining how to lead for fair culture
- Supporting up-skilling and monitoring effectiveness of safety conversations
- 360 degree feedback on safety leadership behaviours
- Your voice- greater engagement better safety



## ***Changing 'safety' culture - engagement***

## Bottom Up Engagement



Setting behavioural expectations through:

- Golden thread rules (Life-saving rules) linked to a fair culture process
- Engaging all staff with understanding risk-bowties
- Creating local behavioural agreements - safety lens
- Creating skills for speaking up-big picture
- Creating opportunity to improve safety - close call





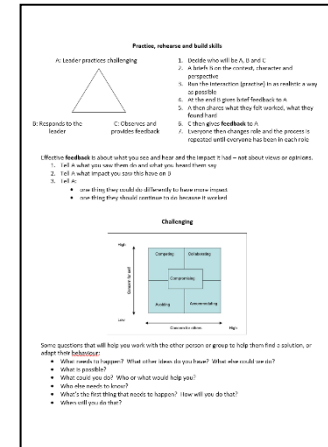
# Changing 'safety' culture - management



Think RISK



## Why have a Safety Hour?



## Developing management of safe behaviours

- Developing presentation and empowerment skills
- Developing listening, delegation and holding to account
- Creating stronger risk management and assurance
- Embedding behavioural evaluation into key development processes


# Interviews

# Performance reviews

# Changing 'safety culture - reinforcing all barriers

Systemic  
Risk






## Safety Advice

Action required following a serious incident

### Ironman lifting incident

Issued to: All users of Permapipe ironman equipment  
Ref: NRA 15/05  
Date of issue: 05/06/2015  
Location: Wakefield  
Contact: Kipley Cables, Rail Plant Support Engineer



Permapipe ironman equipment

### Overview

On 3 June 2015 an incident occurred during a lifting operation involving a Permapipe ironman. While lifting a 60ft length of rail a bolt in the pull lift sheared causing the rail to fall to the ground. An investigation has commenced to establish the root cause.

### Immediate action required

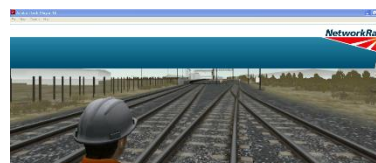
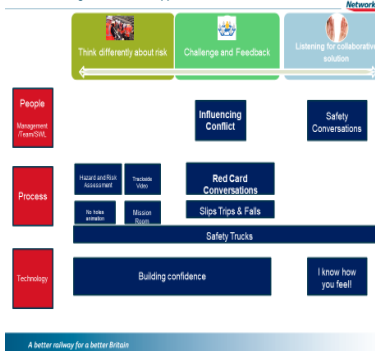
When using Permapipe ironman equipment to undertake a lifting operation, individuals must ensure they stand clear of the suspended load. Supervisors and managers of work involving ironman should make sure that all of their team know of the failure and understand why they must stand clear of the rail throughout its whole length. Further information will be published when the initial investigation has been concluded.

Part of our group of Safety Bulletins

**Safety Alert** **Safety Bulletin** **Safety Advice** **Shared Learning**



## SWL – Change Consultants Approach



**Newark Northgate Incident**  
Lookout struck by Train  
22nd January 2014

Please select the 'Home' button below to continue

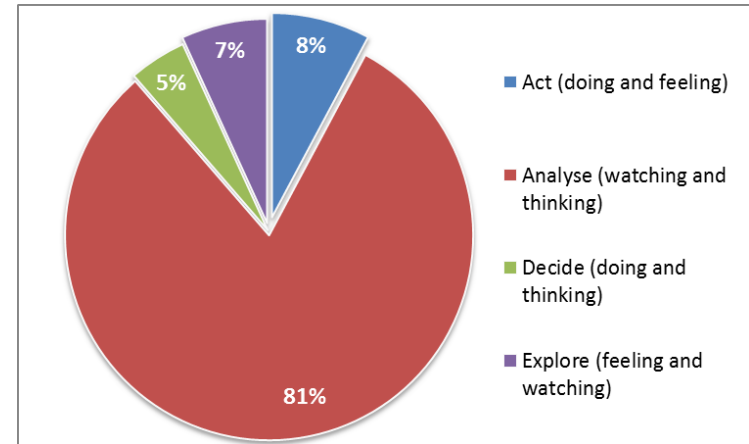
Creating risk management in all corporate decisions:

- Understanding responsibility for safety in all roles
- Using learning events to increase risk awareness
- Embedding safety behaviours in key safety programmes
- Sharing learning quickly and through robust active learning
- Weaving behaviours through all change programmes

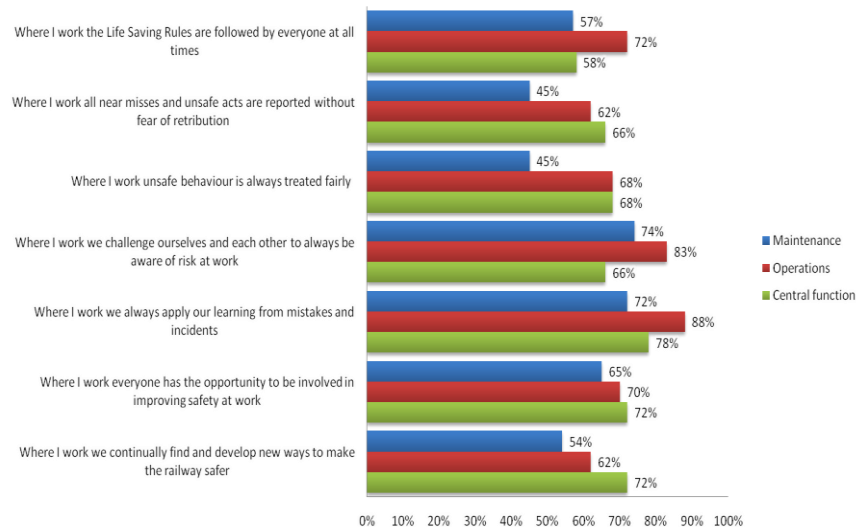
# Changing 'safety' culture- monitoring and driving improvement

Utilising learning events and measurement for improvement:

- Analysing whether full adult learning cycle complete and intervening if not
- Creating simple narrative measures to create ownership of change throughout business
- Tracking and monitoring against leading cultural change measures



## Continuous Improvement



Cultural Change	Exploring what we do to change	Deciding what we do to change	Acting on what we do to change	Measuring what we do to change
Act (doing and feeling)	8%	81%	5%	7%
Analyse (watching and thinking)	81%	8%	5%	7%
Decide (doing and thinking)	5%	81%	8%	7%
Explore (feeling and watching)	7%	81%	5%	8%