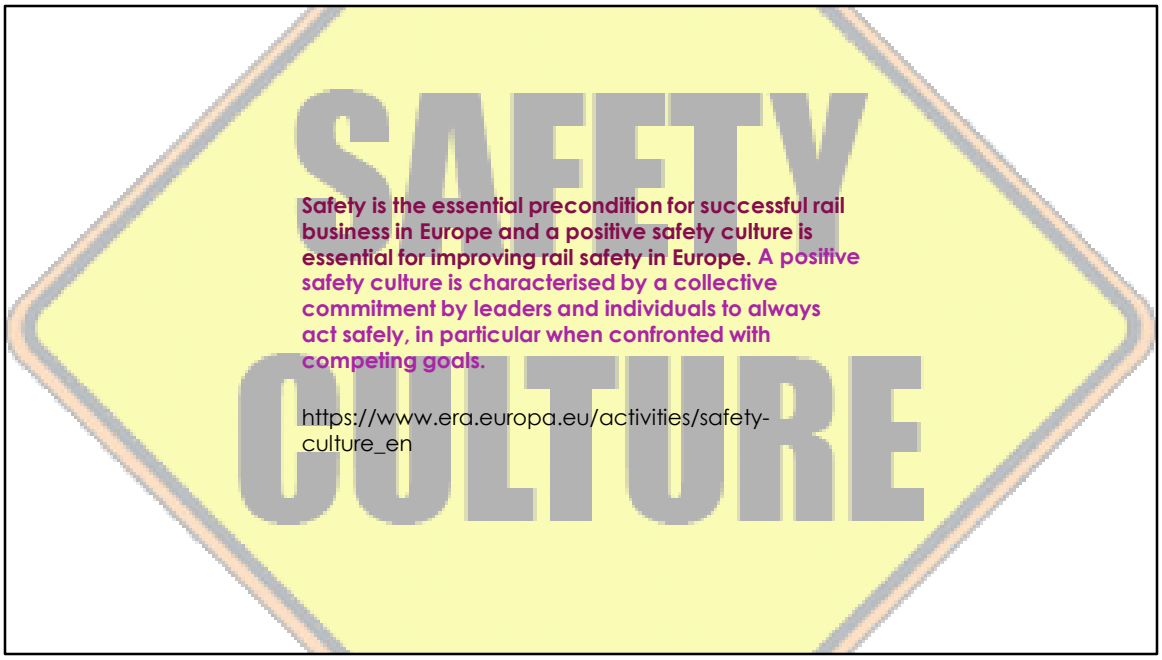
Introduction to who I am and who DNV are.
Correct the use of the term safety culture Vs safety climate and why
Tell the audience what your going to tell them
i.e., Background to the project – how it was conducted – results – lessons learned



Setting the scene.
We would all largely agree with the above statements. Yes?

There are 2 Common Safety Methods (CSMs), 1 for RU's and 1 for IMs
They contain numerous criteria covering risk management, communication, training and competence, change management etc.
They don't include anything on Human Factors or explicit on Culture
BUT
Commission Regulation 2018/762 establishing CSM's on safety management system requirements contains requirements on embedding HF within the org and promoting a positive safety culture.

CRR Supervision

Historically the CRR has

- Supervised the continued application & effectiveness of RU / IM SMSs
- Audited systems, inspected assets & procedures and met with company executives

However the CRR has started

- Questioning RUs/IMs following occurrences, e.g., when human error is considered the immediate cause or when occurrence are not reported (initially)
- Looking at workplaces and observing tasks from a physical and cognitive ergonomics perspective

Questioning RUs and IMs when….

- **E.g., SPADs, Over-speeds, etc.**
- **Do the organisations apportion blame ?**

Project background

- With revised CSMs coming the CRR wished to include some early supervision of HF and organisational / safety culture in its activities
- The CRR had as part of its annual plan a Strategic Management Audit planned on one railway organisation (RO)
- It was decided that this activity should be expanded to include a comparison against High Reliability Organisation characteristics
- The CRR wished to develop a clear understanding of the SMS maturity

CRR on the ERA Working Groups related to the revised CSMs) for Conformity Assessment & Supervision learned that HF and safety culture and would become key supervision activities for NSAs

Railways, by virtue of the risks inherent to their operations, can be readily classed as major hazard organisations.
Therefore, in the management of safety, they should embody the characteristics of high reliability organisations.
The CRR wished to develop an understanding of the SMS maturity that existed within the upper echelons of the ROs and how that may be influencing the comprehension, implementation, and development of competence and safety culture, both at a corporate and higher management level.

Part 1 - SMS Audit:

Criterion F

Distribution of Responsibilities

Criterion G

Securing Control by the Management on Different Levels

Criterion H

Involving Staff and Their Representatives on all Levels

Criterion I

Ensuring Continuous Improvement

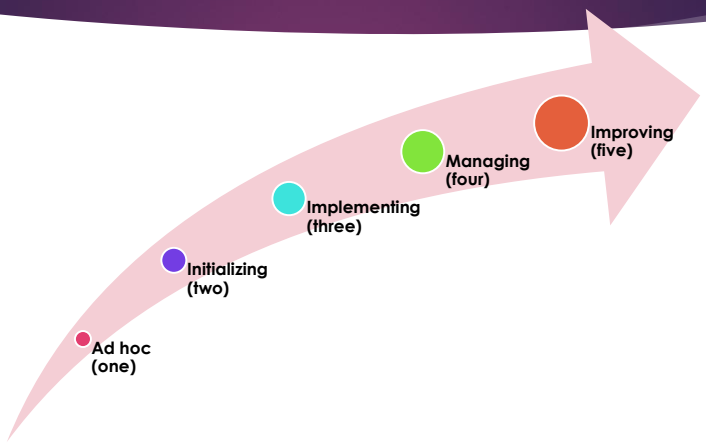
A number of outcomes were identified including:
Increased Use of Leading Indicators, e.g., training days and Strength of Process Indicators (how many compliance verification activities were undertaken Vs plan)
Define the vision for safety and align the SMS to support this. For example if the vision is for a 'learning organisation', or a 'Just Culture', how the SMS helps achieve such goals should be made clear.
Ensure the SMS leads rather than lags in terms of change management
Establish a minimum review cycle for SMS documents

Part 2 - HRO Comparison:

HRO traits

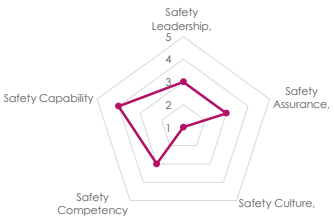
Strategic Safety Areas

CRR HRO Comparison – Maturity Scale:

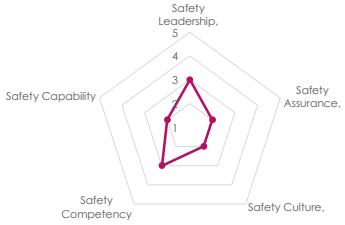


CRR HRO Comparison - Results:

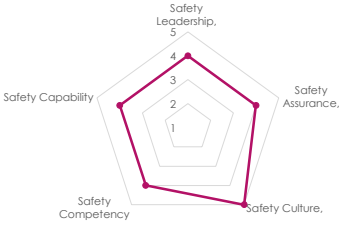
Company 1



Company 2



Company 3



Cant really compare the organisations given they are very different, large V small, old V young.
Only following the next study will we be able to compare / measure progress.

Areas in need of improvement

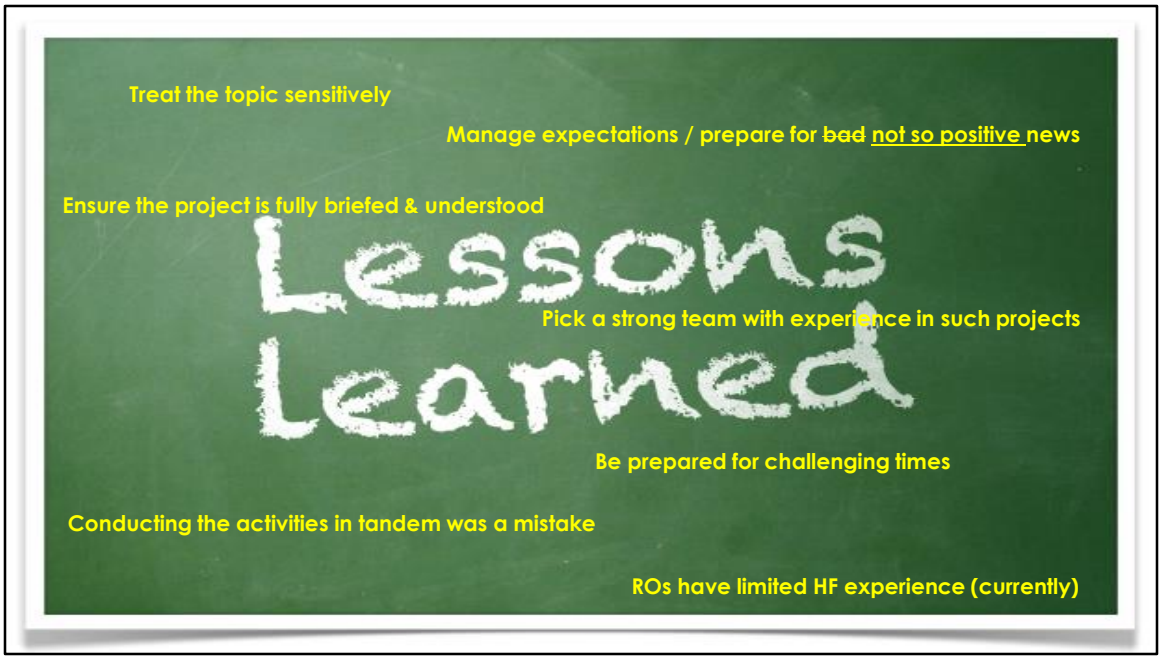
Railway Organisation's understanding of risk

A lack of employee involvement / consultation

An un-just culture in some ROs

Extending understanding and competence in HF

1. Capability & competence in understanding hazards & risk, Qual V Quant,
2. SMS is not fully understood / limited engagement when drafting the SMS
3. Pockets of blame culture still evident and a tendency to simplify
4. Building on initial steps in fatigue management, error management, workload assessment, HMI design, anthropometric assessment, etc.



Commenting on an organisations culture including safety culture are sensitive topics and should be approached cautiously.
Conduct many briefings with the audited/surveyed RO before, during and after the activity
Pick a good team with experience in such projects

Conclusions:

- ☹ There is still a tendency to simplify
- ☹ Attitudes towards blame
- 😐 Views of the executives Vs views of management
- ☺ Investment in learning has started
- ☺ Communication and dialogue is improving
- 😐 Changing culture is not easy and it must start from the top
- ☺ Repeat every safety certificate/authorisation life cycle, i.e., every 5 years mindful of Commission Regulation (EU) 2018/762

Organisational Culture is not easily changed and is not unique to the Railway Sector. Here in Ireland there have, in the past 12 months been two notable inquires. 1. into the Irish banking sectors following the collapse of our banking sector, IMF bailout and the societal impact this had on may people, and 2. more recently into our healthcare sector, wherein there was deliberate non-disclosure of medical information to women who had, unfortunately, developed cervical cancer owing to failings in a cervical screening programme.
a culture of cover-up

Thank you!

Go raibh maith agaibh!

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