INTERNATIONAL RAILWAY SAFETY COUNCIL 2022

IRSC Spain

# IRSC 2022

INTERNATIONAL RAILWAY
SAFETY COUNCIL

SEVILLA, OCTOBER 16-21, 2022

SNCF

EUROPEAN UNION AGENCY FOR RAILWAYS

AESF AGENCIA ESTATAL DE SEGURIDAD FERROVIARIA

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# Just & Fair Approach within the SNCF Group

## An example of Just Culture development

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# INDEX

# CHAPTER 1

## Background & Objective of the approach

# BACKGROUND & OBJECTIVE OF THE APPROACH

- 2015 : PRISME program launch.
  - Objective : Safety performance improvement
  - Observation : All situations impacting safety are not known due to a lack of spontaneous feedback from operational
- 2016 : Just & Fair approach launch with 2 objectives :
  - Create a climate of trust to encourage everyone to report safety problems and thus being able to fix them
  - Get **a better understanding of its system's strengths and weaknesses**

# CHAPTER 2
## Method

# METHOD

## Origins of the approach (2015-2021)

- Benchmark
- Creation of a working group
- Booklet elaboration
- Experimentation in 20 pilot entities
- Generalization throughout the group
- A Just & Fair Referents' network to rely on

## Recent changes (2021-2022)

- State of play (questionnaire and survey)
- Definition of an action plan
- Creation of a new working group
- Booklet review
- Test of the new booklet by operational staff
- Dissemination

# CHAPTER 3
## Results

# STATE OF PLAY'S RESULTS

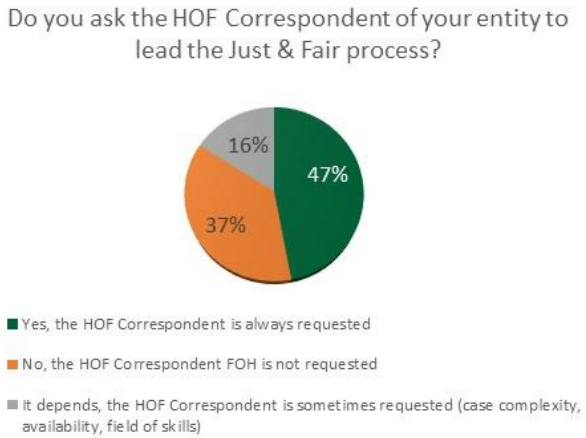
## POSITIVE FINDINGS

- The J&F approach is deployed in 89% of entities
- The booklet is almost always used (90% of respondents always use it)
- 79% of the respondents consider the approach effective to improve the global awareness of risks situations.

*" Thanks to the approach, we had spontaneous feedback from operators about events that might not have been seen otherwise"*

## AREAS FOR IMPROVEMENT

- The process is sometimes used incorrectly because :
  - the goal is not always understood
  - the HOF expert is not systematically involved.
- The actions decided are not enough organizational

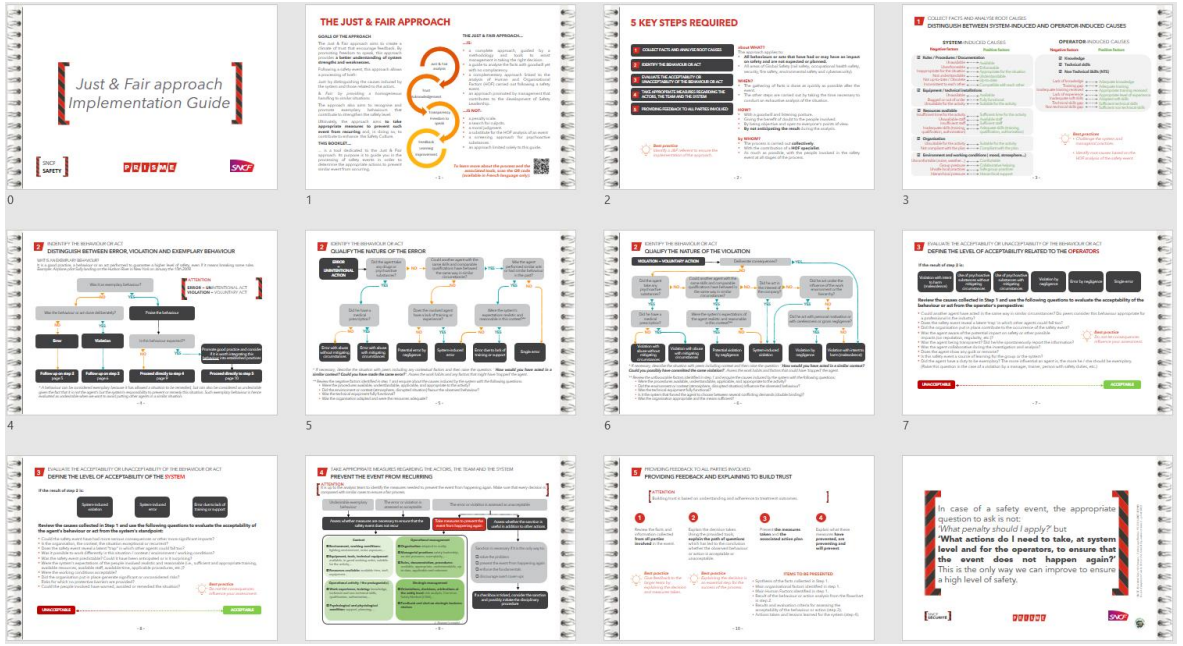



# ACTION PLAN

1. Remind the purpose of the approach i.e., having a better risk awareness.
2. Give some practical advice to apply the approach.
3. Reinforce organisational factors :
   - in the data collection and analysis
   - in the assessment of the behavior's acceptability regarding with the system
   - in the measures decided
4. Encourage the involvement of the HOF network.

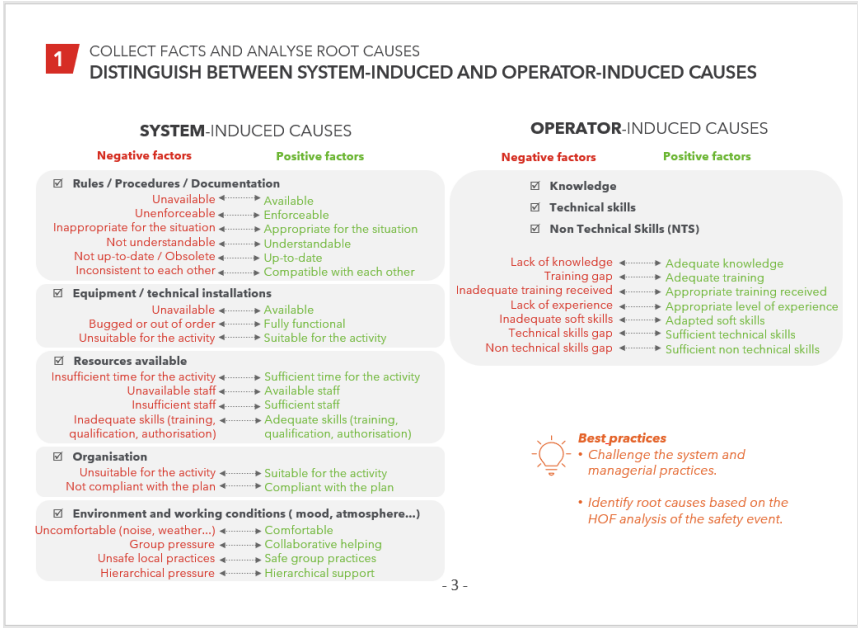
**+** Clarify and promote the exemplary behaviour's treatments.

**+** Expand the scope of the approach.




# THE JUST & FAIR APPROACH

1. COLLECT FACTS AND ANALYSE ROOT CAUSES
2. IDENTIFY THE BEHAVIOUR OR ACT
3. EVALUATE THE ACCEPTABILITY OR UNACCEPTABILITY OF THE BEHAVIOUR OR ACT
4. TAKE APPROPRIATE MEASURES REGARDING THE ACTORS, THE TEAM AND THE SYSTEM
5. PROVIDING FEEDBACK TO ALL PARTIES INVOLVED



1 COLLECT FACTS AND ANALYSE ROOT CAUSES
DISTINGUISH BETWEEN SYSTEM-INDUCED AND OPERATOR-INDUCED CAUSES

**SYSTEM**-INDUCED CAUSES

| Negative factors | Positive factors |
|---|---|
| ☑ **Rules / Procedures / Documentation** | |
| Unavailable | Available |
| Unenforceable | Enforceable |
| Inappropriate for the situation | Appropriate for the situation |
| Not understandable | Understandable |
| Not up-to-date / Obsolete | Up-to-date |
| Inconsistent to each other | Compatible with each other |
| ☑ **Equipment / technical installations** | |
| Unavailable | Available |
| Bugged or out of order | Fully functional |
| Unsuitable for the activity | Suitable for the activity |
| ☑ **Resources available** | |
| Insufficient time for the activity | Sufficient time for the activity |
| Unavailable staff | Available staff |
| Insufficient staff | Sufficient staff |
| Inadequate skills (training, qualification, authorisation) | Adequate skills (training, qualification, authorisation) |
| ☑ **Organisation** | |
| Unsuitable for the activity | Suitable for the activity |
| Not compliant with the plan | Compliant with the plan |
| ☑ **Environment and working conditions ( mood, atmosphere...)** | |
| Uncomfortable (noise, weather...) | Comfortable |
| Group pressure | Collaborative helping |
| Unsafe local practices | Safe group practices |
| Hierarchical pressure | Hierarchical support |

**OPERATOR**-INDUCED CAUSES

| Negative factors | Positive factors |
|---|---|
| ☑ **Knowledge** | |
| ☑ **Technical skills** | |
| ☑ **Non Technical Skills (NTS)** | |
| Lack of knowledge | Adequate knowledge |
| Training gap | Adequate training |
| Inadequate training received | Appropriate training received |
| Lack of experience | Appropriate level of experience |
| Inadequate soft skills | Adapted soft skills |
| Technical skills gap | Sufficient technical skills |
| Non technical skills gap | Sufficient non technical skills |

***Best practices***
- *Challenge the system and managerial practices.*
- *Identify root causes based on the HOF analysis of the safety event.*

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2 INDENTIFY THE BEHAVIOUR OR ACT
DISTINGUISH BETWEEN ERROR, VIOLATION AND EXEMPLARY BEHAVIOUR

WAT IS AN EXEMPLARY BEHAVIOUR?
It is a good practice, a behaviour or an act performed to guarantee a higher level of safety, even if it means breaking some rules.
*Example: Airplane pilot Sully landing on the Hudson River in New York on January the 15th 2009.*

Was it an exemplary behaviour?
NO → Was the behaviour or act done deliberately?
YES → Praise the behaviour
NO → Error → Follow up on step 2 page 5
YES → Violation → Follow up on step 2 page 6
Praise the behaviour → Is this behaviour expected?*
NO → Proceed directly to step 4 page 9
YES → Promote good practice and consider if it is worth integrating this behaviour into established practices → Proceed directly to step 5 page 10

ATTENTION
**ERROR = UN**INTENTIONAL ACT
**VIOLATION =** VOLUNTARY ACT

** A behaviour can be considered exemplary because it has allowed a situation to be remedied, but can also be considered as undesirable given the fact that it is not the agent's but the system's responsibility to prevent or remedy this situation. Such exemplary behaviour is hence evaluated as undesirable when we want to avoid putting other agents in a similar situation.*

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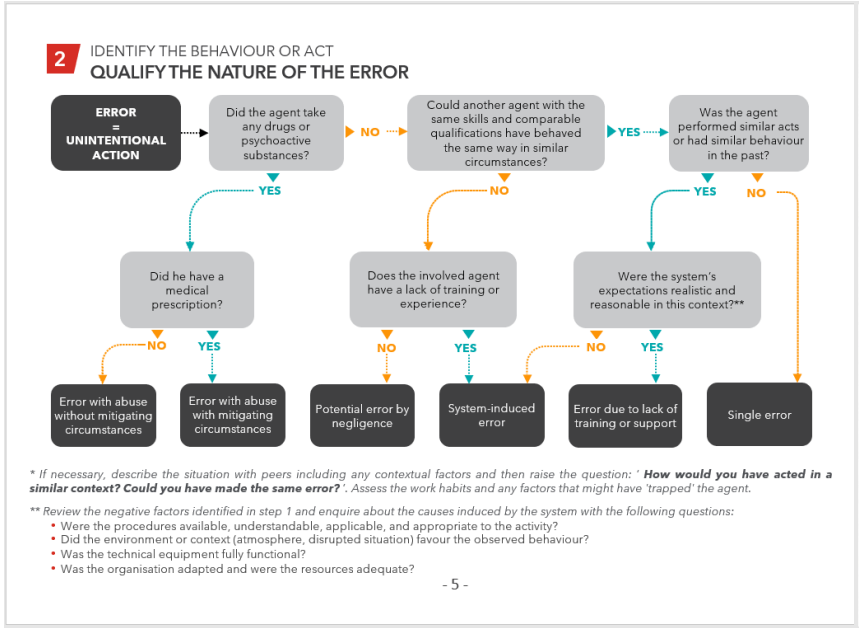


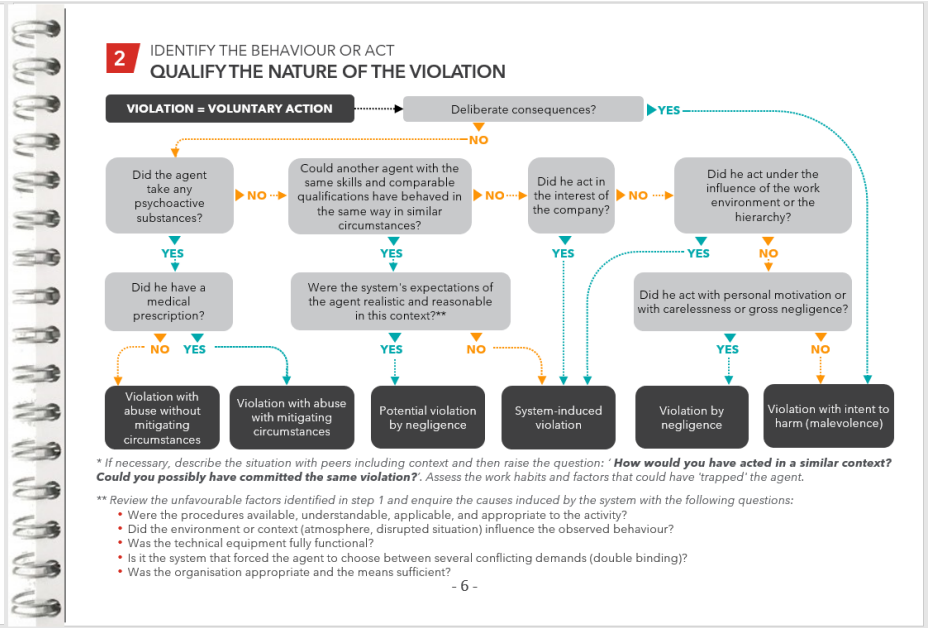

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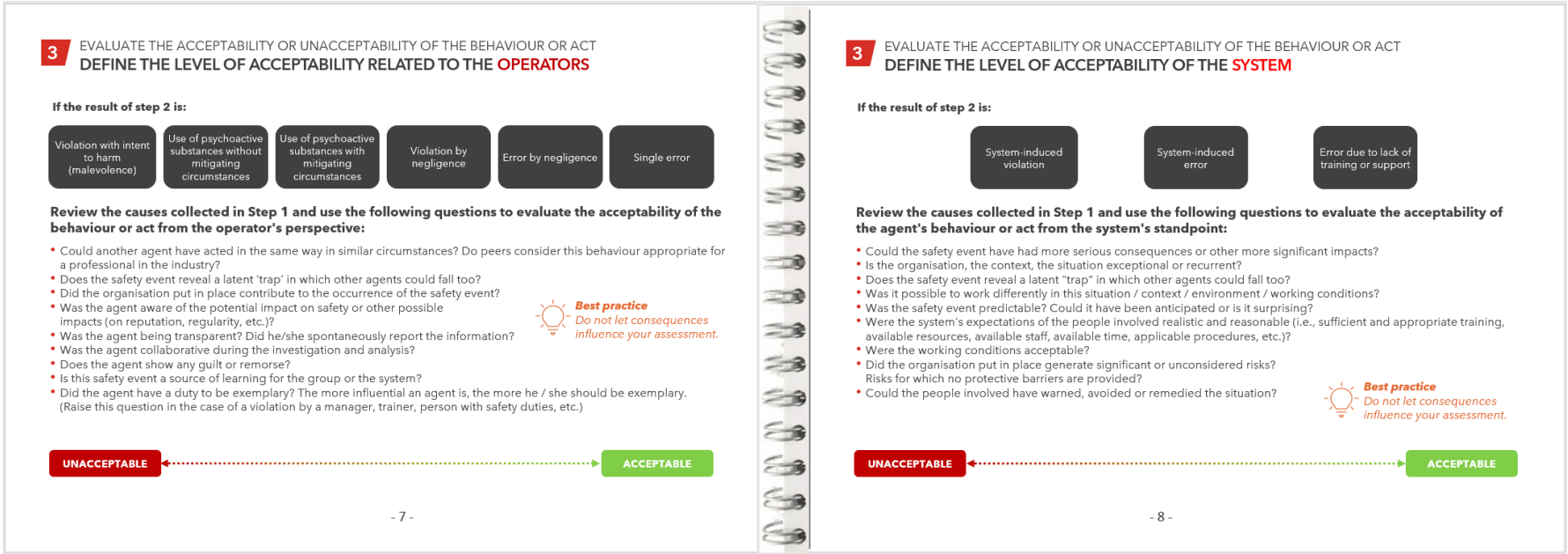

3 EVALUATE THE ACCEPTABILITY OR UNACCEPTABILITY OF THE BEHAVIOUR OR ACT
DEFINE THE LEVEL OF ACCEPTABILITY RELATED TO THE OPERATORS

**If the result of step 2 is:**

Violation with intent to harm (malevolence) | Use of psychoactive substances without mitigating circumstances | Use of psychoactive substances with mitigating circumstances | Violation by negligence | Error by negligence | Single error

**Review the causes collected in Step 1 and use the following questions to evaluate the acceptability of the behaviour or act from the operator's perspective:**

- Could another agent have acted in the same way in similar circumstances? Do peers consider this behaviour appropriate for a professional in the industry?
- Does the safety event reveal a latent 'trap' in which other agents could fall too?
- Did the organisation put in place contribute to the occurrence of the safety event?
- Was the agent aware of the potential impact on safety or other possible impacts (on reputation, regularity, etc.)?
- Was the agent being transparent? Did he/she spontaneously report the information?
- Was the agent collaborative during the investigation and analysis?
- Does the agent show any guilt or remorse?
- Is this safety event a source of learning for the group or the system?
- Did the agent have a duty to be exemplary? The more influential an agent is, the more he / she should be exemplary. (Raise this question in the case of a violation by a manager, trainer, person with safety duties, etc.)

***Best practice***
*Do not let consequences influence your assessment.*

UNACCEPTABLE ◄ ACCEPTABLE

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3 EVALUATE THE ACCEPTABILITY OR UNACCEPTABILITY OF THE BEHAVIOUR OR ACT
DEFINE THE LEVEL OF ACCEPTABILITY OF THE SYSTEM

**If the result of step 2 is:**

System-induced violation | System-induced error | Error due to lack of training or support

**Review the causes collected in Step 1 and use the following questions to evaluate the acceptability of the agent's behaviour or act from the system's standpoint:**

- Could the safety event have had more serious consequences or other more significant impacts?
- Is the organisation, the context, the situation exceptional or recurrent?
- Does the safety event reveal a latent "trap" in which other agents could fall too?
- Was it possible to work differently in this situation / context / environment / working conditions?
- Was the safety event predictable? Could it have been anticipated or is it surprising?
- Were the system's expectations of the people involved realistic and reasonable (i.e., sufficient and appropriate training, available resources, available staff, available time, applicable procedures, etc.)?
- Were the working conditions acceptable?
- Did the organisation put in place generate significant or unconsidered risks? Risks for which no protective barriers are provided?
- Could the people involved have warned, avoided or remedied the situation?

***Best practice***
*Do not let consequences influence your assessment.*

UNACCEPTABLE ◄ ACCEPTABLE

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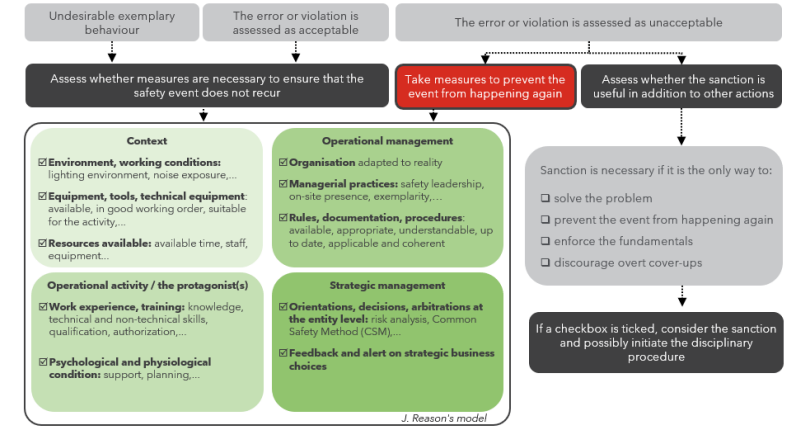
## 4 TAKE APPROPRIATE MEASURES REGARDING THE ACTORS, THE TEAM AND THE SYSTEM
## PREVENT THE EVENT FROM RECURRING

**ATTENTION**
It is up to the analysis team to identify the measures needed to prevent the event from happening again. Make sure that every decision is compared with similar cases to ensure a fair process.






## 5 PROVIDING FEEDBACK TO ALL PARTIES INVOLVED
## PROVIDING FEEDBACK AND EXPLAINING TO BUILD TRUST

**ATTENTION**
Building trust is based on understanding and adherence to treatment outcomes.

1. Review the facts and information collected **from all parties involved** in the event.
2. Explain the decision taken. Using the provided tools, **explain the path of questions** which has led to the conclusion whether the observed behaviour or action is acceptable or unacceptable.
3. Present **the measures taken** and **the associated action plan**.
4. Explain what these measures **have prevented, are preventing and will prevent**.

***Best practice***
*Give feedback to the larger team by explaining the decision and measures taken.*

***Best practice***
*Explaining the decision is an essential step for the success of the process.*

**ITEMS TO BE PRESENTED**

- Synthesis of the facts collected in Step 1.
- Main organisational factors identified in step 1.
- Main Human Factors identified in step 1.
- Result of the behaviour or action analysis from the flowchart in step 2.
- Results and evaluation criteria for assessing the acceptability of the behaviour or action (step 3).
- Actions taken and lessons learned for the system (step 4).

# CONCLUSION

- Just & Fair approach helps SNCF to get **a better understanding of its system's strengths and weaknesses.**
- The work carried out contributes to one of the 7 characteristics of the SNCF's **Safety Culture model.**
- The state of play results showed a heterogeneous level of maturity between the different operational entities.
- SNCF will have to be attentive to **keep the process alive** and continue to feed it.
- To sustain the approach, the group decided to write **a charter to encourage the freedom to speak** thanks to a management's commitment not to sanction spontaneously reported errors.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