Inspectie SZW
Ministerie van Sociale Zaken en Werkgelegenheid

Everything you always wanted to know about…

Safety Culture

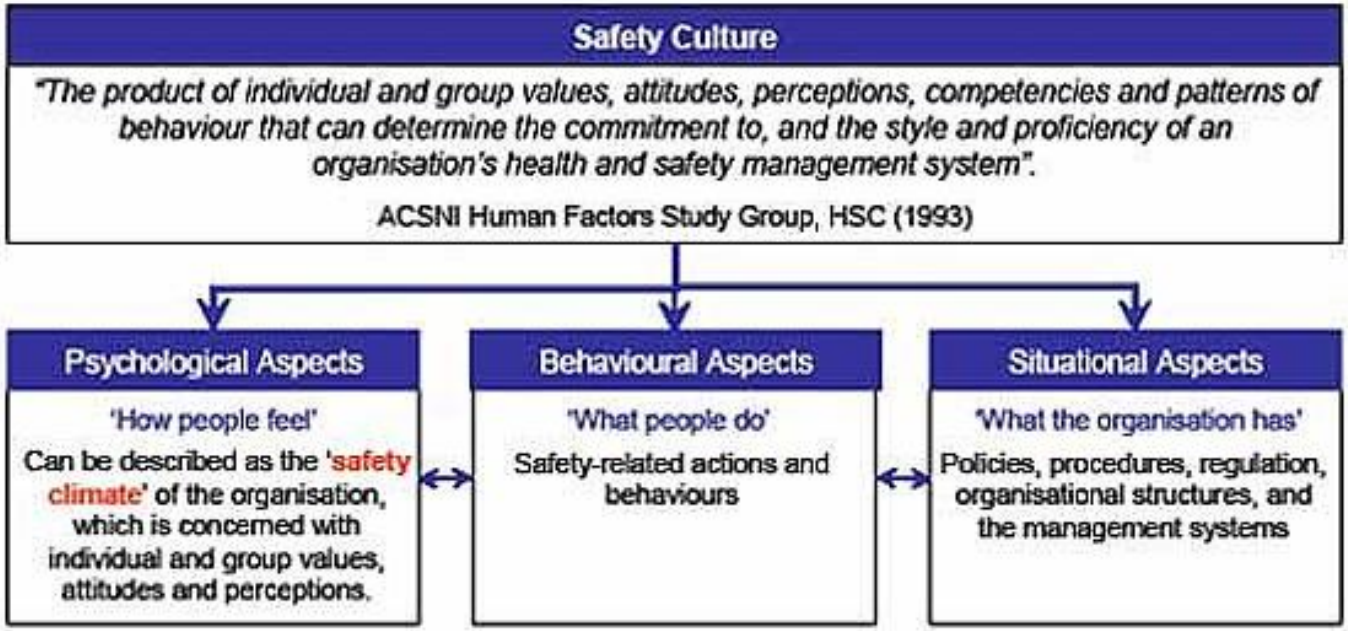
Menno Meems

22-9-2015

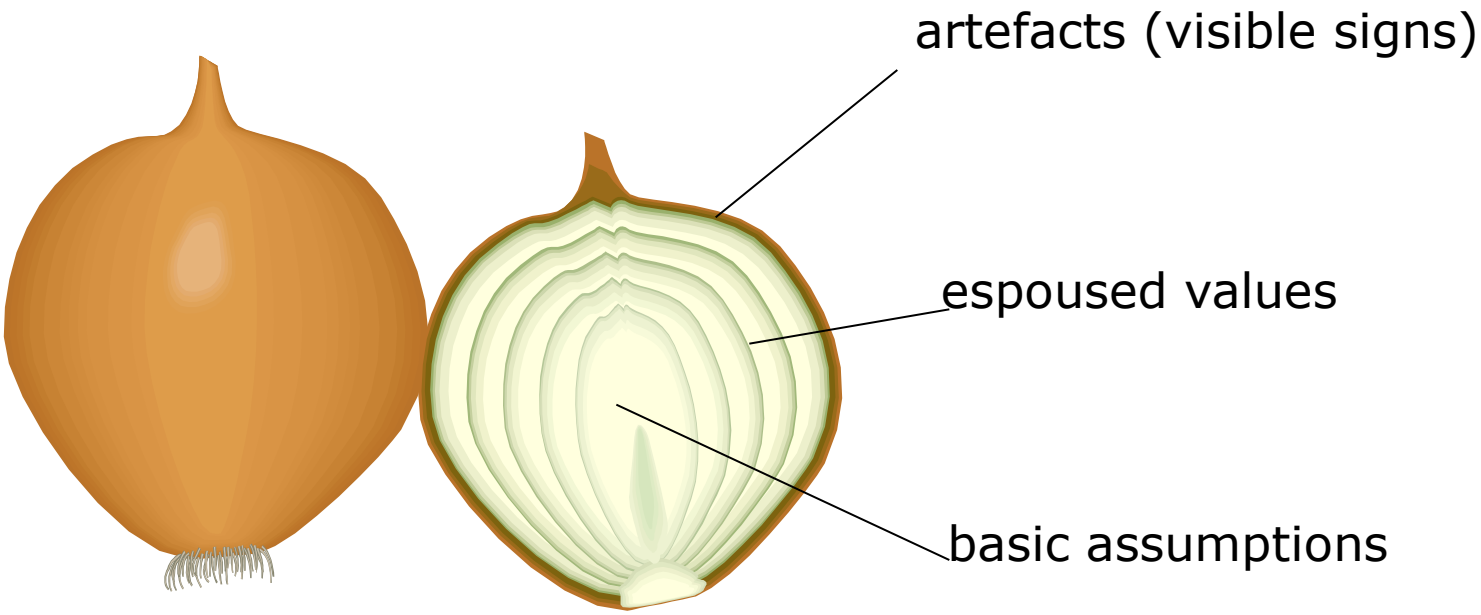
Trevor Kletz

Remembering_Trevor_Kletz.mp4

ACSNI model safety culture



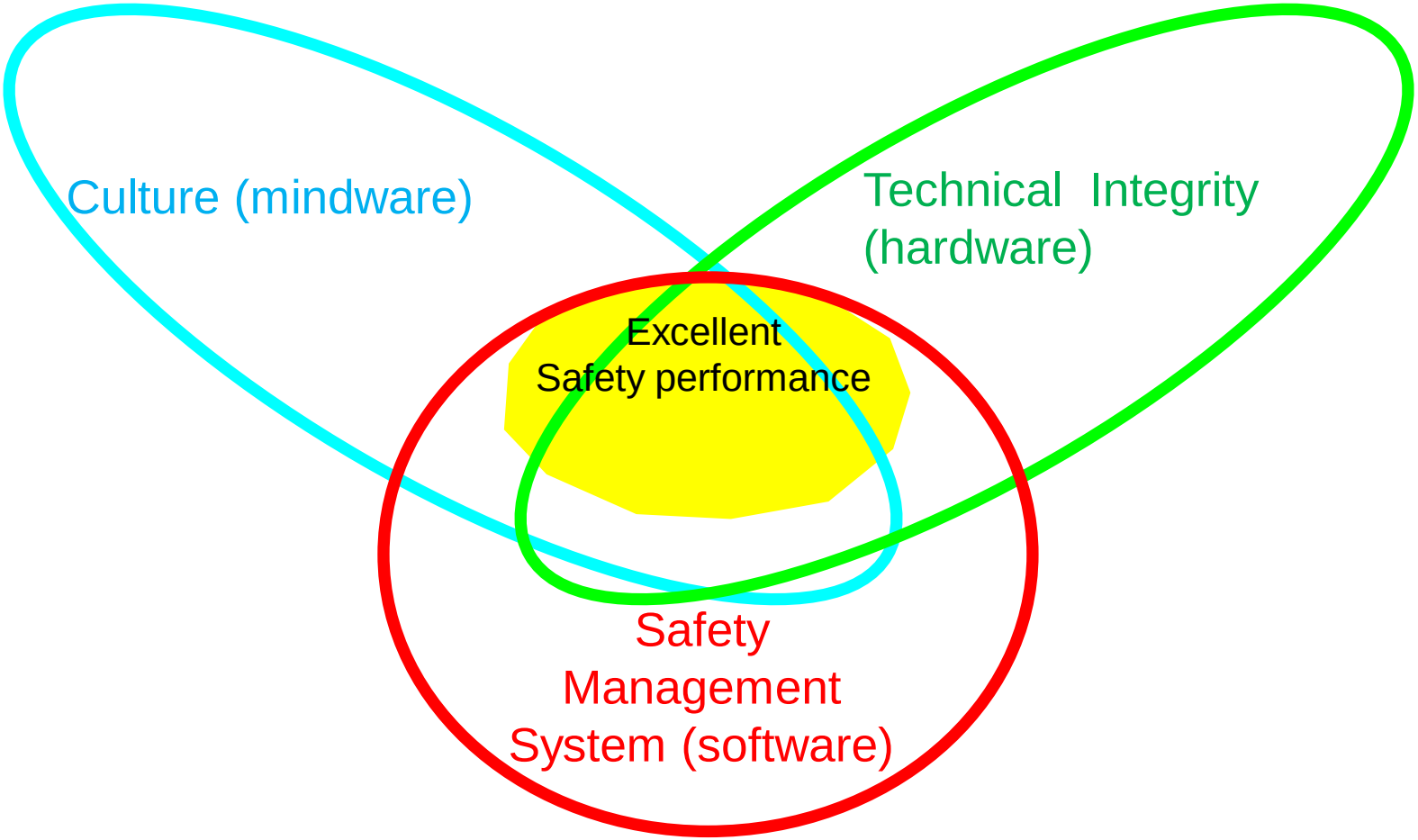
Edgar Schein’s culture model



Basic assumptions: the explanation of why we do things in a certain way.

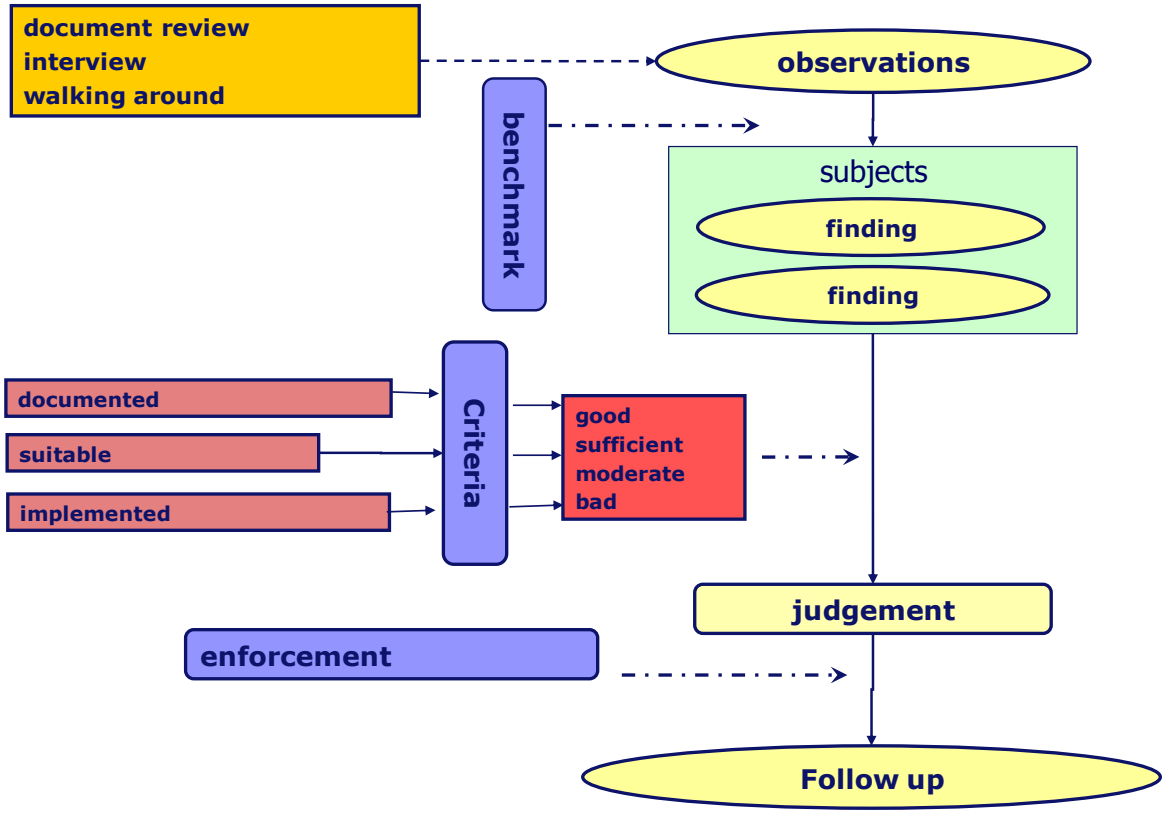
- Time is money
- We must achieve our targets

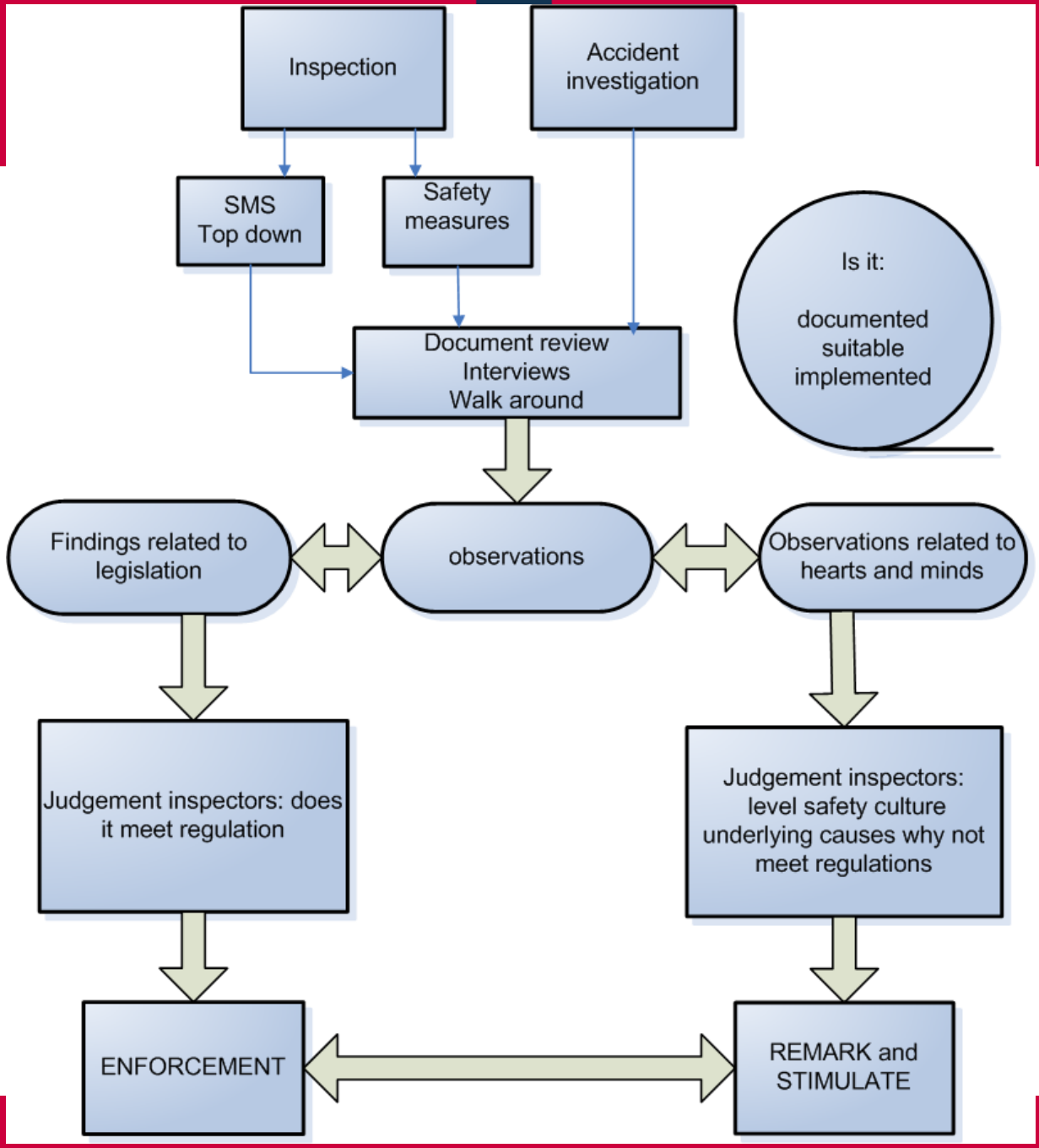
Safety performance model



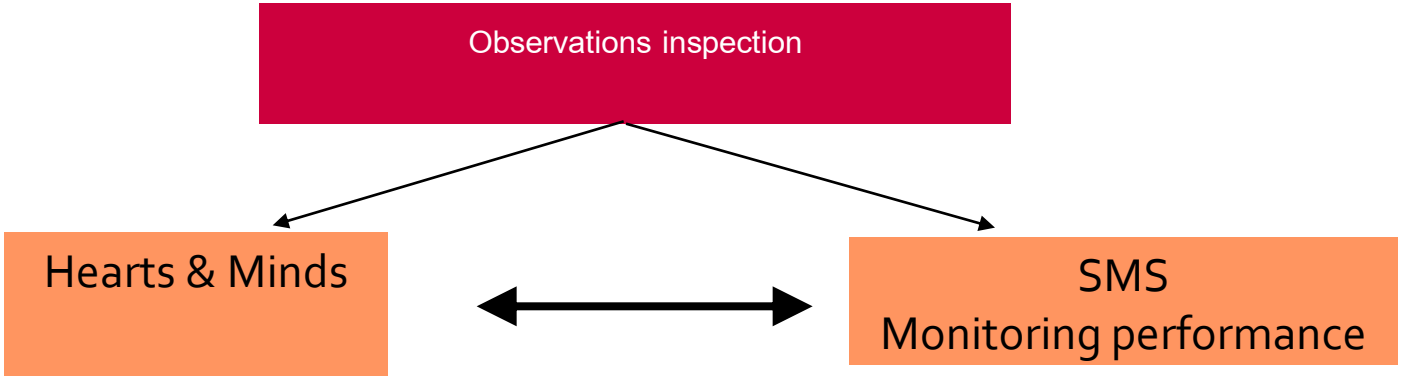
Hearts and Minds - understanding your culture

Dutch inspection model




Inspection
Accident investigation
SMS Top down
Safety measures
Is it:
documented
suitable
implemented
Document review
Interviews
Walk around
Findings related to legislation
observations
Observations related to hearts and minds
Judgement inspectors: does it meet regulation
Judgement inspectors: level safety culture underlying causes why not meet regulations
ENFORCEMENT
REMARK and STIMULATE

example



Who causes accidents in the eyes of management?

Incident/accident reporting investigation and analysis

What happens after an accident? Is the feedback loop closed?

Is a system implemented for reporting major accidents or 'near misses', and their investigation and follow-up on the basis of lessons

Culture levels monitoring performance (accidents)

Pathalogical (denying)

Many incidents are not reported. Only serious accidents.

After incident focus on involved employees.

Priority get back to production

Reactive

There is a reporting system and investigations of incidents is aimed only at immediate causes. Who can be blamed.

Management annoyed by 'stupid' accidents. Warning letters. Investigation reports not lined up.

Calculative (bureaucratic)

System for reporting and evestigation in place but investigation not all times thouroughly to underlying causes.

Top management worries about incident rating statistics

Culture levels monitoring performance (accidents)

Pro-active

System for reporting and investigating accidents and near misses is implemetend well. Investigation focuses on underlying causes.

Learning loop is closed.

The accident is well communicated.

Generative

Just like pro-active.

Also learning from accidents in other companies.

Can we inspect on safety culture

- Yes we can

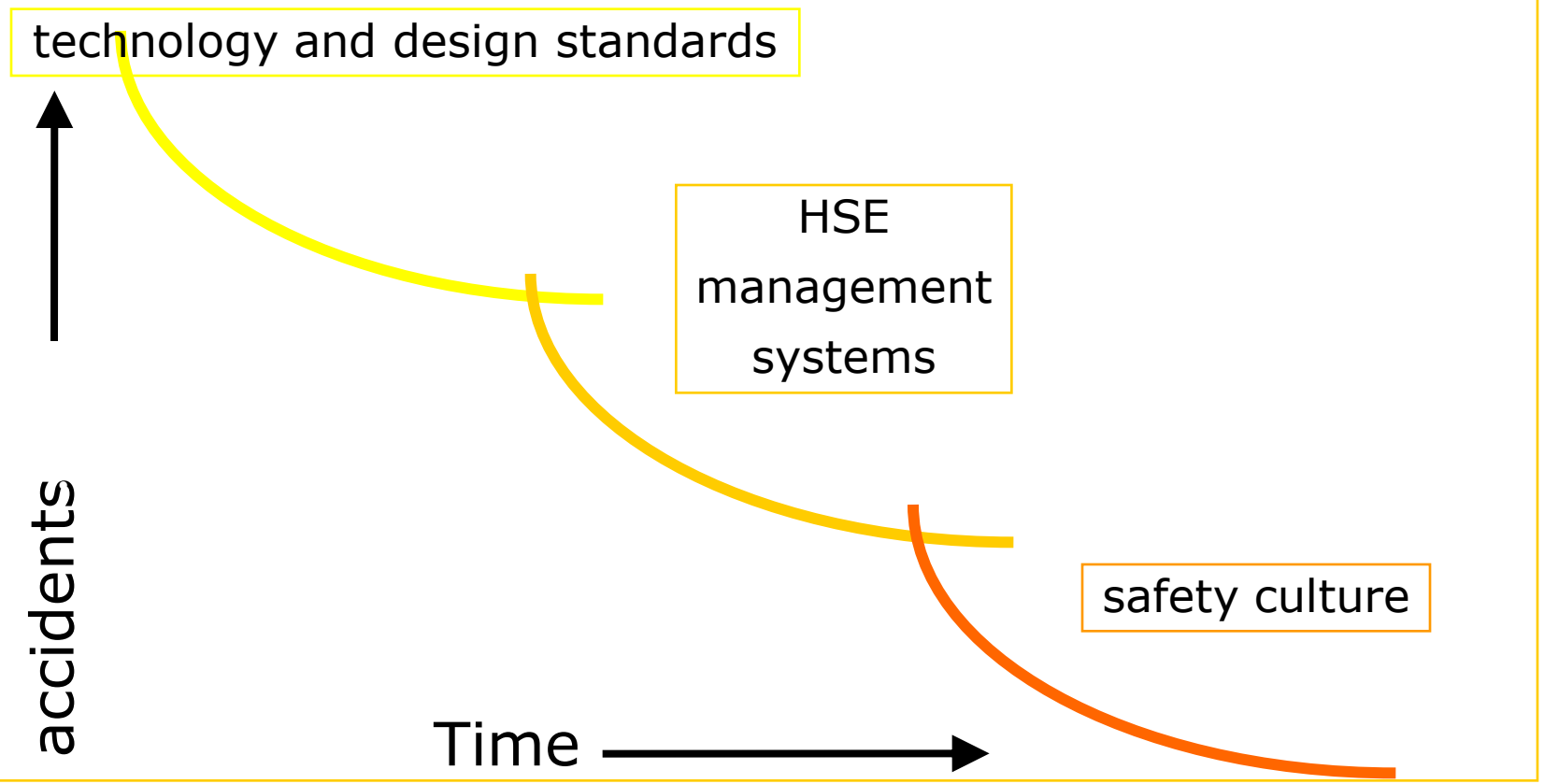
- watch points
  - Train inspectors, it is not as easy as it looks
  - Safety culture is a tool/instrument and should not be the end
  - Risc of getting “close” to the inspected persons (threatening)

Developments

Instrument for estimating the safety culture level

- based on hearts and minds
- short questionnaire for inspectors (15 min)
- used for the relative ranking of companies

HSE performance over time



Accidents

http://www.csb.gov/

Major accident reporting system (MARS):

https://emars.jrc.ec.europa.eu/?id=4

Industrial accidents worldwide

270 million, 1 million fatal

12.000 children involved

Why accidents happen again and again

We forget about the lessons from accidents, and do not learn

We often think:"it never went wrong, it will not happen to us"

Ignore (weak) signals (not my problem)

Complacency and lack of self criticism

Production versus Safety

Poor safety culture awareness?

Poor safety culture?

How to establish organisational learning

- SMS ->create structure in learning processes
- create a strong safety culture

<u>Learning processes:</u>

- Safety perfomance indicators
- Audits
- Investigation of incidents/accidents, near misses and dangerous situations.

- Taking appropriate action!! and evaluate them

Heart of safety culture and sustainable safety: LOC

LEADERSHIP – Management Commitment

OWNERSHIP – Empowerment

COMMUNICATION

Key conditions for organisational learning and improve safety culture:

Trust and equivalence
Openness
Valid information (well informed)
Common responsibility
Be concrete, honesty
Be positive critical

Baker Report (BP Texas)

"We are under no illusion that deficiencies in process safety culture, management and corporate oversight are limited to BP"

1. BP does not have a designated , high ranking leader for process safety

Consequence: Process safety is not a core value

2. BP has not established a positive, trusting and open environment with effective lines of communication between management and the workforce.

Chemie-Pack Moerdijk (Dutch Safety Board)

The Board has also determined that the Netherlands is mostly unaware of the important lessons learned in the United Kingdom regarding the vulnerability of IBC’s in the event of a fire

Questions?


NON SEQUITUR
DON'T WORRY, I'VE DONE THIS A MILLION TIMES
THAT DOESN'T LOOK SO HARD TO DO
WHAT'S THE WORST THAT CAN HAPPEN?
YES, I KNOW WHAT I'M DOING
HEY, TRUST ME
PULL MY FING
IT'S THE BLACK WIRE TO THE RED WIRE, RIGHT?