# Just culture

## Five-step plan | Chemicals/petrochemicals

20 November 2018

Sustainable Safety Programme 2030

## Executive summary

*A 'just culture' is a form of safety culture which is about trust and learning. Its starting point is trust rather than judgment and punishment, and it results in collective and individual learning. Just culture is a term used in risk management, particularly in the world of research and is actively employed in the aviation industry. The chemicals/petrochemicals sectors have shown interest in the concept and have expressed the need for a description of this methodology adapted for these sectors. This document meets that need.*

*The plan involves five steps and six building blocks. The building blocks are: a just culture attitude, storytelling, rules are tools, in-depth analysis, part of the whole, and resilience. The building blocks are described in general terms and illustrated with examples from the chemicals/petrochemicals sectors. This document should be used as a guide. It is an initial exploration of how the concept of a just culture can be applied in specific terms to the chemicals/petrochemicals sectors. Application of this five-step plan will enrich experience of this concept and provide an illustrative appendix to this document.*

*The five steps describe the activities which are preconditions to create a just culture: understanding and embracing the just culture principle; describing the characteristics of the current safety culture; analysing needs; a plan for how to make the necessary adjustments – this could involve amending existing procedures ('building blocks') or creating new building blocks. The final step is an integrated approach to connect all those building blocks.*

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# 1. BACKGROUND

*This five-step plan is the result of collective efforts in phase 2 of the just culture project by a joint working group consisting of members of the teams set up under the Sustainable Safety 2030 programme to address industry transparency ('road map 3') and high-quality knowledge ('road map 5').*

*In phase 1 the working group considered which sectors might serve as examples. The primary focus was on aviation. The conclusion drawn in this phase was that insights from aviation (including the importance of a just culture) are certainly applicable but that they must be adapted to reflect the specific situations encountered in the chemicals/petrochemicals industry.*

*In the current second phase the working group has investigated the potential for application of a just culture within the chemicals/petrochemicals industry. To that end this document describes the six building blocks of a safety culture – including a just culture – in general terms and also gives sector-specific examples. Furthermore it includes a five-step plan for practical implementation purposes.*



*The purpose of this document is to help raise awareness and foster behaviour which will make the chemicals/petrochemicals industry safer.*

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# 2. WHAT IS A JUST CULTURE?

The term 'safety culture' first appeared in an International Atomic Energy Commission report into the causes of the Chernobyl nuclear disaster in 1986. Since then the concept of 'safety culture' has been studied by various international academics from different backgrounds which has generated very different but often complementary approaches to researching and assessing safety in an organisation.

'A **just culture** is a culture of trust, learning and accountability…'

Sidney Dekker, 2017

Sidney Dekker was one of the founders of the 'just culture' concept (2007) as it is currently understood, which is based on a model originally framed by James Reason (1997). Dekker – a sociologist, psychologist *and* pilot – was fascinated by the fallibility of human behaviour in relation to justice. *What is right and when is something wrong? And what is the function or significance of what goes 'wrong' for that which apparently goes 'right'*? His multifaceted background ensured that his ideas really took off, particularly in the aviation sector. The concept of a just culture is now also applied in healthcare, education and in the military.



There is no just culture 'programme' or' blueprint' because a culture cannot be rolled out or implemented. However, a culture can take shape through principles, which are referred to in this document as 'building blocks'. Six building blocks play a key role in this **five-step plan,** but bear in mind, in the words of Sidney Dekker, that …

*'you should never see these principles as an algorithm, a policy, a programme for how to achieve a just culture. A just culture can only be built from WITHIN the own organisation's practice. The various ideas need to be tried, negotiated, and bargained among the people inside the organisation.'*

# 3. WHY IS A JUST CULTURE NEEDED?

*The result of a just culture is an organisation with higher safety levels, higher quality, lower costs and improved employee satisfaction. But how is that culture created?*

In the first instance rules and procedures are extremely effective in fostering safety, but their effect is finite. At some point procedures cause most organisations to seize up: they bring more costs than benefits, and there may be so many of them that they threaten to make it impossible for people to do their jobs and are no longer applied consistently. Sometimes procedures are only wheeled out when things go wrong, serving only to enable people to protect themselves from blame and attribute blame to others. They no longer have any significance for the work itself.

Therefore it is not rules and enforcement that create high safety levels and *High Performance Organizations* (Weick & Sutcliffe 2007). What does create them is a safety culture which has a positive influence on more dimensions than safety alone. All that is required for the safety culture to grow is a breeding ground of six elements, six building blocks with a 'just culture' as the most important. There is no need to introduce all the elements at the same time. Each element can be introduced separately, and each brings improvements in its own right. However, if they are to deliver their full potential, they must all be present and be interconnected.



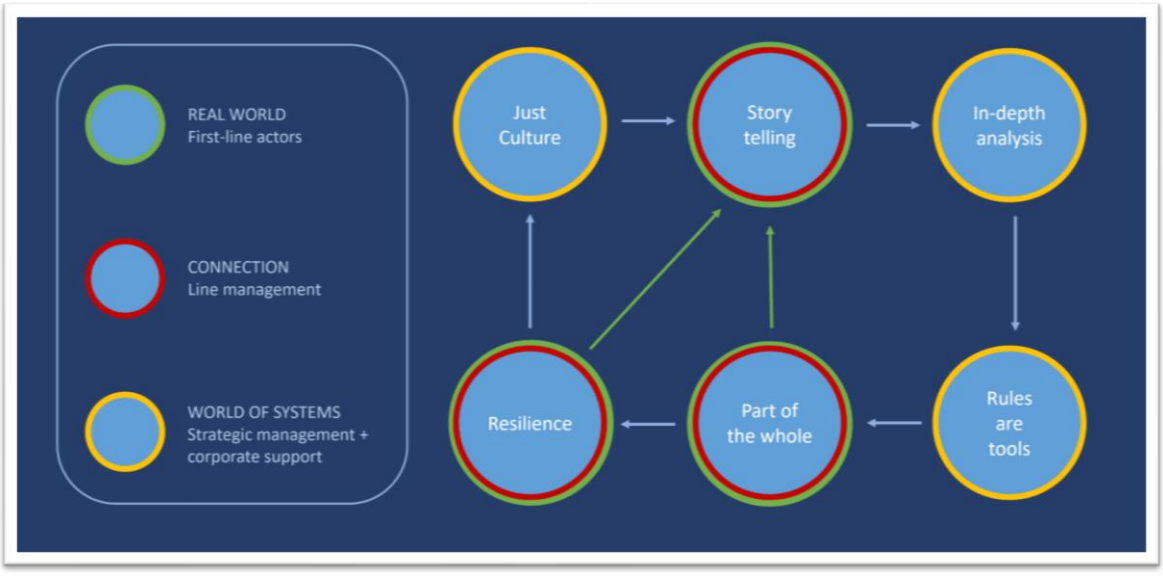


*Illustration 1: DEGAS CIRCLE*

# 4. SIX BUILDING BLOCKS

*This section briefly describes and explains the six building blocks of a safety culture.*

## 1. A just culture

A just culture is the most important element of a safety culture: only in a just culture can people talk in detail about what went wrong without fear of repercussions. As soon as an incident occurs, a provisional distinction must first be made between actions taken in bad faith and actions taken in good faith. This distinction means that any criminal justice approach can be limited to actions taken in bad faith, to incidents which arise from deliberate intent and gross negligence (*see Appendix 1*). The approach to actions taken in good faith is a different one: it is not about prosecution and punishment but about learning lessons from the incident. It is important not to confuse a just culture with a no-blame culture. People and organisations are certainly held to account for gross negligence or criminal behaviour. But mistakes or aberrations which are based on actions taken in good faith are discussed and analysed to help the organisation in question become a learning organisation and one that is constantly improving.



> The following example illustrates this type of culture. A refuse collection service has to deal with a fatal accident. A child dies in a collision because the driver did not see them. What is to be done? All the parties involved suffer. Naturally, first and foremost the child and the parents, but also the driver, the refuse collection team, the child's school, friends, neighbours and other people who are involved in some way. The parents are offered comfort and compensation. The driver is offered counselling by victim support but is also sent on a driver refresher course, all mirrors are checked again, safety systems are reviewed and when necessary replaced with even better on-board cameras with a greater range, control procedures are tightened and new working agreements drawn up. In short, a range of measures are taken to prevent a recurrence.

These actions can be categorised under various building blocks. First of all, of course, that of a just culture: there was no question of an action taken in bad faith, so the response is not punitive but focuses instead on learning lessons. This building block provides scope for 'storytelling', which facilitates 'in-depth analysis', resulting in improvements in 'rules as tools' alongside the technical improvements.

In addition to all the interventions listed above, the firm in question completely stripped down a refuse collection vehicle and rebuilt it as a mobile classroom. It reasoned that, if such a thing as a blind spot exists and, no matter what we do, we can't entirely eliminate

the risk, we will take responsibility for it and explain the danger. In other words, we go out to primary schools to tell children what we can see and what we sometimes can't see, so that they can also act in the knowledge that our lorry driver can't always see them, and that other drivers may have the same problem. The effect of this initiative is far-reaching. The children learn to develop an awareness of blind spots and how to anticipate them in traffic. But they also learn implicitly about a sustainable circular economy and how they can help achieve it. The refuse collection workers take turns in the mobile classroom and experience a sense of personal growth from proudly telling the story of what they do. Their collective self-esteem grows as a result.

In this example we can identify two more building blocks. 'Part of the whole': everything that can reasonably be done has been done. The risk has not been eliminated entirely and the refuse does still need to be collected. And 'resilience': by making the risks clear to those involved, you reduce the residual risk. As philosopher Damiaan Denys puts it: it's better to teach people to swim than deny them access to every stretch of water.

Even where a tragedy has undeniably taken place, by taking responsibility the 'system' can draw optimal lessons from it. Not only is the situation restored and the suffering compensated, the community as a whole moves forward.

Only in a just culture is it possible to draw lessons from the real stories behind incidents. It is simply not possible to create a safety culture without those stories. In the same way that a just culture is the precondition for a safety culture, the precondition for a just culture is the provisional distinction between action taken in good faith and bad faith. Much of the literature on this subject refers to the question of where 'to draw the line' and who has the right to do so. Since making that distinction is both crucial and complex, it is discussed separately in section 5.



## 2. Storytelling

So in a just culture it is in fact possible to tell the true stories about incidents, and those stories are the lifeblood of that system. You can record the statistics of what goes wrong, and most organisations do just that. But statistics only show that things do go wrong and where they go wrong. They don't tell you what the real problem is. In order to really get to the bottom of the problem, you need to know the full story. Including all the details, even the uncomfortable details which the people involved would prefer not to talk about.

Telling the story is not only about errors. In the next step on the road to high reliability you also need to learn from things which went wrong but where people took restorative action before any real damage was done. Or from cases in which people broke the rules because that was what the situation required. Those incidents are a cheap source of knowledge and there are plenty of them too. But the real and full story will only be told if people can be confident that there will be never be any repercussions for actions taken in good faith, even if those actions prove to have been mistakes once they are analysed.

> … It's not just about telling stories in a literal sense. What we mean here is creating space to work on a collective identity. An organisation lives, grows and develops like an individual does. And an individual exists thanks to the story they tell or consciously omit to tell. The essence of this building block lies in the capacity of an organisation to truly listen: to listen to each other without rushing to judgment, instead allowing room for nuance, an alternative perspective or an alternative approach. Sharing the narrative of an incident or action to form the basis for a common frame of reference, a collective memory, all of which can be developed into a coherent identity. The latter provides a solid foundation for institutional trust, which is a precondition for people to feel and experience a sense of safety.
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> Fortunately, there are more and more examples to be found, ranging from an employee's column in the staff magazine through to time being allotted at a management event to listen to a story told by a board member.

## 3. In-depth analysis

A detailed story allows for a detailed analysis. That is the next step on the road to higher reliability and higher quality. Often the analysis of an incident stops as soon as it becomes clear that someone has failed to follow rules or procedures. If action has been taken in bad faith – in other words in cases of gross negligence or wilful intent – that may indeed be sufficient. But if people acted in good faith, it's the wrong approach.



In normal organisations when normal people do normal work, it's much more probable that people acted in good faith. In such situations the better approach is to investigate what caused them to depart from the rules and why. This makes it possible to bring underlying causes to light, for instance poor training, inadequate maintenance or incomplete information.

The best approach goes one step further. When people violate the rules, the most valuable insights and therefore the best opportunities for improvement are created when an attempt is made to understand why those people believed that the action they took was the right thing to do (even though it is clear in retrospect that it was not) in that specific situation, based on the inevitably limited information and time available.

> An example is a leak at a tank storage company with the potential to become a huge explosion with disastrous consequences. When all the risks came to light, the ensuing public and political outrage was initially directed towards finding an agency or body that could be held responsible. Who had failed and was therefore to blame?

The answer in this case was that the errors and actions could not be explained in isolation, but were linked to the permitting system. The permit application, supervision and enforcement system was not equipped to prevent this type of event. That was the real issue to be tackled.

## 4. Rules are tools

Once the analysis is complete, the next question is whether the findings point to a need to change the rules and procedures. Do they need to be tightened up or even abolished? Do they need to be explained in more detail or communicated more widely? After all, rules are not set in stone: they are instruments, they are means to an end. Checklists, procedures and teamwork routines are all in place to organise and structure work in line with specific agreements and standards. It's a way of ensuring that everybody involved knows what's expected of them.

Rules are made where shared experiences coalesce. But in some circumstances, following the rules may be more hazardous than breaking them. That's when people need the presence of mind and sufficient understanding of the situation to depart from the rules. In the analysis phase they can then explain why they believed they needed to take that rule-breaking action. The collective must then decide if the rule should be adjusted or if the rule is essentially good but may need to be broken in exceptional cases.



When it comes to checklists, it is important to realise that they are merely tools in the toolkit. Unfortunately, extremely effective tools like checklists are often not used as such. When they are used as lists to be ticked off and filed, they change from simple tools to help you get your work done into instruments for retrospective accountability or monitoring other people. They then become a burden instead of a useful tool.

Is deviating from the procedure allowed? When employees know the whys and wherefores of a procedure, its effective goal has been reached. It's not about the procedure as such, but about the desired effect of following the procedure.

In contrast to many other industries, in the chemical industry consistency is a very important factor. It offers a form of certainty. When we're talking about safety and reliability, then we must be able to rely on people to actually observe the agreements which have been made. 'Understanding' is not enough, because there's always a possibility that people will interpret rules and regulations differently. So you need to demonstrate clearly that the rules have been followed if you want people to start trusting you.

Of all the building blocks, this one will be the most challenging in societal terms. A just culture is based on 'trust'. And trust is not a hard science. It is the sum of experience and interaction. And if past interactions with your industry were built on a real or perceived lack of information or negative information following an incident or near-incident, you are already on the back foot. Then it's not enough to say that you 'understand what happened'. Instead you will have to systematically demonstrate that you know how to use

the tools (i.e. that you follow the rules) so that if you decide to apply them differently after an incident you can give a plausible explanation of why this makes sense.

> Example: equipment maintenance. Rule: when controlling production equipment always switch off and unplug from the mains. In this case a piece of metal had come off a rotating screw and blocked the rotating mechanism. This meant that the machine in fact needed to be turned on, albeit carefully, to allow for removal of the piece of metal and ensure continued production. People therefore needed to understand the rule in order to know exactly how they could deviate from it. It would not be sufficient to simply state that things need to be in motion to solve the problem. Both have occurred in practice.
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> The first, less successful attempt, did free the piece of metal, but the maintenance engineer in question lost three fingers when it shot out of the machine. In an alternative situation the maintenance engineer consulted the working drawings of the machine and two other maintenance teams; he also asked the manufacturer if they had any experience with this kind of incident. Here again the original rule was violated – the machine was switched on during the repair. But because the risks of the rotation had been carefully identified in advance, the obstruction could be removed in a controlled manner. The procedure was subsequently supplemented and tightened up.



## 5. Part of the whole

In this fifth element the safety measures taken must be balanced against the organisation's other objectives. Politicians and organisations tend to say that safety is always the top priority. But that can never be true in the real world. Organisations supply products or services which must be affordable and delivered on time – not late. Naturally the safety level must also be acceptable to society. So a balance will always need to be found between conflicting objectives. If one of the objectives is overlooked, the results will be unsatisfactory. Organisations and politicians fail to recognise this when they state that safety is the highest priority since this means by definition that a balance cannot be struck.

But naturally – inevitably – there is always a trade-off between safety and other objectives, and this must be acknowledged. After all, only then is it possible to share with others how that trade-off was arrived at and ensure that the best choices are made for the organisation in particular and for society as a whole, and ensure that the best possible balance has been found.

Safety is an integral part of operations—just as industry is inseparable from society. Measures do not exist in isolation. A trade-off relating to costs or investments impacts all levels of a business, organisation or industry. Safety is never a goal in its own right, but always the result of a weighing up of conflicting interests.

> Example: new research methods demonstrate that the pores in existing measuring equipment to detect harmful particles are far too big to 'catch' the particles in question. The fact that they are not showing up in the measurements does not mean that they are not present, but that we cannot demonstrate their presence. In other words, the measuring equipment is inadequate. These new insights and their potential application in industry mean more than simply the installation of an adapted filter. We are seeing things which we did not or could not see before. The 'extra' dimension means that we see things better and can observe things more accurately. We can therefore take measures to eliminate the additional risks which are now visible as well. There is no point in tackling this in isolation. The investments may be incredibly high and the measure may have a limited shelf life. The whole system will need to be examined, as well as the significance of these new insights and what they add to our understanding of the current situation. Are additional measures needed? And if so, at what level do we need to fundamentally adjust our understanding of the system? Do we need to look at legislation, the regulations themselves, or only at the underlying guidelines?

'You cannot put a price on safety, but it does come at a cost'. This maxim has a degree of validity. Safety is a feeling of security which has a certain value to society. As economic prosperity increases, so too does the need for safety measures. We can do more, we want more…but we want more security too. We want things joined up. Safety is not a separate issue way down the list of priorities, it's a part of the whole.



When an organisation procures new equipment it boosts its production capacity, but it also introduces new risk into its operations. It needs to raise awareness and arrange training, and additional measures and procedures. It's part of an integrated investment, which includes safety too.

1. **HARDWARE** reliable
   *redundant & fail-safe*
2. **SOFTWARE** solidified experience
   *reality check & escapes*
3. **MINDWARE** knowledge and experience
   *culture & tools*

## 6. Resilience

The world is fundamentally unpredictable. Which is why resilience is vital if you want to make an organisation highly reliable. To start with, the technology and the procedures must meet specific requirements. But the most important factor is human resilience. The actors within the organisation must possess the knowledge and skills to be capable of taking the right decisions in unexpected situations. They must know how to act when things don't go to plan or as expected, how to cope with deviations from the norm, what to do and whom to listen to. After all, since the world is fundamentally unpredictable, it's impossible for a procedure to anticipate every eventuality.

> Example: a chemical plant in the south of the Netherlands. A man dies when inspecting a tank. An accident investigation takes place and the case goes to court. The company is ordered to pay compensation of around €40,000 to the widow. The lady in question does not want the money; she asks the court to order the company to use the money for an internal safety information campaign. She also takes proactive measures to share her experience with other companies. As a result of her decision and proactive approach, several million euros have since been invested in information campaigns, events, lectures and symposia in which she and the company tell and share their story. In this way, the death of this employee and the narrative relating to this tragic accident has had a positive impact on safety awareness and on resilience in the entire region and sector.



Interestingly, the human characteristics which cause people to fail in certain situations are exactly those that enable people to save the day in slightly different circumstances. In other words, it would be foolish to design the human factor out of the system. Rather, systems should be designed to ensure that people can be the heroes more often than the source of failure. The way to achieve this is to provide those fallible people with a just culture and to support them through teamwork routines, checklists and procedures which have proven their effectiveness.

If there is an atmosphere of trust (1: just culture) in which people can share their experiences of an incident (2: storytelling), if this is then analysed (3: in-depth analysis), if the rules and procedures are adapted accordingly (4: rules are tools) and safety measures have been weighed up (5: part of the whole), then it's up to resilient people (6: resilience) to put the outcome into practice. They can only do so if they trust that their decisions will have no repercussions, even if in retrospect those decisions prove to have been mistaken (1: just culture). The circle is complete.

# 5. FIVE-STEP PLAN

*What steps are needed to develop a safety culture based on a just culture?*

## 1. Embrace a just culture

The first step on the road to a just culture must be for the management team, with the CEO in the lead, to endorse these insights. Then middle management and line management must immediately embrace and communicate the ideas underlying a just culture. This step is of fundamental importance. Without it, all other steps are pointless.

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*One option is to hold a session with the CEO and management team to present and discuss the just culture approach. Set aside at least two hours. Once it has been decided to introduce this approach, organise a session for the entire Safety, Health, Environment and Quality (SHEQ) department. Again this should consist of an introduction followed by discussion, but longer than the discussion with management. Allow at least half a day.*



## 2. Make an inventory

This step includes two possible elements: an internal inventory and an external inventory. Internal relates to the current operations of the business and is relatively simple if the processes and procedures are all in order (*see Appendix 2*). It's a different story when it comes to the external inventory, since that relates to the social and legal context necessary for a just culture to operate effectively. Generally speaking, the conditions needed to achieve this are no different to those required within the organisational setting, but the scope and complexity of the framework needed to anchor the principles are much greater.

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*This is a task for the SHEQ department as they are most closely involved. They may well have a ready-made inventory of the current situation or could produce one within a few days.*

## 3. Analysis

The third step is trickier. It compares the findings from step 2 with how a just culture operates. How do the existing activities relate to the building blocks of a safety culture? Answering that question demands a proper understanding of those building blocks, which is why these aspects are explained briefly in the substantive section on the just culture.

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*Again this is a task for the SHEQ department. They need to ask themselves: how do we carry out the analysis? Do we stop when we conclude that a procedure has been violated, and do we automatically place extra emphasis on compliance aspects, or do we look further? Do we respond to statistics which flag up a problem by creating additional procedures and rules, or do we look at the issue in more depth? What rules and procedures do we actually have in place? Are they mainly – or perhaps exclusively – dedicated to documenting actions and providing accountability, or do they try to support people's actions in practice? After an incident do we look mainly for who's responsible and perhaps to blame, or do we look at causes without preconceptions and without the bias of hindsight?*



## 4. Adjust and/or add

If the previous step establishes that the existing approach does not align with the requirements of a just culture, the approach must be adjusted. This is a tricky moment, because this is where the change really starts: the shift from the prevailing culture to one based on a just culture. And yet the concept is quite simple. In this context culture is defined as a set of habits, and changes in those habits will happen naturally. Not through talking about them continuously, but by actually doing things differently in daily practice.

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*To reiterate, this is a task for the SHEQ department. If the previous step shows that existing practice does not align with the approach described in the different building blocks, the existing approach must be adjusted. This is where the culture change in the organisation really starts, and that must be in the SHEQ department.*

As well as adjusting existing elements, it may be necessary to add building blocks which are missing entirely. As stated earlier, in most cases many of the building blocks are already in place in some form. Those that tend to be missing are part of the whole (5) and resilience (6). These are the trickiest building blocks because they require the organisation to anchor responsibility as close as possible to the field of operations. In other words, the organisation must let go of the idea that management can and must be able to completely control all aspects of an operation. Letting go becomes easier when you realise that 'control' is often only the illusion of control.

*At this point the 'business end' of the organisation – line management and employees – becomes involved in the process. Once again, start by presenting the vision and discussing it with different parts of the organisation. Then look at the individual knowledge and skills in the workplace and adjust where necessary, while at the same time emphasising the importance of speaking up if any processes are not working or cannot be implemented, or if staff think that they or their colleagues need additional knowledge and skills. Make it clear that the company will not impose sanctions as a result but will look for solutions.*

## 5. Connect

The fifth and final step is to connect all the building blocks so that they reinforce and augment each other. It is this connection which creates the safety culture, the organisation which is constantly learning in a structured way, made possible by the introduction of the first building block, namely the just culture element.

*This final step is for the SHEQ department and front-line staff, including line management. Demonstrate that reports and notifications of issues are taken up, and how. And if nothing happens after the analysis, explain why. Line managers play the most important role here, since they must ensure that staff do in fact possess knowledge and skills and keep them up to date, and that staff do in fact speak up when processes are failing or not being followed, and that the stories behind these incidents are in fact communicated to the SHEQ department for in-depth analysis.*



*The key factor here is to ensure that the elements are connected at the level of each separate activity in the organisation rather than at overarching corporate level. The vision is uniform and applies to the organisation as a whole, but the implementation should be local and completely tailored to the local situation and local process.*

The final outcome of the implementation of the six building blocks is an organisation in which tasks and responsibilities are allocated in a well-considered, visible and effective manner.

*Senior management* ensures a **just culture** and thereby creates the conditions in which a safety culture can grow.

*The first-line actors …*

- ✓ possess **knowledge and skills**;
- ✓ **report** things that go wrong;
- ✓ tell **the story underlying** the incident;
- ✓ **speak up** if rules and procedures prove not to work in practice.

*Line management…*

- ✓ **ensures and monitors** that the actors do in fact have the knowledge and skills required;
- ✓ **arranges additional training** where needed;
- ✓ collects the **stories underlying incidents** and ineffective rules and procedures;
- ✓ ensures that these are **communicated to the SHEQ department** for in-depth analysis.

*The SHEQ department* is responsible for the **analysis** and for developing **rules and procedures** which are **tools** for the first-line actors. The department itself uses tools including the bow-tie method, TRIPOD, Lean Six Sigma, etc. But it's not necessary for the first-line actors, the people doing things in practice, to use these tools. The only tools they need are the outputs from the SHEQ department: rules and procedures which really help them. *The challenge for everyone* is to keep the overarching **vision** in mind and to connect the six elements in such a way that they feed the process of constant improvement (see the DEGAS Circle illustration on page 6).

Once the connections have been created and are really working, it is time to introduce the element of supervision into the process. (We will examine this in more detail in the next phase of the project). This is all about creating the circumstances for mutual trust to grow: inspectorates need to be confident that the organisation has introduced a just culture effectively; the organisation needs to be confident that the inspectorates will give them space to put the just culture into operation successfully.

Once that trust has been created, the organisation and the inspectorates can enter into a dialogue with the Public Prosecutor's Office to see whether it too can become involved in the just culture.

# *Actions taken in good faith and bad faith*

*Incidents are part of the normal process in an organisation. The prospect of punishment cannot prevent them. This is the fundamental principle of the safety culture sketched in this document. Incidents rarely occur as a result of malice, intentional errors or deliberate recklessness, and criminalisation is counter-productive in most cases. After all, the threat of punitive measures may lead to situations in which people fail to report errors made in good faith because they are afraid of repercussions. It may also generate wariness and defensive behaviour by professionals.*

*But what if a problem is caused by an action taken in bad faith? In that case, it is beyond the scope of the just culture and must be dealt with outside the organisation by the inspection and enforcement agencies and by means of sanctions.*

*From a societal perspective, those exceptional cases of criminal behaviour must be detected and the people responsible must be brought to justice through the courts. The dividing line between good faith and bad faith is therefore essential to a just culture. But where exactly is that line and who draws it?*

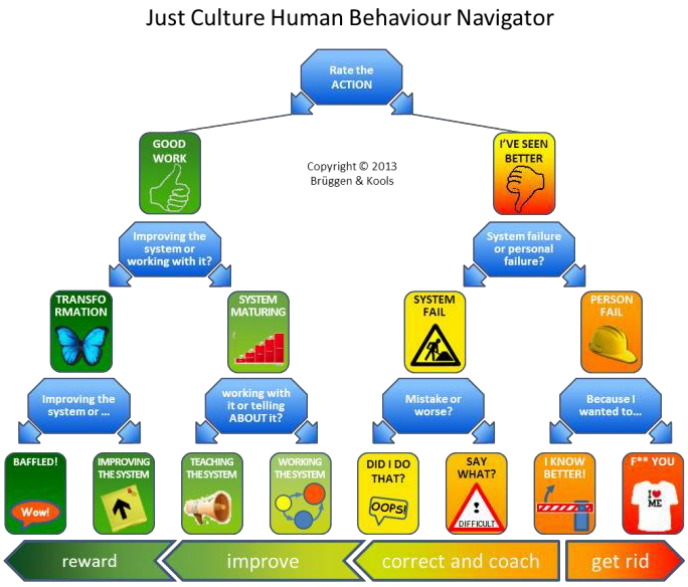
## *Dividing line*

*The literature about just culture constantly stresses that there is zero tolerance for 'unacceptable behaviour'. Equally the literature always states that the line between acceptable and unacceptable behaviour is not fixed. In a just culture, it is a subject of constant discussion between professionals. If people haven't followed the rules, it's not certain that you can categorise this as a 'violation'. After all, the word suggests that the rule is wiser than the human being and that the rule takes priority over professional judgement. But there may be good reasons to adapt the rules to the actual situation and to depart from the regulations. It is impossible to precisely demarcate violations in advance.*



*The question of whether an error was intentional is also a matter of interpretation. Blame and intent are not automatically part of the description of an incident: they must be attributed to a person in this situation. The final verdict on blame, intent and recklessness must be given on a case-by-case basis. In other words, that verdict requires continuous consultation. For instance, in order to be able to recognise negligence, an organisation's staff must maintain a constant dialogue on what professional behaviour can reasonably be expected to entail.*

*In short, the boundaries and the verdicts can be determined, but that must take place in a constant dialogue. Its purpose is neither to excuse nor to accuse individuals, but to work out what makes the greatest contribution to safety and justice. Decision trees, toolkits and frameworks for analysis are available to facilitate this dialogue and to consider what is acceptable and what is unacceptable, e.g. the 'Just Culture Human Behaviour Navigator' created by Job Brüggen and Patrick Kools.*




### *Who draws the line?*

*But if the verdict on behaviour is a matter for interpretation , the key question is: who has the right to draw the line between acceptable and unacceptable behaviour. This question is even more crucial than the question of where the line should be drawn.*

*Organisations do not work in a vacuum. They always work in a context of one or more inspectorates, the Public Prosecutor's Office and often local residents or other citizens. They too must understand and embrace the ideas underlying the just culture if the organisation is to be successful in implementing it. Without a just culture in the organisation, it will simply be the public prosecutor that draws the line between actions taken in good faith or bad faith. But if the organisation does have a just culture, that dividing line will be the subject of discussion between the organisation, the inspectorates and the public prosecutor.*



*The starting point for that debate is that the public prosecutor will not bring a prosecution when errors are made except in cases of criminal intent or gross negligence. But who determines that? Who draws the line? The public prosecutor? Surely that would lead to a form of circular reasoning. There are alternatives: for instance, the task could be delegated to an examining magistrate; or could be considered by disciplinary bodies. Another alternative would be to develop partnership arrangements which include the public prosecutor. All these options have merits and drawbacks. The most important factor is to ensure that the dividing line is drawn by a body which brings both independence and professional expertise to the table, and to ensure that prosecutions are only brought in exceptional cases.*

*The organisation itself must also decide who draws the line between acceptable and unacceptable behaviour. Which departments or bodies will be given the powers to do this? And how will the organisation as a whole gain the authority to reach verdict on behaviour internally? This is a 'chicken and egg' situation: the organisation can only gain this authority if other bodies, namely the inspectorates and the public prosecutor, are convinced that the organisation does in fact work according to the principles of a just culture. The only way to solve that dilemma is simply to make a start. Apply just culture principles as best you can in practice and involve first the inspectorates and then the public prosecutor in the process. The debates about dividing lines are part and parcel of a just culture, and proper agreements about who draws the line carry more weight than where exactly to draw the line*

APPENDIX II

# *Existing systems*

Now that the contours of a just culture have been outlined, it is important to realise that a just culture does not replace existing methods to improve safety levels, but rather complements and strengthens them.

*Take the Life Saving Rules from the 'Hearts & Minds' programme at SHELL. Safety nearly always starts with common sense rules like these, and ever more organisations are implementing similar life saving rules.*


*SHELL's poster campaign states that you will be fired if you break the rules. That is effective when it comes to action taken in bad faith, if people do their work with a 'couldn't care less about the rules' attitude. But when it comes to action taken in good faith, the just culture approach is more fruitful. It seeks answers to questions like: what caused you to break the rule? Was there a reason or direct cause for that behaviour? What lessons can the organisation draw?*

*Processes which have proven their effectiveness are almost always introduced as a second layer. In the aviation industry they are known as Standard Operating Procedures, other sectors call them processes, protocols or working practices. In the first instance they are created in response to an incident but are subsequently developed proactively.*

*The third and most recent level of thinking about safety has arisen from the focus on culture in the organisation. The safety ladder is often used as a framework. The concept is based on the culture ladder, which was created by Parker, Lawrie and Hudson, (see: A framework for understanding the development of organisational safety culture, Safety Science 44, 2006, pages 551–562). Today this is an undisputed indicator of the safety maturity of an organisation.*

*The term 'ladder' is somewhat misleading since you do not actually climb a ladder from Reactive, via Proactive to reach a Safety Culture. It is possible, indeed better, to skip the first rungs of the ladder and start working on a Safety Culture immediately. The culture ladder is primarily an instrument to measure, analyse and record the culture level in an organisation. The Safety Maturity Tool is based on this ladder. One key element missing from these otherwise useful tools is the fact that criminal behaviour is beyond their scope, even though this can be the main cause of problems.*


SOURCE: Parker, Lawrie en Hudson
*A framework for understanding the development of organisational safety culture*
Safety Science 44 (2006)



*The first two layers mentioned above, the common sense rules and the protocols, are effective at first but then get bogged down in control and hence accountability processes. An additional disadvantage is that the emphasis shifts increasingly to process management and control. All the attention is focused on preventing things going wrong with the focus firmly on the 'world of systems' to the detriment of support for the first-line professionals operating in the 'real world'. Attention shifts from encouraging people to do things well.*

*Using the culture ladder as an instrument to progress up the ladder only serves to magnify this drawback. After all the ladder is primarily an instrument for the world of systems which soon shifts the emphasis back to supervision and enforcement.*

*Notwithstanding the focus on culture, the most practical approach is to take behaviour as the main basis for an analysis because, unlike culture, behaviour is immediately visible. A just culture, which focuses on behaviour, allows you to restore the balance between preventing things going wrong and encouraging things to go right. That's how you create a highly reliable organisation.*

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