



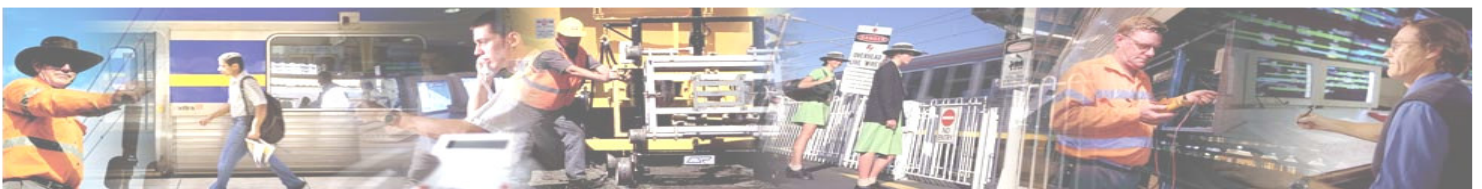
INDEPENDENT  
TRANSPORT  
SAFETY  
REGULATOR



# Organisational Safety Culture Appraisal Tool (OSCAT)

September 2012

Version 1.0



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## **Acknowledgements**

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## **Related documents**

Other documents available to support the use of the Organisational Safety Culture Appraisal Tool are:

- Data collection sheets for Scenarios 1 to 5
- Blank record of interviews
- Sample record of interviews
- Data analysis spreadsheet
- Report template

# Introduction

## **About this document**

This document is for accredited rail operators who intend to use the Organisational Safety Culture Appraisal Tool (OSCAT) to gain insight into the safety culture of their organisation.

This document contains information on how to conduct and report the findings of a safety culture appraisal. It is presented in six sections.

## **Section 1**

### **Background**

This section describes the purpose and development of OSCAT and outlines why measurement of culture is important for organisations.

## **Section 2**

### **The Organisational Safety Culture Appraisal Tool**

This section outlines the elements of OSCAT including a description of the scenario-based interviewing approach used in the tool.

## **Section 3**

### **Data collection**

This section outlines a recommended approach to collecting data using the tool.

## **Section 4**

### **Data analysis**

This section provides an introduction to data analysis using an associated document – the *Data Analysis Spreadsheet*.

## **Section 5**

### **Communicating the results**

This section provides information about how the results of the appraisal might be communicated.

## **Section 6**

### **References and further resources**

Lists the references used in the development of the tool and this document.

Further resources that may assist organisations to develop safety culture improvement strategies are also provided.

## **Appendices**

The appendices contain further information about the background of the tool, and a complete set of the data collection sheets.

# 1. Background

Safety culture can generally be described as “the way things are done around here” with respect to safety. It encompasses the values, beliefs and attitudes that are held within the organisation that guide the way that people behave in the workplace. It shapes the decisions people make, their priorities and the actions that they take.

Safety culture has been implicated in several large-scale organisational accidents in Australia and overseas.

## 1.1. Safety management and safety culture

The final report of the special commission of inquiry into the Waterfall rail accident (McInerney, 2005), and contemporary safety theory argue that successful safety management is dependent upon the safety culture of an organisation.

The promotion of a positive safety culture is now considered to be a viable way of managing risk (Farrington-Darby, Pickup, and Wilson, 2005), and consequently safety culture is receiving considerable attention from both regulators and operators.

Safety culture is emerging as a significant system component that can, and should, be managed in practical, proactive ways to promote safety. As Professor Andrew Hopkins, puts it,

“...the cultural perspective does not replace the system perspective, it augments it. No one is saying, ‘ignore systems, all we need to do is get the culture right’; on the contrary, the right culture is necessary to make safety systems work.” (Hopkins, 2005, p. 5)

The recognition that managing safety culture is a vital part of managing overall safety risk is reflected in the New South Wales *Rail Safety (General) Regulations 2008* and the Victorian *Rail Safety Regulations 2006*. These regulations require that rail operators identify in their SMS how they are promoting and maintaining a positive safety culture in their organisations.

### **Safety culture initiatives**

In recognition of the importance of safety culture, the Independent Transport Safety Regulator (ITSR) has supported various safety culture initiatives in the rail industry. In 2006, ITSR and Transport Safety Victoria (TSV) decided to collaborate in the development of an ‘Organisational Safety Culture Appraisal Tool’ which would enable a qualitative insight into the safety culture of rail organisations.

Initially the tool was developed to be used by regulators as an educational tool. However, it was recognised that providing the rail industry access to the tool for use within their own organisations would also be beneficial.

## 1.2. Measuring safety culture

### **Safety culture versus safety climate**

A simple way of distinguishing climate and culture is that safety climate is generally perceptions and surface features that may or may not reflect *the way things are*. Safety culture is the underlying values, beliefs and attitudes that guide behaviour, and generally provides a truer reflection of *the way things are*.

To obtain a valid measure of the safety culture within an organisation, employee (and management) perceptions, attitudes and actual behaviour need to be assessed. Unfortunately, this can be time consuming, labour intensive and expensive.

In comparison, safety climate assessments are generally less time consuming as they usually use surveys to gain an understanding of perceptions that members of the organisation have regarding safety.

Given the time-consuming nature of detailed behavioural observations required to gain a true reflection of the underlying culture, a compromise or "hybrid" approach was taken within OSCAT.

## 1.3. A tool for assessing safety culture

The Organisational Safety Culture Appraisal Tool has been designed to assess the safety culture within rail organisations.

The tool uses a "story-telling" interview approach which asks interviewees to describe actual examples and their decisions and behaviours in the situation. This enables the assessment to capture "what actually happens" (as opposed to climate surveys which are often answered in a generalised manner that does not necessarily reflect the reality).

The appraisal should include interviews with a cross section of management and frontline staff. Ideally a cross section of people of all levels and divisions of the organisation should be sought.

The tool has five scenarios with prompt questions that assist in guiding the interview and ascertaining the information relevant to safety culture.

The prompt questions are linked to a set of safety culture elements and sub-elements (see Appendix A for the complete list and Appendix B which cross references the scenarios and elements). The elements have been selected based on research literature, the Waterfall and Glenbrook special commissions of inquiry findings (McInerney, 2005; 2001) and input from subject matter experts. Positive and negative performance indicators are included to allow for scoring on the sub-elements as shown in the example in Table 1.



**Table 1: Example prompting questions and performance indicators for the Information Flow sub-element 'Feedback'**

| Element             | Sub-element  | Prompting questions  | Positive performance indicators   | Negative performance indicators   |
|---------------------|--------------|--|---|---|
| 3. Information Flow | 3.3 Feedback | <p>Are staff provided with feedback about the progress or outcome of the reported concern?</p> <p>Were staff kept informed on the status of the issue?</p> <p>How was this feedback given?</p> <p>Was there a check to ensure that the message was received?</p> | <p>+ Staff were kept informed about the status of the issue</p> <p>+ Message was communicated and checked to see if received and understood</p> | <p>- Staff were not given any information about the status of the issue</p> <p>- Staff did not take action to find out about the status of the issue</p> <p>- Message given but not checked that it was received and understood</p> |

## 1.4. Development of the tool

### Organisational Safety Culture Appraisal Tool - Objectives

In recognition that safety culture is an important factor in the overall safety performance of an organisation, the tool was designed for safety improvement rather than as a compliance instrument.

- The objectives for the development of the tool were to:
- Assist transport organisations to gain some insight into their safety culture to promote continuous improvement
- Provide a structured and systematic tool to take an in-depth look at practical aspects of safety culture.

### Development background

The main activities that have been undertaken in the development of the Organisational Safety Culture Appraisal Tool are summarised in Table 2.

The tool was developed by Lloyd's Register Rail with support from specialists at ITSR and TSV.

## 1.5. Why conduct a safety culture appraisal?

### Cultural insight

The Organisational Safety Culture Appraisal Tool was designed to give rail organisations some insight into their own culture. By understanding the strengths and weaknesses of organisational culture, strategies can be implemented to improve areas of culture that are known to affect safety outcomes.

Conducting a safety culture appraisal also demonstrates to staff that management is committed to listening to the concerns of staff and to making positive changes.

**Table 2: Development process for the Organisational Safety Culture Appraisal Tool**

|  |   |
|--|---|
| <p><b>1. Concept</b></p>                   | <p><b>Literature review</b></p> <ul style="list-style-type: none"> <li>• Identification and review of recent literature relating to best practice in safety culture / safety climate assessment.</li> <li>• Review of the Special Commission of Inquiry reports for the Waterfall and Glenbrook Rail accidents (see Appendix C for a brief summary of the review).</li> </ul> |
| <p><b>2. Design &amp; development</b></p>  | <p><b>Version 0.1 - Organisational Safety Culture Appraisal Tool</b></p> <ul style="list-style-type: none"> <li>• Initial design - based on the literature reviewed and input from specialists in the areas of Human Factors, Safety, Risk and Appraisal.</li> </ul>  |
|  | <p><b>Version 0.2 - Organisational Safety Culture Appraisal Tool</b></p> <ul style="list-style-type: none"> <li>• Consultation with a group of potential users within ITSR including members of the appraisal team.</li> <li>• Input incorporated into the tool.</li> </ul>   |
| <p><b>3. Pilot testing 1</b></p>           | <p><b>Appraisal or training</b></p> <ul style="list-style-type: none"> <li>• ITSR appraisers trained in administration of the tool in preparation for the pilot.</li> </ul>   |
|  | <p><b>Pilot testing - NSW</b></p> <ul style="list-style-type: none"> <li>• Pilot appraisal with an accredited operator in NSW<sup>1</sup> conducted under the direction of Lloyd's Register Rail.</li> </ul>  |
| <p><b>4. Revision &amp; refinement</b></p> | <p><b>Version 0.3 - Organisational Safety Culture Appraisal Tool</b></p> <ul style="list-style-type: none"> <li>• Formal evaluation of the pilot and the tool's performance by Lloyd's Register Rail.</li> <li>• Tool subsequently refined at a workshop involving a number of specialists.</li> </ul>  |
| <p><b>5. Pilot testing 2</b></p>           | <p><b>Review - Victorian context</b></p> <ul style="list-style-type: none"> <li>• Review by TSV appraisers to ensure appropriateness for the Victorian rail context.</li> </ul>   |
|  | <p><b>Pilot testing - Victoria</b></p> <ul style="list-style-type: none"> <li>• Pilot appraisal by Lloyd's Register Rail with an accredited rail operator in Victoria.</li> <li>• This confirmed that the tool performed well.</li> </ul>   |
| <p><b>6. Revision &amp; refinement</b></p> | <p><b>Version 0.4 - Organisational Safety Culture Appraisal Tool</b></p> <ul style="list-style-type: none"> <li>• Minor areas for improvement identified in the Victorian pilot were implemented.</li> </ul>  |
| <p><b>7. Implementation</b></p>            | <p><b>Access to tool</b></p> <ul style="list-style-type: none"> <li>• Decision to provide tool for use by accredited rail operators and development of instructions and other related materials.</li> </ul>   |

<sup>1</sup> Note that there are strict confidentiality rules around the release of information regarding the pilot appraisals based on operators volunteering to take part.

## **1.6. How should a safety culture appraisal be conducted?**

Organisations conducting this kind of safety culture appraisal should set firm rules around the activity and ensure these are clearly communicated to participants. These are summarised below.

- The appraisal should be conducted independently of any compliance activities.
- Accordingly, the appraisal should be non-punitive with no negative consequences for people openly discussing safety concerns.
- All information provided should be treated confidentially.
- A safety culture appraisal would ideally be led and/or conducted by a neutral person possibly external to the organisation. Preferably, the person should:
  - have a background in safety culture analysis,
  - be experienced with behavioural interviewing techniques, and,
  - have an understanding of the operational context of the organisation.

## **1.7. How does the safety culture appraisal fit with safety climate surveys?**

Safety climate surveys are questionnaires which are sometimes referred to as safety culture surveys; however, these surveys measure the attitudes and perceptions of employees rather than actual behaviour. Both climate surveys and other initiatives like the Organisational Safety Culture Appraisal Tool provide good information about the underlying culture of an organisation.

Surveys, such as the Rail Industry Safety and Standards Board (RISSB) safety culture survey<sup>2</sup>, enable a large proportion of workforce attitudes and perceptions to be identified across the organisation. The safety culture appraisal uses a smaller sample size to perform a more in-depth cultural analysis based on actual behaviours.

These two approaches are complementary. For example, a survey might be conducted on a regular basis. A safety culture appraisal might then be performed based on factors identified from the survey, or from other significant safety issues or changes in the organisation (e.g. accidents, complaints, poor performance on safety performance indicators).

## **1.8. How can the findings be used effectively?**

Findings from the safety culture appraisal can be used to improve safety management. Primarily they should be used to inform a strategy for continuously improving the organisation's safety culture. They may also:

- Provide insights into the implementation of the SMS such as whether policies and processes are actually translated into day to day operation (e.g. a weak just culture could hinder an effective reporting system)
- Highlight unidentified or untreated risks to safety
- Assist in choosing areas to focus Rail Resource Management (RRM) or other training.

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<sup>2</sup> RISSB website accessed 20 February 2012, [http://www.rissb.com.au/site/safety\\_safety\\_culture\\_tool\\_kit.php](http://www.rissb.com.au/site/safety_safety_culture_tool_kit.php)

## 2. The Organisational Safety Culture Appraisal Tool

### 2.1. How does the tool gather information about culture?

|  |  |
|--|--|
| <b>Key elements</b>                      | <p>The key elements of the OSCAT are:</p> <ul style="list-style-type: none"><li>• It is administered by interview.</li><li>• It uses a scenario based story-telling approach, where those interviewed are asked to describe a recent scenario or event that they had been involved in, e.g. an incident investigation.</li><li>• The interviewer uses a series of prompt questions to assist in guiding interviewees in the story-telling process and ascertain safety culture information.</li><li>• The prompt questions are linked to the set of safety culture elements, so that information is obtained to illuminate the safety culture element(s) of interest.</li><li>• Each prompt question is linked to a set of positive and negative performance indicators.</li><li>• The performance indicators are used to undertake evidence-based scoring. For example, if the information relayed in the scenario indicates predominantly negative evidence for a particular safety culture element, then that element will be scored lower than if positive evidence was obtained.</li><li>• The tool can be administered to a cross-section of employees from all levels and divisions of an organisation.</li></ul> |
| <b>Story-telling scenarios</b>           | <p>Five workplace scenarios were developed based on (a) expert input, and (b) literature review, in particular, the UK Health and Safety Executive's Safety Culture Inspection Toolkit (HSE, 2005). The scenarios are used to guide the "story-telling" within the interview, eliciting rich information about day-to-day operations and the attitudes, beliefs and processes guiding behaviour.</p> <p>Descriptions of the scenarios are provided in Table 3.</p> <p>A listing of which safety culture elements are assessed in which scenarios is provided in Appendix B.</p>  |
| <b>Benefits of the scenario approach</b> | <p>The scenario-based approach (sometimes called behavioural interviewing) is widely used in the recruitment sector and studies in this area have found high validity for these types of interviews (e.g. Green, Alter, &amp; Carr, 1993).</p> <ul style="list-style-type: none"><li>• The scenario-based questioning approach has the following benefits:</li><li>• Links questions and responses to real events</li><li>• Increased likelihood of obtaining true (honest) responses</li><li>• "Over-generalising" is reduced</li><li>• Reduced likelihood of bias towards overly positive or overly negative responses.</li></ul>  |

**Table 3: The five workplace scenarios used in the tool**

| Scenario  | Scenario questions  | Purpose   |
|---|---|---|
| <p><b>1.</b><br/><b>Safety concern identified</b></p>         | <p>“Describe a recent time when you identified a safety concern.</p> <ul style="list-style-type: none"> <li>• What was it?</li> <li>• How did you raise it / report it?</li> <li>• How was it addressed / managed?</li> <li>• What was the outcome?”</li> </ul>   | <p>This scenario is designed to reveal information about what management do when a safety concern is reported to them and what frontline staff do when they have a safety concern.</p>  |
| <p><b>2.</b><br/><b>Non-routine / degraded operations</b></p> | <p>“Describe a recent time when you were involved in a situation that was non-routine or out of the ordinary in some way. This could be an incident, a delay or a situation that required activities that were outside the normal way in which things are done.</p> <ul style="list-style-type: none"> <li>• What was the situation?</li> <li>• Why did it occur?</li> <li>• What was the sequence of events?</li> <li>• Who was involved?</li> <li>• What was your involvement in the situation?”</li> </ul> | <p>This scenario is designed to reveal information about the emphasis that management place on safety compared to operational performance and how this is communicated to operational staff. It should indicate whether a commitment to safety is reflected in actual behaviour during the situation.</p>                     |
| <p><b>3.</b><br/><b>Incident management</b></p>               | <p>“Describe a recent safety incident that you were involved in, e.g. SPAD, derailment, misroute, maintenance error, etc.</p> <ul style="list-style-type: none"> <li>• What happened?</li> <li>• Who was involved?</li> <li>• How was it identified and reported?</li> <li>• Who identified and reported it?</li> <li>• How was it investigated?</li> <li>• Who investigated it?</li> <li>• What mitigation actions were taken?”</li> </ul>   | <p>This scenario is designed to reveal information about the actions taken by management to investigate the underlying causes of an incident and the implement actions to address the issues. It should also reveal information about the involvement of operational staff in the investigation and disciplinary process.</p> |
| <p><b>4.</b><br/><b>Change management</b></p>                 | <p>“Describe a recent change that has occurred, relevant to your role, e.g. new equipment, new system / procedure, change to workplace, change to organisational structure, etc.</p> <ul style="list-style-type: none"> <li>• What was the change?</li> <li>• What was the reason for the change?</li> <li>• Who was involved in planning / preparing for the change?</li> <li>• How was it implemented?</li> <li>• How was the impact monitored?”</li> </ul>   | <p>This scenario is designed to reveal information about how changes are managed, how management involve operational staff in the change process and the extent to which staff are consulted and involved in safety related decisions.</p>  |
| <p><b>5.</b><br/><b>Safety management</b></p>                 | <p>“Describe how senior and middle management manage safety”.</p>   | <p>This scenario should reveal information about how safety is managed within the organisation. It should reflect perceptions of management commitment to safety and staff awareness about how safety is managed.</p>   |

### 3. Data collection

Table 4 below summarises the recommended approach to data collection using the OSCAT.

**Table 4: Recommended approach to data collection**

|                             |   |
|-----------------------------|---|
| <b>Mode</b>                 | Interviews  |
| <b>Sample</b>               | <p>A cross section of management and frontline staff at all levels should be sought.</p> <p>A general guide would be to interview a selection of operational and safety managers, plus approximately 10% of the frontline staff. Where possible, the sample should contain both long term and new staff. Within these parameters, sampling should be as random as possible.</p>   |
| <b>Timing</b>               | There need be no particular timing schedule for using OSCAT. The use of the tool should be driven by the need to gather more in depth information following the discovery of cultural issues (e.g. through accidents, a survey etc.) within an organisation.  |
| <b>Setting</b>              | <p>One interviewer and one scribe should be present and one interviewee.</p> <p>The interviews should occur in a quiet room where the interviewee's responses will not be overheard by others.</p>  |
| <b>Interview length</b>     | 40 - 60 minutes   |
| <b>Scenarios</b>            | <p>Prior to the interview, choose one or two scenarios from the set of five.</p> <p>Note:</p> <p>It is better to go for depth on a couple of scenarios than gather superficial information for all scenarios. It is important to ensure that the scenarios are varied across interviews to ensure that all scenarios are covered during the appraisal.</p>  |
| <b>Introduction</b>         | <p>The interviews should be introduced in a standard manner. Ensure the interviewee is made comfortable and feels safe to take part in the interview.</p> <p>A sample introduction script is provided in Appendix D.</p>  |
| <b>Supporting materials</b> | <p>In addition to this guidance document, the following materials are provided for use of the tool and analysis of the data gathered:</p> <ul style="list-style-type: none"> <li>• Data collection sheets for Scenarios 1 to 5 (provided in Appendix E of this document)</li> <li>• Blank record of interviews</li> <li>• Sample record of interviews</li> <li>• Data analysis spreadsheet</li> <li>• Report template.</li> </ul> |

### 3.1. Preparing for the interview

#### Selecting interviewers & scribes

It is recommended that two people lead and document the interviews. This enables the interviewer to focus on ensuring that sufficient information is gathered from the interviewee to rate each of the sub-elements. The scribe focuses on recording the evidence. Having two interviewers also ensures that there is discussion about the ratings which helps to manage the likelihood of bias in ratings.

The interviewer should, at minimum, have:

- skills and experience in conducting behavioural interviews, and,
- basic knowledge about organisational/safety culture and its relationship with safety outcomes.

The scribe may not have behavioural interviewing experience but should understand the impact of aspects of organisational culture on safety. At least one of the team should have an adequate level of operational knowledge to interpret the information provided by the interviewee about what happens in the workplace.

#### Selecting interviewees

Determine the proportion of the overall organisation that will be interviewed as part of the appraisal. It is suggested that a cross section of the organisation be included, with a selection of operational and safety managers, plus approximately 10% of the frontline staff. The sample should contain some long term staff and some new staff where possible.

Alternatively, you may want to focus your appraisal on a sub-group within the organisation (such as maintenance areas, drivers, customer service areas, a particular division, etc).

#### Scheduling interviews

When scheduling interviews, ensure enough time is available to conduct the interview and then score the sub-elements for each scenario. The scoring should occur immediately after the interview to minimise the likelihood of forgetting aspects of the interviewee's responses.

It is suggested that each interview be scheduled for no longer than one hour, which should provide time to cover two scenarios with each interviewee.

#### Preparing for the interviews

Issues around confidentiality of the information provided during interviews and what action will be taken should safety issues be identified should be discussed with relevant management before the tool is used. There should be agreement between the organisation and the interviewer regarding confidentiality and what, if any, issues raised during the interview should be disclosed and to whom. This agreement should then be communicated to all interviewees prior to beginning the interview (see Appendix D for a recommended approach).

When approaching personnel to be involved in interviews, it may be of benefit to provide them with information that explains the initiative and why it is being conducted. This material could include the aims of the appraisal, what to expect in the interviews, and the confidentiality arrangements that have been agreed with management.

Prior to beginning interviews, print the scenarios that will be required (one copy each for the interviewer and scribe). The *Record of Interviews* document can be of use in ensuring that interviews cover a range of scenarios spread evenly across interviewees of all job levels. It is

recommended that you carry an extra scenario for each interview to be used if the interviewee cannot recall an example for a planned scenario.

### 3.2. Conducting the interview

#### **Instructions for interviewers**

A standard introduction should be provided (see Appendix D for an example). The introduction should describe the initiative, the concept of scenario-based interviewing and explain the agreed rules around confidentiality or anonymity for the interview.

Having introduced the process to the interviewee, the interviewer should then:

- Confirm demographic information as required on the scenario template
- Ask the interviewee the scenario question/s, noting that:
- The example should be recent (last 6 months)
- The interviewee must have been personally involved in the example
- The interviewee must describe what actually happened.
- Use the prompt questions to ensure that all sub-elements are properly addressed
- Tailor the prompt questions to the particular example that the interviewee has selected
- Ensure that all questions have been asked/covered
- Thank the interviewee for their time.
- Once the interviewee has left the room, the interviewer should confer with the scribe to agree ratings for each sub-element.

#### **Instructions for scribes**

The role of the scribe is to document the interview. The scribe is responsible for the following tasks:

- Document demographic information on the scenario template
- Document responses/evidence provided by the interviewee that relate to the performance indicators
- Circle positive or negative indicators as appropriate according to the information provided by the interviewee
- Bring the interviewer's attention to any areas not fully canvassed or where clarification is needed.

Once the interviewee has left the room, the scribe should confer with the interviewer to agree ratings for each sub-element.

#### **Rating the interview**

The following rating scale should be used to determine the extent to which the sub-element was demonstrated by the evidence provided in the interview.

Each sub-element should be scored by the interviewer and scribe with reference to the rating scale (see Table 5 below). Where necessary, the interviewer and scribe may choose to use half marks where they feel that this is appropriate. The rating must be based on evidence of behaviour during the scenario described.



**Table 5 - Rating scale used in the tool**

| <b>Rating</b> | <b>Label</b>          | <b>Description</b>                                       |
|---------------|-----------------------|--|
| <b>-2</b>     | <b>Very poor</b>      | Extensive negative evidence, no positive evidence        |
| <b>-1</b>     | <b>Weak</b>           | Considerable negative evidence, little positive evidence |
| <b>0</b>      | <b>Intermediate</b>   | Some positive evidence, some negative evidence           |
| <b>+1</b>     | <b>Good</b>           | Considerable positive evidence, little negative evidence |
| <b>+2</b>     | <b>Outstanding</b>    | Extensive positive evidence, no negative evidence        |
| <b>N/A</b>    | <b>Not applicable</b> | Not applicable, unable to demonstrate in this scenario   |

## 4. Data analysis

### Using the data analysis spreadsheet

The *Data Analysis Spreadsheet* was created to assist with data entry and collation following the appraisal. The spreadsheet automatically calculates means (i.e. averages) for each sub-element and a summary mean for each element. It also displays the information in tables and charts.

Alternative methods of data collation and analysis could be developed and used depending on the needs of the organisation conducting the appraisal.

Figure 1 provides a sample of the data entry form for Scenario 1.

| Scenario 1 - Data entry sheet  |                     |                     |                     |                     |                     |                     |                     |                     |                     |                     |
|--|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|
| <b>Instructions:</b><br>~ Enter the reference number for the interviewee whose data you are entering<br>~ Transfer your ratings from the data collection sheet for that interviewee – matching the sub-elements on the data collection sheet to those in the spreadsheet<br><i>NOTE: The sub-element numbers below are not in order. However, the data entry sheet follows the order of the interview questions to support easy data entry</i><br><i>NOTE: If there is missing data (ie. an N/A was recorded or no information was recorded for the sub-element), leave the cell blank. This will not affect the analysis</i><br>~ Repeat steps above for other interviewees that have completed the same scenario<br><i>NOTE: This spreadsheet allows for up to 10 interviewees for each scenario. If you have less than 10, leave the extra columns blank- this will not affect the analysis</i><br>~ Select the worksheet tab for the next scenario |                     |                     |                     |                     |                     |                     |                     |                     |                     |                     |
| Sub-elements   | [insert ref number] | [insert ref number] | [insert ref number] | [insert ref number] | [insert ref number] | [insert ref number] | [insert ref number] | [insert ref number] | [insert ref number] | [insert ref number] |
| 1.3 Visibility   |                     |                     |                     |                     |                     |                     |                     |                     |                     |                     |
| 3.1 Employee Reporting Behaviour   |                     |                     |                     |                     |                     |                     |                     |                     |                     |                     |
| 1.7 Encouragement  |                     |                     |                     |                     |                     |                     |                     |                     |                     |                     |
| 2.1 Trust  |                     |                     |                     |                     |                     |                     |                     |                     |                     |                     |
| 3.2 Organisational Reporting Systems   |                     |                     |                     |                     |                     |                     |                     |                     |                     |                     |
| 1.6 Actions  |                     |                     |                     |                     |                     |                     |                     |                     |                     |                     |
| 1.4 Time & Resource Commitment   |                     |                     |                     |                     |                     |                     |                     |                     |                     |                     |
| 4.3 Management of Risk   |                     |                     |                     |                     |                     |                     |                     |                     |                     |                     |
| 6.3 Staff Involvement in Safety Improvements   |                     |                     |                     |                     |                     |                     |                     |                     |                     |                     |
| 3.3 Feedback   |                     |                     |                     |                     |                     |                     |                     |                     |                     |                     |
| 3.4 Communication Flow   |                     |                     |                     |                     |                     |                     |                     |                     |                     |                     |
| 5.1 Internal Monitoring and Evaluating   |                     |                     |                     |                     |                     |                     |                     |                     |                     |                     |

**Figure 1: Data entry sheet for Scenario 1 from the data analysis spreadsheet**

### Entering data

If using the spreadsheet, take the completed data collection sheets and enter the agreed scores into the sheets relevant to each scenario. The spreadsheet enables entry of data for up to 10 interviews for each scenario. If there is more than this number of entries, the spreadsheet will need to be adapted or an alternative method of data collation and analysis developed.

Instructions for using the spreadsheet are provided on the front page of the spreadsheet.

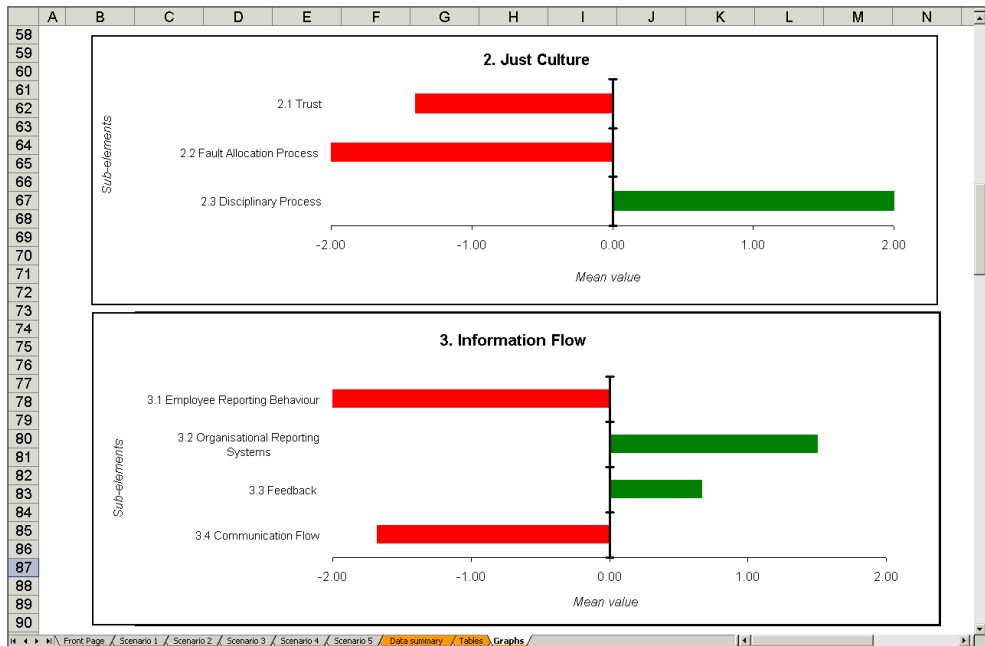
### Viewing the results

The spreadsheet will automatically calculate the mean scores for the elements and sub-elements, and present these in tables and charts for use in reports and presentations. Figure 2 illustrates how means for each element and sub-element from the *Data Analysis Spreadsheet* are displayed.

|    | A | B   | C         | D         | E        | F        | G        | H | I |
|----|---|---|-----------|-----------|----------|----------|----------|---|---|
| 8  |   |   |           |           |          |          |          |   |   |
| 9  |   | <b>Overview Summary</b>                         | <b>-2</b> | <b>-1</b> | <b>0</b> | <b>1</b> | <b>2</b> |   |   |
| 10 |   | 1. Management & Leadership                      |           |           |          | X        |          |   |   |
| 11 |   | 2. Just Culture                                 |           |           | X        |          |          |   |   |
| 12 |   | 3. Information Flow (reporting / feedback loop) |           |           | X        |          |          |   |   |
| 13 |   | 4. Risk Awareness                               |           |           |          | X        |          |   |   |
| 14 |   | 5. Learning Culture                             |           |           | X        |          |          |   |   |
| 15 |   | 6. Staff Involvement                            |           |           | X        |          |          |   |   |
| 16 |   |   |           |           |          |          |          |   |   |
| 17 |   | <b>1. Management &amp; Leadership</b>           |           |           |          | X        |          |   |   |
| 18 |   | 1.1 Safety Message                              |           |           |          | X        |          |   |   |
| 19 |   | 1.2 Actions Support Safety Message              |           |           |          |          |          | X |   |
| 20 |   | 1.3 Visibility                                  |           |           |          | X        |          |   |   |
| 21 |   | 1.4 Time & Resource Commitment                  |           |           |          | X        |          |   |   |
| 22 |   | 1.5 Decisions                                   |           |           |          | X        |          |   |   |
| 23 |   | 1.6 Actions                                     |           |           | X        |          |          |   |   |
| 24 |   | 1.7 Encouragement                               |           |           |          |          |          | X |   |
| 25 |   | 1.8 Systems                                     |           |           |          |          |          | X |   |
| 26 |   |   |           |           |          |          |          |   |   |
| 27 |   | <b>2. Just Culture</b>                          |           |           | X        |          |          |   |   |
| 28 |   | 2.1 Trust                                       |           |           | X        |          |          |   |   |
| 29 |   | 2.2 Fault Allocation Process                    | X         |           |          |          |          |   |   |
| 30 |   | 2.3 Disciplinary Process                        |           |           |          |          |          |   | X |
| 31 |   |   |           |           |          |          |          |   |   |

**Figure 2: Summary tables displaying means for each element and sub-element from the *Data Analysis Spreadsheet***

Figure 3 illustrates graphs displaying means for each sub-element from the *Data Analysis Spreadsheet*.



**Figure 3: Summary graphs displaying means for each element and sub-element from the *data analysis Spreadsheet***

## 5. Communicating the outcome

The outcome of the appraisal can be communicated in a range of ways to meet the needs of different audiences. A report incorporating the results of the appraisal and recommendations for improvements should be provided. Presentations could also be delivered to key groups to communicate the results.

The person responsible for interpreting the findings of the appraisal and writing the report should have a good understanding about the impact of organisational culture on safety and how culture can be improved. This will ensure that any recommendations made will be effective in improving culture and, in turn, reducing the risk of incidents and accidents. The *Report Template* can be used to assist in developing a written report. If the report template is used, it should be tailored as much as possible to meet the needs of the organisation.

In communicating the findings, it may be useful to note that the rating scale of +2 to -2 may be unfamiliar to the audience to whom the data is communicated. An example of how to understand the rating scale may be useful.

Further, it should be explained that the scoring is subjective and therefore care should be taken in comparing results over time, particularly where different personnel are administering the tool.

## 6. References and other resources

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## Appendix A - Safety culture elements & sub-elements

| Element  | Sub-element                          | Description   |
|--|--------------------------------------|---|
| <b>1. Management &amp; Leadership</b>                  | 1.1 Safety Message                   | Consistent, clear and strong safety message is communicated   |
|  | 1.2 Actions Support Safety Message   | Management act as role models, they lead by example, their actions match their words, they have credibility, their actions support the safety message even under difficult or non-routine situations    |
|  | 1.3 Visibility                       | Management regularly interact with operational staff, regular site tours  |
|  | 1.4 Time & Resource Commitment       | Adequate time and resources are devoted to safety   |
|  | 1.5 Decisions                        | Decisions prioritise safety over performance (production), risk & safety decisions are made at the proper level by appropriate qualified people   |
|  | 1.6 Actions                          | Actions are taken to address known safety issues, culture is active rather than passive, "things get done"  |
|  | 1.7 Encouragement                    | Safe behaviour is encouraged, managers encourage discussion about safety, supervisors do not permit cutting corners to get the job done   |
|  | 1.8 Systems                          | There are systems for management of safety that are clear, comprehensive, understood by all levels of the organisation and actively "lived" (e.g. the systems are used and used effectively)            |
| <b>2. Just Culture</b>                                 | 2.1 Trust                            | Operational staff trust that they won't be unfairly penalised if they report incidents or raise issues, management are approachable   |
|  | 2.2 Fault Allocation Process         | Care taken not to apportion blame before root cause analysis is complete. The purpose of the process should be to learn from the incident, rather than apportion blame                                  |
|  | 2.3 Disciplinary Process             | Clear procedures for deciding upon the relevant disciplinary actions, clear distinction between acceptable and unacceptable behaviour, actions taken to manage unsafe behaviour are fair and consistent |
| <b>3. Information Flow (reporting / feedback loop)</b> | 3.1 Employee Reporting Behaviour     | Employees report safety issues, e.g. hazards, concerns, near-misses, incidents, etc, and believe that they will be taken seriously  |
|  | 3.2 Organisational Reporting Systems | There is a system that is in place and is known by management and staff and is easy and straightforward to use for reporting  |

| <b>Element</b>              | <b>Sub-element</b>   | <b>Description</b>   |
|-----------------------------|--|--|
|                             | 3.3 Feedback   | Operational staff are kept informed of safety issues relevant to them, they are given feedback about safety concerns that they raise   |
|                             | 3.4 Communication flow   | Good communication flow up and down the organisation and across divisions  |
| <b>4. Risk Awareness</b>    | 4.1 Employee Understanding of Safety Risks                               | Operational staff are able to identify and recognise hazards and risks associated with their tasks / environment   |
|                             | 4.2 Proactivity & a Questioning Attitude                                 | Planning ahead, preparing for and controlling potential risks, questioning towards "the way things are done", not accepting complacency, a sense of cautiousness and wariness about operations and the operational environment |
|                             | 4.3 Management of Risk   | Safety issues or identified hazards are ranked and prioritised according to risk   |
| <b>5. Learning Culture</b>  | 5.1 Internal Monitoring and Evaluating                                   | Organisation monitors and evaluates changes, new systems, etc. Continuous improvement focus  |
|                             | 5.2 Systemic Analysis  | Systemic analysis for incidents & accidents, identifying root causes, monitoring patterns and trends, the organisation knows what their key hazards are  |
|                             | 5.3 External Monitoring  | Looking outside own organisation, proactively looking for ways to continuously improve   |
|                             | 5.4 Safety Measurement   | Positive performance indicators as well as negative performance indicators, successes are celebrated   |
| <b>6. Staff Involvement</b> | 6.1 Staff Involvement in Changes   | Including input into changes or new initiatives, input into risk assessments   |
|                             | 6.2 Staff involvement in development of policies, systems and procedures | Involvement of staff in development of tools and materials   |
|                             | 6.3 Staff Involvement in Safety Improvements                             | Involvement of staff in safety changes and improvements  |



## Appendix B - Cross referenced safety culture elements by scenario

**Scenario 1:** Safety Concern Identified  
**Scenario 2:** Non-Routine / Degraded Operations  
**Scenario 3:** Incident Management  
**Scenario 4:** Change Management  
**Scenario 5:** Management of Safety

| Safety Culture Sub-Element   | Scenario 1 | Scenario 2 | Scenario 3 | Scenario 4 | Scenario 5 |
|--|------------|------------|------------|------------|------------|
| 1.1 Safety Message   |            | ✓          |            | ✓          | ✓          |
| 1.2 Actions Support Safety Message                                       |            | ✓          |            |            | ✓          |
| 1.3 Visibility   | ✓          |            |            |            | ✓          |
| 1.4 Time & Resource Commitment   | ✓          |            | ✓          |            | ✓          |
| 1.5 Decisions  |            | ✓          | ✓          | ✓          | ✓          |
| 1.6 Actions  | ✓          |            | ✓          | ✓          | ✓          |
| 1.7 Encouragement  | ✓          | ✓          |            |            | ✓          |
| 1.8 Systems  |            |            |            |            | ✓          |
| 2.1 Trust  | ✓          |            | ✓          |            |            |
| 2.2 Fault Allocation Process   |            |            | ✓          |            |            |
| 2.3 Disciplinary Process   |            |            | ✓          |            |            |
| 3.1 Employee Reporting Behaviour   | ✓          |            | ✓          |            |            |
| 3.2 Organisational Reporting Systems                                     | ✓          |            | ✓          |            |            |
| 3.3 Feedback   | ✓          |            | ✓          | ✓          |            |
| 3.4 Communication flow   | ✓          | ✓          | ✓          | ✓          | ✓          |
| 4.1 Employee Understanding of Safety Risks                               |            |            |            |            | ✓          |
| 4.2 Proactivity & a Questioning Attitude                                 |            |            |            | ✓          |            |
| 4.3 Management of Risk   | ✓          |            | ✓          | ✓          | ✓          |
| 5.1 Internal Monitoring and Evaluating                                   | ✓          | ✓          | ✓          | ✓          | ✓          |
| 5.2 Systemic Analysis  |            |            | ✓          |            |            |
| 5.3 External Monitoring  |            |            |            |            | ✓          |
| 5.4 Safety Measurement   |            |            |            |            | ✓          |
| 6.1 Staff Involvement in Changes   |            |            |            | ✓          |            |
| 6.2 Staff involvement in development of policies, systems and procedures |            |            |            |            | ✓          |
| 6.3 Staff Involvement in Safety Improvements                             | ✓          | ✓          |            |            |            |

| <b>Safety Culture Sub-Element</b>          | <b>Scenario Assessed In</b>  |
|--|--|
| 1.1 Safety Message                         | Scenario 2: Non-Routine / Degraded Operations<br>Scenario 4: Change Management<br>Scenario 5: Management of Safety   |
| 1.2 Actions Support Safety Message         | Scenario 2: Non-Routine / Degraded Operations<br>Scenario 5: Management of Safety  |
| 1.3 Visibility                             | Scenario 1: Safety Concern Identified<br>Scenario 5: Management of Safety  |
| 1.4 Time & Resource Commitment             | Scenario 1: Safety Concern Identified<br>Scenario 3: Incident Management<br>Scenario 4: Change Management  |
| 1.5 Decisions                              | Scenario 2: Non-Routine / Degraded Operations<br>Scenario 3: Incident Management<br>Scenario 4: Change Management<br>Scenario 5: Management of Safety  |
| 1.6 Actions                                | Scenario 1: Safety Concern Identified<br>Scenario 3: Incident Management<br>Scenario 4: Change Management<br>Scenario 5: Management of Safety  |
| 1.7 Encouragement                          | Scenario 1: Safety Concern Identified<br>Scenario 2: Non-Routine / Degraded Operations<br>Scenario 5: Management of Safety   |
| 1.8 Systems                                | Scenario 5: Management of Safety   |
| 2.1 Trust                                  | Scenario 1: Safety Concern Identified<br>Scenario 3: Incident Management   |
| 2.2 Fault Allocation Process               | Scenario 3: Incident Management  |
| 2.3 Disciplinary Process                   | Scenario 3: Incident Management  |
| 3.1 Employee Reporting Behaviour           | Scenario 1: Safety Concern Identified<br>Scenario 3: Incident Management   |
| 3.2 Organisational Reporting Systems       | Scenario 1: Safety Concern Identified<br>Scenario 3: Incident Management   |
| 3.3 Feedback                               | Scenario 1: Safety Concern Identified<br>Scenario 3: Incident Management<br>Scenario 4: Change Management  |
| 3.4 Communication flow                     | Scenario 1: Safety Concern Identified<br>Scenario 2: Non-Routine / Degraded Operations<br>Scenario 3: Incident Management<br>Scenario 4: Change Management<br>Scenario 5: Management of Safety |
| 4.1 Employee Understanding of Safety Risks | Scenario 5: Management of Safety   |
| 4.2 Proactivity & a Questioning Attitude   | Scenario 4: Change Management  |
| 4.3 Management of Risk                     | Scenario 1: Safety Concern Identified<br>Scenario 3: Incident Management<br>Scenario 4: Change Management<br>Scenario 5: Management of Risk  |

| Safety Culture Sub-Element   | Scenario Assessed In   |
|--|--|
| 5.1 Internal Monitoring and Evaluating                                   | Scenario 1: Safety Concern Identified<br>Scenario 2: Non-Routine / Degraded Operations<br>Scenario 3: Incident Management<br>Scenario 4: Change Management<br>Scenario 5: Management of Safety |
| 5.2 Systemic Analysis  | Scenario 3: Incident Management  |
| 5.3 External Monitoring  | Scenario 5: Management of Safety   |
| 5.4 Safety Measurement   | Scenario 5: Management of Safety   |
| 6.1 Staff Involvement in Changes   | Scenario 4: Change Management  |
| 6.2 Staff involvement in development of policies, systems and procedures | Scenario 5: Management of Safety   |
| 6.3 Staff Involvement in Safety Improvements                             | Scenario 1: Safety Concern Identified<br>Scenario 2: Non-Routine / Degraded Operations   |

# Appendix C - Summary of safety culture findings in the Waterfall & Glenbrook inquiry reports

## Waterfall

| Element                               | Positive Performance Indicator   |
|---------------------------------------|--|
| <b>Reward structure</b>               | Systems of reward or encouragement based on safety performance (p 221)                       |
| <b>Responsibility</b>                 | Accountability and responsibility in individuals for the safety of the organisations (p 222) |
| <b>Leadership</b>                     | Leadership, especially CEO and top management (p 222)  |
| <b>Blame culture</b>                  | Particularly in regards to what happens when you raise a safety concern (p 222)              |
| <b>Addressing safety deficiencies</b> | Strategic and systematic approach to dealing with problems, proactivity (p 222)              |
| <b>Us and Them</b>                    | Operational and management staff working towards the same objective                          |

## Glenbrook

| Element  | Positive Performance Indicator  |
|--|---|
| <b>Risk Awareness</b>                                  | Analytical thought, rather than blind application of rules. Risk based decisions (p 49, 50)   |
| <b>Safety over on-time running (operations)</b>        | See page 42 of inquiry report   |
| <b>Just Culture</b>                                    | Atmosphere of trust, people are encouraged and rewarded for providing essential safety information, line drawn between acceptable and unacceptable behaviour (p 44)   |
| <b>Flexible Culture</b>                                | Control is transferred from normal chain of command to experts on the spot when an incident occurs (p 44)   |
| <b>Reporting Culture</b>                               | Management will act on reported issues, reports will not cause trouble for those who reported it or their peers   |
| <b>Wariness</b>  | Collective effort towards safety, wariness, "don't forget to be afraid", constant vigilance   |
| <b>Jointly held beliefs about importance of safety</b> | Importance of safety is something that everyone believes in, all levels of the organisation share the same goals and values (p 41)  |
| <b>Management commitment &amp; leadership</b>          | Leadership by example, "actions speak louder than words", management as role models and being "sincere" in their messages, consistency in messages and clear messages, risk taking not tolerated, open discussion of safety incidents (p 48). |
| <b>Communication</b>                                   | Communication of safety, referencing safety in all operational messages   |

## Appendix D - Sample interview introduction

The following information should be conveyed in the introduction:

|                                  |  |
|----------------------------------|--|
| <b>Introductions</b>             | Introduce yourself and team  |
| <b>Beginning...</b>              | I'm just going to begin with some background about what you can expect in this interview.  |
| <b>About the interview</b>       | We are conducting interviews about "safety culture". Safety culture can generally be described as "the way things are done around here, with respect to safety". It involves collecting information from individuals about what happens within the organization from their perspective and then piecing this together to form a general picture. Safety culture is an important indicator of the "safety health" of an organisation.   |
| <b>Not a compliance activity</b> | The interview is not part of a compliance activity; it is a safety initiative being conducted to identify areas that need attention to improve the safety culture of our organisation.   |
| <b>Anonymity</b>                 | You will remain anonymous – information will be fed back to management, but individuals will not be identified. Instead, information will be described in general terms, for example, the "maintenance staff..." or "management...".   |
| <b>Describe your experiences</b> | We will be asking you to describe a range of recent experiences. We will give you time to think about specific examples of events that have occurred. We would like the event that you chose to be something that you have experienced yourself and that you were involved in to the extent to which you can give us a rich picture from your perspective. It's OK that others' might have different experiences of the same event from their perspective. We want your honest views and recollections. While we might get down to details in the interview, remember that it is only broad and general themes that we will report on. Feel free and open to say what is on your mind. |
| <b>Questioning method</b>        | We have a pro-forma set of questions, but we will be flexible with the use of this and prefer a less formal interview style. Therefore, we might appear to jump around a little bit and also we might appear sometimes to ask repetitive questions. This may feel frustrating for you, but it's our way of making sure that we understand the information you are providing to us. Some of the questions that we ask won't necessarily be directly about safety, but might be related to factors that can contribute to safety.  |
| <b>Questions</b>                 | Do you have any questions?   |

# Appendix E - Scenarios

## **SCENARIO 1: Safety Concern Identified**

### **Interview details**

Organisation: \_\_\_\_\_ Interviewee Reference No: \_\_\_\_\_

Interviewee job level (circle): Front-line staff   Supervisor   Manager

Interview Date: \_\_\_\_\_ Time: \_\_\_\_\_

### **About this scenario**

This scenario should reveal information about what management do when a safety concern is reported to them and what frontline staff do when they have a safety concern.

The interviewer should ask the questions below. They must ensure that the scenario selected by the interviewee is something in which they were personally involved. The interviewee must describe what actually occurred (e.g. not what hypothetically might have occurred in an "ideal" world).

"Describe a recent time when you identified a safety concern"

What was it?

How did you raise it / report it?

How was it addressed / managed?

What was the outcome?

| Element                    | Sub-Element                      | Prompting Questions  | Positive Performance Indicators  | Negative Performance Indicators  | Response and Supporting Evidence | Rating (-2 to +2) |
|----------------------------|----------------------------------|--|--|--|----------------------------------|-------------------|
| 1. Management & Leadership | 1.3 Visibility                   | Were managers available to discuss safety concerns?<br>Are there opportunities for face to face discussions with managers?                                   | + Managers were available<br>+ There are opportunities for face to face discussion with managers | - Managers not available<br>- Little opportunity for face to face communication with managers  |                                  |                   |
| 3. Information Flow        | 3.1 Employee Reporting Behaviour | Who was the issue reported to?<br>Did staff know who to report safety concerns to?<br>Was the concern reported promptly?                                     | + Reported to the appropriate level / responsible party<br>+ Reported the issue promptly         | - Didn't report at all<br>- Reported to inappropriate person<br>- Delayed reporting  |                                  |                   |
| 1. Management & Leadership | 1.7 Encouragement                | Did staff feel comfortable and at ease with reporting?<br>Did staff find it easy to approach management about safety concerns?<br>Are managers approachable? | + Managers are approachable<br>+ Felt comfortable reporting the issue                            | - Managers not approachable<br>- Felt uneasy reporting, fear of blame<br>- Evidence that the person who reported was blamed for the problem identified: either perception that they "felt" blame or actual blame, e.g. punished in some way. |                                  |                   |



| Element             | Sub-Element                          | Prompting Questions   | Positive Performance Indicators   | Negative Performance Indicators  | Response and Supporting Evidence | Rating (-2 to +2) |
|---------------------|--------------------------------------|---|---|--|----------------------------------|-------------------|
| 2. Just Culture     | 2.1 Trust                            | Did staff feel comfortable that they would not be penalised for raising the concern?                                      | <ul style="list-style-type: none"> <li>+ Staff feel comfortable that they or others will not be penalised</li> <li>+ Staff feel that it is worthwhile reporting, as something will get done</li> <li>+ Staff feel that they or others will not be blamed for the issue</li> </ul> | <ul style="list-style-type: none"> <li>- Staff are concerned that the report might get themselves or someone else into trouble</li> <li>- Staff perceive that nothing will get done</li> <li>- Staff feel that they may be blamed for causing the issue</li> </ul> |                                  |                   |
| 3. Information Flow | 3.2 Organisational Reporting Systems | <p>Was there a system for reporting?</p> <p>Did staff know this system?</p> <p>Was the system followed? Why, why not?</p> | <ul style="list-style-type: none"> <li>+ System in place</li> <li>+ System known</li> <li>+ System followed and issue reported correctly</li> <li>+ System supported needs</li> </ul>   | <ul style="list-style-type: none"> <li>- No appropriate system available</li> <li>- System in place but not known</li> <li>- System did not adequately support needs, could have been better designed for this purpose</li> </ul>                                  |                                  |                   |

| Element                    | Sub-Element | Prompting Questions   | Positive Performance Indicators  | Negative Performance Indicators  | Response and Supporting Evidence | Rating (-2 to +2) |
|----------------------------|-------------|---|--|--|----------------------------------|-------------------|
| 1. Management & Leadership | 1.6 Actions | <p>How was the issue dealt with?</p> <p>Did management recognise the importance of the issue?</p> <p>Was the safety concern treated seriously?</p> <p>Was the action taken appropriate and was the issue resolved?</p> <p>Did management accept that it was their responsibility to deal with the safety concern once it had been reported?</p> | <p>+ The person that the issue was reported to listened and took the issue seriously</p> <p>+ Management took responsibility</p> <p>+ The issue was dealt with appropriately given the level of risk</p> <p>+ Longer term solutions were planned and implemented if required</p> | <p>- The person that the issue was reported to did not listen and did not take the issue seriously</p> <p>- The person that the issue was reported to said that they were going to take action but did not (words but no action)</p> <p>- The same issue is raised time and time again, but not resolved</p> <p>- Management expect staff to "live with it" rather than resolve it</p> <p>- Responsibility was vague; no-one took responsibility to respond to the issue</p> <p>- Short term reactive action was taken, no long term management of the issue</p> |                                  |                   |

| Element                    | Sub-Element                           | Prompting Questions  | Positive Performance Indicators   | Negative Performance Indicators  | Response and Supporting Evidence | Rating (-2 to +2) |
|----------------------------|---------------------------------------|--|---|--|----------------------------------|-------------------|
| 1. Management & Leadership | 1.4 Time and Resource Commitment      | Were adequate resources available<br>Was action taken promptly?  | + Budget was available to address the issue<br>+ Prompt action was taken to address the issue   | - Budget was not available to address the issue<br>- The issue was not dealt with in a timely manner   |                                  |                   |
| 4. Risk Awareness          | 4.3 Management of Risk                | Was the risk associated with the safety concern assessed?<br>Was the issue addressed according to level of risk? | + A risk-based approach was taken to assessing and managing the issue   | - No evidence that risk was assessed and that the issue was dealt with in the context of risk  |                                  |                   |
| 6. Staff Involvement       | 6.3 Staff Involvement in Improvements | Were staff involved in the process of assessing and resolving the issue?<br>In what way?                         | + Staff were encouraged to remain involved<br>+ Staff were involved in assessing the risk<br>+ Staff were involved in developing actions to address the concern<br>+ Staff were involved in implementing actions to address the concern | - Staff not encouraged (or actively discouraged) to be involved once issue had been reported<br>- Staff not involved in assessing risk<br>- Staff not involved in developing actions to address concern<br>- Staff not involved in implementing actions to address concern |                                  |                   |

| Element             | Sub-Element            | Prompting Questions  | Positive Performance Indicators  | Negative Performance Indicators  | Response and Supporting Evidence | Rating (-2 to +2) |
|---------------------|------------------------|--|--|--|----------------------------------|-------------------|
| 3. Information Flow | 3.3 Feedback           | <p>Are staff provided with feedback about the progress of outcome of the reported concern?</p> <p>Were staff kept informed on the status of the issue?</p> <p>How was this feedback given?</p> <p>Was there a check to ensure that the message was received?</p> | <p>+ Staff were kept informed about the status of the issue</p> <p>+ Message was communicated and checked to see if received and understood</p>  | <p>- Staff were not given any information about the status of the issue</p> <p>- Staff did not take action to find out about the status of the issue</p> <p>- Message given but not checked that it was received and understood</p>              |                                  |                   |
| 3. Information flow | 3.4 Communication flow | <p>Was the issue communicated to other areas of the organisation to ensure that similar concerns are identified and resolved?</p> <p>How was this done?</p> <p>How was it identified which parts of the organisation would benefit from the information?</p>     | <p>+ The right areas of the organisation were identified</p> <p>+ The communication was delivered to the right personnel</p> <p>+ The method of communication (e.g. verbal / written) was appropriate</p> <p>+ Checked to see if received and understood</p> | <p>- Relevant areas of organisation not identified</p> <p>- Not communicated at all</p> <p>- Communication delivered to wrong personnel</p> <p>- Method of communication not appropriate</p> <p>- No check to see if received and understood</p> |                                  |                   |

| Element             | Sub-Element                            | Prompting Questions  | Positive Performance Indicators  | Negative Performance Indicators  | Response and Supporting Evidence | Rating (-2 to +2) |
|---------------------|--|--|--|--|----------------------------------|-------------------|
| 5. Learning Culture | 5.1 Internal monitoring and evaluating | <p>What do management do with the information obtained about safety concerns?</p> <p>Are issues tracked from the time that they are raised through to when they are closed?</p> <p>How often do the issues get resolved?</p> <p>Was there follow up to check that the approach taken to resolve the issue was effective?</p> <p>How did this occur?</p> <p>Is the effectiveness of the reporting system ever reviewed?</p> <p>Is there a budget allocated for the management of safety concerns?</p> | <p>+ Safety concerns are tracked from the time that they are raised through to closure</p> <p>+ Safety concerns are tracked and trends are identified and addressed</p> <p>+ Follow up occurs to ensure that the action taken is effective</p> <p>+ The effectiveness of the reporting system is reviewed and improvements are made</p> <p>+ There is a budget allocated for the management of safety concerns</p> | <p>- Safety concerns are not tracked through to closure</p> <p>- Safety concerns are not monitored to identify trends</p> <p>- Follow up does not occur to check that actions are effective</p> <p>- The reporting system is not reviewed</p> <p>- There is no budget allocated to the management of safety concerns</p> |                                  |                   |

## **SCENARIO 2: Non-Routine / Degraded Operations**

### **Interview details**

Organisation: \_\_\_\_\_ Interviewee Reference No: \_\_\_\_\_

Interviewee job level (circle): Front-line staff    Supervisor    Manager

Interview Date: \_\_\_\_\_ Time: \_\_\_\_\_

### **About this scenario**

This scenario should reveal information about the emphasis that management place on safety compared to operational performance and how this is communicated to operational staff. It should indicate whether a commitment to safety is reflected in actual behaviour during the situation.

The interviewer should ask the questions below. They must ensure that the scenario selected by the interviewee is something in which they were personally involved. The interviewee must describe what actually occurred (e.g. not what hypothetically might have occurred in an "ideal" world).

"Describe a recent time when you were involved in a situation that was non-routine or out of the ordinary in some way. This could be an incident, a delay or a situation that required activities that were outside of the normal way in which things are done"

What was the situation?

Why did it occur?

What was the sequence of events?

Who was involved?

What was your involvement in the situation?

| Element                    | Sub-Element                        | Prompting Questions  | Positive Performance Indicators  | Negative Performance Indicators  | Response and Supporting Evidence | Rating (-2 to +2) |
|----------------------------|------------------------------------|--|--|--|----------------------------------|-------------------|
| 1. Management & Leadership | 1.1 Safety Message                 | Was safety specifically discussed during this situation? How?<br>Did management communicate the importance of safety? How?   | + Managers specifically discussed the importance of maintaining safety before and/ or during the situation<br>+ Managers indicate clearly and repeatedly to operational staff that safety is first priority, using both verbal and written communication (e.g. safety tours, briefings, notices) | - Managers did not specifically discuss the importance of maintaining safety before and/ or during the situation<br>- Managers do not stipulate clearly and repeatedly to operational staff that safety is first priority, using both verbal and written communication (e.g. safety tours, briefings, notices) |                                  |                   |
| 1. Management & Leadership | 1.2 Actions Support Safety Message | How was safety managed during the situation?<br>How did line managers become involved?<br>Were the expectations of management clear?<br>Was it clear what to do in this situation?<br>Did managers act according to safety rules and procedures? | + Managers act as role models and demonstrate the desired behaviour and adhere to correct rules and protocols<br>+ Managers communicate clear expectations<br>+ Managers become involved where required  | - Managers do not set the right example, e.g. they do not follow correct rules or procedures<br>- Managers do not become involved where they should<br>- Managers do not make their expectations clear<br>- The safety message is communicated but not supported by actions                                    |                                  |                   |

| Element                    | Sub-Element   | Prompting Questions   | Positive Performance Indicators   | Negative Performance Indicators  | Response and Supporting Evidence | Rating (-2 to +2) |
|----------------------------|---------------|---|---|--|----------------------------------|-------------------|
| 1. Management & Leadership | 1.5 Decisions | <p>Did managers make decisions that prioritised performance over safety?</p> <p>Do managers understand the risks posed when performance is prioritised?</p> <p>Decisions were not being made at the appropriate level, e.g. operational staff were making decisions outside of their competence</p> | <p>+ Managers did not prioritise performance over safety in the decisions that they made</p> <p>+ Managers understand the delicate balance between operations and safety and understand the risks of putting operations ahead of safety</p> <p>+ Decisions were made at the right level</p> | <p>- Managers made decisions that prioritised operations over safety</p> <p>- Managers do not show evidence of understanding the impact their decisions can make on safety, and understanding the risk of putting operations ahead of safety.</p> <p>- Decisions were not made at appropriate levels</p> |                                  |                   |



| Element                    | Sub-Element            | Prompting Questions  | Positive Performance Indicators   | Negative Performance Indicators   | Response and Supporting Evidence | Rating (-2 to +2) |
|----------------------------|------------------------|--|---|---|----------------------------------|-------------------|
| 1. Management & Leadership | 1.7 Encouragement      | <p>Was there pressure to put operational performance (e.g. on time running) ahead of safety?</p> <p>Did you feel pressured to take short-cuts?</p> <p>If pressured, where was that pressure coming from, e.g. management, peers, internal sense of duty, etc.</p> <p>Do managers check that safety is being prioritised by operational staff? How?</p> | <p>+ Staff were explicitly reminded to maintain safety processes under pressure</p> <p>+ Staff did not feel pressure to take short-cuts / bend safety rules</p> <p>+ Managers check that staff are prioritising safety</p>                | <p>- No evidence that there was emphasis on maintaining safety ahead of performance</p> <p>- No evidence that staff were actively reminded to maintain safety</p> <p>- Staff felt pressured to achieve performance even if safety was compromised</p> <p>- Management did not check that staff prioritised safety</p> |                                  |                   |
| 3. Information Flow        | 3.4 Communication Flow | <p>How did people communicate during the situation?</p> <p>Was it difficult to coordinate the management of the situation?</p> <p>Was there confusion or panic?</p>  | <p>+ Evidence that communication and coordination were effective</p> <p>+ Evidence that communication protocols (procedures and standard terminology) were in place and used appropriately</p> <p>+ No evidence of confusion or panic</p> | <p>- Evidence that communication / coordination was not effective</p> <p>- No communication protocols</p> <p>- Communication protocols (procedures and standard terminology) in place but not used appropriately</p> <p>- Evidence of confusion or panic</p>  |                                  |                   |

| Element              | Sub-Element                                 | Prompting Questions   | Positive Performance Indicators   | Negative Performance Indicators   | Response and Supporting Evidence | Rating (-2 to +2) |
|----------------------|---|---|---|---|----------------------------------|-------------------|
| 6. Staff Involvement | 6.3 Staff Involvement in Safety Initiatives | <p>What actions did others in the situation take?</p> <p>Did managers / supervisors become involved?</p> <p>Do employees understand their roles and responsibilities in this situation?</p> <p>Was the degree of involvement by others adequate for best management of the situation?</p> | <p>+ Others became involved in the situation where required</p> <p>+ Responsibility was shed / shared appropriately</p> <p>+ The involvement of others facilitated rather than hindered the effective management of the situation</p> | <p>- Others did not become involved in the situation where it was required</p> <p>- Certain staff were overloaded, others under-loaded, responsibility not shared appropriately</p> <p>- The involvement of others hindered the situation</p> |                                  |                   |

| Element             | Sub-Element                            | Prompting Questions  | Positive Performance Indicators   | Negative Performance Indicators   | Response and Supporting Evidence | Rating (-2 to +2) |
|---------------------|--|--|---|---|----------------------------------|-------------------|
| 5. Learning Culture | 5.1 Internal Monitoring and Evaluating | <p>Were there any "lessons learned", e.g. things that could be done better next time?</p> <p>How were these identified?</p> <p>How were they communicated?</p> <p>Were they communicated to the appropriate staff?</p> <p>Were systems / processes developed to avoid these situations occurring again?</p> <p>Are reviews conducted to ensure that safety is prioritised in these situations?</p> | <p>+ "Lessons" were identified</p> <p>+ Lessons were communicated</p> <p>+ Lessons were communicated to appropriate staff</p> <p>+ Systems developed to avoid these situations and / or better manage them next time</p> <p>+ Reviews are undertaken to ensure that safety is prioritised in these situations</p> | <p>- No lessons identified where they should have been</p> <p>- Lessons identified but not communicated</p> <p>- Lessons not communicated to appropriate staff</p> <p>- No systems put in place to avoid these situations and / or better manage them next time</p> |                                  |                   |

### **SCENARIO 3: Incident Management**

#### **Interview details**

Organisation: \_\_\_\_\_ Interviewee Reference No: \_\_\_\_\_

Interviewee job level (circle): Front-line staff    Supervisor    Manager

Interview Date: \_\_\_\_\_ Time: \_\_\_\_\_

#### **About this scenario**

This scenario should reveal information about the actions taken by management to investigate the underlying causes of an incident and the implement actions to address the issues. It should also reveal information about the involvement of operational staff in the investigation and disciplinary process.

The interviewer should ask the questions below. They must ensure that the scenario selected by the interviewee is something in which they were personally involved. The interviewee must describe what actually occurred (e.g. not what hypothetically might have occurred in an “ideal” world).

“Describe a recent safety incident that you were involved in, e.g. SPAD, derailment, misroute, maintenance error, etc”.

What happened?

Who was involved?

How was it identified and reported?

Who identified and reported it?

How was it investigated?

Who investigated it?

What mitigation actions were taken?

| Element                    | Sub-Element                          | Prompting Questions  | Positive Performance Indicators   | Negative Performance Indicators   | Response and Supporting Evidence | Rating (-2 to +2) |
|----------------------------|--------------------------------------|--|---|---|----------------------------------|-------------------|
| 3. Information Flow        | 3.1 Employee Reporting Behaviour     | Was the incident reported?<br>How?<br>Who was it reported to?  | + Reported through appropriate channels<br>+ Reported by person(s) involved<br>+ Reported to the appropriate person<br>+ Reported incident promptly | - Not reported<br>- Reported through inappropriate channels<br>- Reported to inappropriate person<br>- Delayed reporting      |                                  |                   |
| 3. Information Flow        | 3.2 Organisational Reporting Systems | Was there a system for reporting incidents?<br>If so, was the system followed?<br>Why, why not?  | + System in place<br>+ System known<br>+ System followed and issue reported correctly<br>+ System supported needs                                   | - No appropriate system available<br>- System in place but not known or not used<br>- System did not adequately support needs |                                  |                   |
| 1. Management & Leadership | 1.5 Decisions                        | How was it decided whether to investigate the incident further?<br>What proportion of incidents are investigated?<br>What criteria is used to select an incident for investigation?<br>How was the specific incident investigated? | + Clear criteria for which incidents to investigate further<br>+ Formal procedures in place to investigate the incident                             | - No clear criteria for which incidents to investigate<br>- No formal procedures to investigate the incident                  |                                  |                   |

| Element                    | Sub-Element | Prompting Questions  | Positive Performance Indicators  | Negative Performance Indicators   | Response and Supporting Evidence | Rating (-2 to +2) |
|----------------------------|-------------|--|--|---|----------------------------------|-------------------|
| 2. Just Culture            | 2.1 Trust   | <p>Did staff feel comfortable and at ease in reporting the incident?</p> <p>How were staff treated during the investigation?</p> <p>How did staff feel during the investigation?</p> | <p>+ Felt comfortable reporting the incident</p> <p>+ Treated with respect</p> <p>+ Put at ease during the investigation</p>   | <p>- Felt uneasy reporting, fear of blame, fear of being a "nuisance"</p> <p>- Felt uneasy and uncomfortable during the investigation</p>   |                                  |                   |
| 1. Management & Leadership | 1.6 Actions | <p>What were the outcomes of the investigation?</p> <p>Do you think that the solutions to address problems identified were appropriate?</p>  | <p>+ Recommendations for improvement were likely to improve safety</p> <p>+ Recommendations addressed the issues identified accordingly</p> <p>+ Immediate as well as long term actions identified and implemented</p> | <p>- Recommendations for improvement were not likely to avoid a similar incident occurring</p> <p>- Only short term actions identified, no long term strategies for prevention identified</p> |                                  |                   |

| Element                    | Sub-Element                      | Prompting Questions  | Positive Performance Indicators  | Negative Performance Indicators  | Response and Supporting Evidence | Rating (-2 to +2) |
|----------------------------|----------------------------------|--|--|--|----------------------------------|-------------------|
| 1. Management & Leadership | 1.4 Time and Resource Commitment | <p>Was the incident investigation completed within a reasonable time frame?</p> <p>Were mitigation actions implemented within a reasonable time frame?</p> <p>Was adequate budget available to implement the appropriate mitigation actions?</p> | <p>+ Incident investigated promptly</p> <p>+ Actions taken to address issues implemented in a timely manner</p> <p>+ Adequate budget available</p> | <p>- Incident investigation drawn out or took a long time to commence</p> <p>- Actions to address issues were not implemented in a timely manner</p> <p>- Budget not available to implement all required actions</p> |                                  |                   |

| Element         | Sub-Element                  | Prompting Questions  | Positive Performance Indicators   | Negative Performance Indicators   | Response and Supporting Evidence | Rating (-2 to +2) |
|-----------------|------------------------------|--|---|---|----------------------------------|-------------------|
| 2. Just Culture | 2.2 Fault Allocation Process | <p>Did the investigation look for causes? Did it consider reasons for human failure?</p> <p>Was there a process for differentiating between intentional and unintentional behaviour?</p> <p>How were decisions made about behaviour, e.g. acceptable, not acceptable?</p> <p>What factors were considered in the investigation? Were they sufficient to identify what really happened?</p> | <p>+ A thorough analysis was undertaken to investigate all possible underlying causes and events leading to the incident</p> <p>+ Care was taken not to apportion blame before analysis is complete</p> <p>+ Investigation looked for reasons for human behaviour rather than blaming the individual</p> <p>+ Openness by management to acknowledge problems / accept responsibility for problems where appropriate</p> <p>+ Openness by staff to accept responsibility for problems where appropriate</p> <p>+ Factors investigated were sufficient to identify what really happened</p> | <p>- Investigation pinned "blame" on the individual without adequate assessment of causes of behaviour</p> <p>- Blame was apportioned or insinuated before the analysis was complete</p> <p>- Blame was apportioned until individuals involved are proven "not guilty"</p> <p>- Unintentional errors / mistakes were blamed</p> <p>- Factors investigated were not adequate to identify what really happened, e.g. Surface issues only.</p> |                                  |                   |



| Element           | Sub-Element              | Prompting Questions   | Positive Performance Indicators   | Negative Performance Indicators  | Response and Supporting Evidence | Rating (-2 to +2) |
|-------------------|--------------------------|---|---|--|----------------------------------|-------------------|
| 2. Just Culture   | 2.3 Disciplinary Process | <p>What disciplinary procedures were used?</p> <p>Were these appropriate and consistent with other investigations?</p>  | <p>+ Disciplinary procedures consistent with other investigations</p> <p>+ The disciplinary procedures clear distinguish between different degrees of culpability, e.g. blameless, system induced or reckless errors</p>                                | <p>- Disciplinary procedures appeared inconsistent with other investigations</p> <p>- Disciplinary procedures do not distinguish between different degrees of culpability</p> <p>- There are no clear procedures for deciding upon the relevant disciplinary actions</p> |                                  |                   |
| 4. Risk Awareness | 4.3 Management of Risk   | <p>Was the issue risk assessed and addressed according to the level of risk?</p> <p>Were immediate as well as long-term actions considered?</p> <p>Were the actions implemented according to risk priority?</p> <p>Was an action plan developed to prevent re-occurrence.</p> | <p>+ Was risk assessed</p> <p>+ Solutions were evaluated and prioritised in terms of their likelihood of preventing a similar occurrence and / or mitigating consequences</p> <p>+ The hierarchy of controls, e.g. eliminate, mitigate etc was used</p> | <p>- Was not risk assessed</p> <p>- Solutions were not evaluated / prioritised in context of risk</p> <p>- Hierarchy of controls not used</p>  |                                  |                   |

| Element             | Sub-Element            | Prompting Questions   | Positive Performance Indicators   | Negative Performance Indicators  | Response and Supporting Evidence | Rating (-2 to +2) |
|---------------------|------------------------|---|---|--|----------------------------------|-------------------|
| 5. Learning Culture | 5.2 Systemic Analysis  | <p>Did the investigation identify precursors that may have led to the incident rather than just looking at behaviour of individuals?</p> <p>To what extent do you think that the recommendations will prevent a similar incident?</p> | <p>+ Recommendations for improvement were long-term proactive strategies to minimise risk</p> <p>+ Recommendations sought to identify and address underlying problems</p>   | <p>- Recommendations were short-term "firefighting" strategies that could still result in a similar incident occurring</p> <p>- Recommendations addressed surface "easy to fix" issues</p>   |                                  |                   |
| 3. Information Flow | 3.4 Communication flow | <p>Were the outcomes and recommendations from the incident investigation communicated?</p> <p>How was it ensured that all relevant divisions / areas were informed?</p>   | <p>+ Relevant divisions identified</p> <p>+ Communicated effectively to divisions</p> <p>+ Appropriate strategies for communicating the outcomes of the investigation</p> <p>+ Check to see that divisions received message</p> | <p>- Relevant divisions not identified</p> <p>- Not communicated to divisions</p> <p>- Not communicated effectively to divisions</p> <p>- No strategies for communicating outcomes</p> <p>- Not checked to see if message received</p> |                                  |                   |
| 3. Information Flow | 3.3 Feedback           | <p>Was feedback given to the individual(s) involved regarding investigation findings and improvement strategies?</p>  | <p>+ Those involved were informed of the status and outcomes of the investigation</p>   | <p>- Those involved were not informed of the status or outcomes of the investigation</p>   |                                  |                   |

| Element             | Sub-Element                            | Prompting Questions  | Positive Performance Indicators  | Negative Performance Indicators   | Response and Supporting Evidence | Rating (-2 to +2) |
|---------------------|--|--|--|---|----------------------------------|-------------------|
| 5. Learning Culture | 5.1 Internal Monitoring and Evaluating | Follow-up to check recommendations implemented effectively | <p>+ Follow up occurred to check that recommendations were implemented</p> <p>+ Follow up occurred to check that recommendations were effective`</p> | <p>- No follow up to check that recommendations were implemented</p> <p>- No follow up to check that recommendations were effective</p> |                                  |                   |

## **SCENARIO 4: Change Management**

### **Interview details**

Organisation: \_\_\_\_\_ Interviewee Reference No: \_\_\_\_\_

Interviewee job level (circle): Front-line staff    Supervisor    Manager

Interview Date: \_\_\_\_\_ Time: \_\_\_\_\_

### **About this scenario**

This scenario should reveal information about how changes are managed, how management involve operational staff in the change process and the extent to which staff are consulted and involved in safety related decisions.

The interviewer should ask the questions below. They must ensure that the scenario selected by the interviewee is something in which they were personally involved. The interviewee must describe what actually occurred (e.g. not what hypothetically might have occurred in an "ideal" world).

"Describe a recent change that has occurred, relevant to your role, e.g. new equipment, new system / procedure, change to workplace, change to organisational structure, etc."

What was the change?

What was the reason for the change?

Who was involved in planning / preparing for the change?

How was it implemented?

How was the impact monitored?

| Element                    | Sub-Element                    | Prompting Questions   | Positive Performance Indicators   | Negative Performance Indicators   | Response and Supporting Evidence | Rating (-2 to +2) |
|----------------------------|--------------------------------|---|---|---|----------------------------------|-------------------|
| 1. Management & Leadership | 1.4 Time & Resource Commitment | <p>Did the planning and change management occur in a timely manner, e.g. was there enough time to adequately plan?</p> <p>Was there enough time to implement appropriate strategies to manage the change?</p> <p>Was adequate budget available to implement the appropriate actions to manage the change?</p> | <p>+ Planning and change management occurred in a timely manner</p> <p>+ There was enough time to plan and take appropriate actions</p> <p>+ Appropriate people were made available and enough of their time was allocated to the change management process</p> <p>+ There was sufficient budget available to manage the change</p> | <p>- There was not enough time to adequately plan or manage the change</p> <p>- The appropriate people were too busy or unavailable to take part in the change management process</p> <p>- There was insufficient budget to manage the change</p> |                                  |                   |
| 1. Management & Leadership | 1.5 Decisions                  | <p>Did the decisions that were made support safety?</p>   | <p>+ Decisions were made that supported safe operations throughout the change</p>   | <p>- Decisions were made that negatively impacted on safety</p>   |                                  |                   |

| Element           | Sub-Element                              | Prompting Questions  | Positive Performance Indicators  | Negative Performance Indicators   | Response and Supporting Evidence | Rating (-2 to +2) |
|-------------------|--|--|--|---|----------------------------------|-------------------|
| 4. Risk Awareness | 4.2 Proactivity & a Questioning Attitude | <p>Are proposed changes planned using a structured method?</p> <p>Were the processes in place to manage change within the organization actually used?</p> <p>Did people know and understand them?</p> <p>Were they effective and of value?</p> | <p>+ There is a structured method for preparing for a change</p> <p>+ The processes were used in this example</p> <p>+ These were well understood</p> <p>+ They were seen to be effective and of value</p> | <p>- There is no structured method for preparing for a change</p> <p>- There are no processes in place in the organization for change management</p> <p>- There were processes in place, but not applied in this example</p> <p>- The systems were not well understood</p> <p>- The systems were not seen to be effective or of value</p> |                                  |                   |

| Element                    | Sub-Element            | Prompting Questions  | Positive Performance Indicators  | Negative Performance Indicators  | Response and Supporting Evidence | Rating (-2 to +2) |
|----------------------------|------------------------|--|--|--|----------------------------------|-------------------|
| 4. Risk Awareness          | 4.3 Management of Risk | <p>Were the potential safety impacts of the change identified prior to the change occurring? E.g. risk assessment of the change.</p> <p>How was this done?</p> <p>Was the risk identification process effective?</p> <p>Is a log maintained of the key risks associated with the change and are actions developed and action owners assigned?</p> <p>Did you believe that adequate planning occurred prior to the change to identify and manage any potential problems that could occur as a result of the change?</p> | <p>+ Safety risks associated with the change were identified prior to the change</p> <p>+ The identification of risks was seen to be effective</p> <p>+ If risks were identified, they were treated seriously and assessed and managed appropriately</p> <p>+ Time and effort spent on identifying potential problems and resolving them prior to the change being implemented</p> | <p>- The safety risks associated with the change were not identified prior to the change</p> <p>- Some safety risks were identified but process not seen to be effective / comprehensive</p> <p>- Risks were identified but inadequately managed</p> <p>- The change was rushed</p> <p>- Inadequate time and effort allocated to identifying and managing potential problems</p> <p>- Potential issues were identified but not managed</p> |                                  |                   |
| 1. Management & Leadership | 1.6 Actions            | <p>Did management ensure that the appropriate actions were taken to manage the change, e.g. did things get done?</p>   | <p>+ Management actively ensured that all actions were undertaken to manage the change effectively</p>   | <p>- Management did not undertake all required actions to manage the change</p>  |                                  |                   |

| Element                    | Sub-Element                      | Prompting Questions   | Positive Performance Indicators  | Negative Performance Indicators   | Response and Supporting Evidence | Rating (-2 to +2) |
|----------------------------|----------------------------------|---|--|---|----------------------------------|-------------------|
| 1. Management & Leadership | 1.1 Safety message               | Did managers reinforce the importance of safety throughout the change?  | + Safety was reinforced through communication, e.g. briefings, notices.  | - Safety was not reinforced   |                                  |                   |
| 6. Staff Involvement       | 6.1 Staff Involvement in Changes | <p>Were the appropriate staff involved in the change?</p> <p>Who is responsible for identifying and involving the appropriate staff?</p> <p>How are staff at all levels involved in the change management process?</p> <p>Are staff given the opportunity to comment on proposed changes before they are implemented?</p> <p>Do management involve staff in a timely manner?</p> <p>Do management recognise the potential impacts of not involving staff in the change process?</p> | <p>+ A range of relevant stakeholders was identified and involved in the change process</p> <p>+ Staff are involved in a timely manner</p> <p>+ Staff are involved in a meaningful and productive way</p> <p>+ Staff have opportunity to provide input at all phases of the change</p> <p>+ Management recognise the importance of involving staff</p> | <p>- Not all relevant stakeholders were identified and involved</p> <p>- Staff had some involvement, but not deemed to be adequate</p> <p>- Staff only involved in a superficial manner</p> <p>- Staff not involved early enough in the process</p> <p>- Management do not understand the impact of not involving staff</p> |                                  |                   |



| Element             | Sub-Element            | Prompting Questions   | Positive Performance Indicators   | Negative Performance Indicators   | Response and Supporting Evidence | Rating (-2 to +2) |
|---------------------|------------------------|---|---|---|----------------------------------|-------------------|
| 3. Information Flow | 3.4 Communication Flow | <p>Were relevant stakeholders / staff informed about aspects of the change relevant to them?</p> <p>Did staff know who to communicate with about various aspects of the change and who to seek information from?</p> <p>Were there specific briefing sessions and / or training?</p> <p>Was there opportunity to comment on the change?</p> | <p>+ Information was given to all those affected by / involved in the change</p> <p>+ There were clear lines of communication for the change, e.g. people knew who to talk to, who to raise issues with, etc.</p> <p>+ Specific forums were held to communicate about the change, e.g. Briefings.</p> | <p>- People felt ill-informed about the change</p> <p>- There was confusion about who to communicate with and about what</p> <p>- There were no specific forums held to discuss the change and communicate issues</p> |                                  |                   |
| 3. Information Flow | 3.3 Feedback           | <p>Did you receive feedback about the progress leading up to the change?</p> <p>Did you receive information about the status and effectiveness of the change when implemented?</p>  | <p>+ Status reports were regularly given throughout the change process to those affected / involved</p>   | <p>- The status of the change was not communicated during the change process to those affected / involved</p>   |                                  |                   |

| Element             | Sub-Element                          | Prompting Questions   | Positive Performance Indicators  | Negative Performance Indicators   | Response and Supporting Evidence | Rating (-2 to +2) |
|---------------------|--------------------------------------|---|--|---|----------------------------------|-------------------|
| 5. Learning Culture | 5.1 Internal Monitoring & Evaluating | Was information collected relevant to the change to identify impacts? E.g. Data about safety incidents, data about performance, etc. Was there increased monitoring during and after the change transition? | <p>+ Increased monitoring of performance during the transition occurred</p> <p>+ Specific information relevant to the change was collected</p> <p>+ The information that was monitored was based on the planning and risk assessments conducted prior to the change, e.g. Information relevant to those factors that may be impacted by the change</p> | <p>- No increase in monitoring occurred</p> <p>- No specific information collected relevant to the change</p> |                                  |                   |

## **SCENARIO 5: Management of Safety**

### **Interview details**

Organisation: \_\_\_\_\_ Interviewee Reference No: \_\_\_\_\_

Interviewee job level (circle): Front-line staff    Supervisor    Manager

Interview Date: \_\_\_\_\_ Time: \_\_\_\_\_

### **About this scenario**

This scenario should reveal information about how safety is managed within the organisation. It should reflect perceptions of management commitment to safety and staff awareness about how safety is managed.

The interviewer should ask the questions below. These questions are slightly different from the other scenarios as they don't necessarily require the interview to describe a specific situation. They ask for a range of evidence around a number of different parameters of safety management.

The interviewer must still ensure that the interviewee can describe the way that safety is managed from their own personal experience (e.g. not second or third hand). The interviewee must describe what actually occurs, and not what hypothetically may occur in an "ideal" world.

"Describe how senior and middle management manage safety"

Refer to prompt questions as outlined below.

| Element                    | Sub-Element    | Prompting Questions  | Positive Performance Indicators   | Negative Performance Indicators   | Response and Supporting Evidence | Rating (-2 to +2) |
|----------------------------|----------------|--|---|---|----------------------------------|-------------------|
| 1. Management & Leadership | 1.8 Systems    | <p>What formal systems are in place for managing safety in the workplace, e.g. safety management systems?</p> <p>Are systems understood by all levels of the organisation?</p> <p>Are systems actively "lived", e.g. Are they actually used?</p> <p>Are safety responsibilities defined? Are personnel aware of their responsibilities for their own safety and the safety of others? How?</p> | <p>+ Safety management systems exist and of a high quality and comprehensive</p> <p>+ Systems are well understood</p> <p>+ Demonstrated evidence that the systems are actually used</p> <p>+ Evidence that the systems have become part of "the way things are done around here"</p> <p>+ Responsibilities and accountabilities are clear and well understood</p> | <p>- No safety management systems or limited or poor quality</p> <p>- Systems are not well understood</p> <p>- There is limited evidence that the systems are actually used</p> <p>- Systems appear to exist but are not used</p> <p>- Responsibilities are unclear</p> |                                  |                   |
| 1. Management & Leadership | 1.3 Visibility | <p>Do management spend time out in operational areas?</p> <p>How do management interact with operational staff?</p>  | <p>+ Evidence that management regularly interact with operational staff, e.g. evidence in schedules of regular visits</p> <p>+ Interactions involve conversations, not just visibility</p>  | <p>- Management do not regularly visit operational areas</p> <p>- Management visit operational areas but do not interact with operational staff</p> <p>- Management only visit when "something goes wrong"</p>  |                                  |                   |

| Element                    | Sub-Element                        | Prompting Questions  | Positive Performance Indicators  | Negative Performance Indicators  | Response and Supporting Evidence | Rating (-2 to +2) |
|----------------------------|------------------------------------|--|--|--|----------------------------------|-------------------|
| 1. Management & Leadership | 1.2 Actions support safety message | <p>Are management aware of risks in operational areas?</p> <p>Do they wear appropriate PPE?</p> <p>Do managers demonstrate the right safety behaviours?</p> <p>Do managers set the right example with respect to safety?</p> | <p>+ Management show good understanding of risks in operational areas</p> <p>+ Operational staff see management "doing the right thing"</p>  | <p>- Management do not display a good understanding of risks in operational areas</p> <p>- Management do not demonstrate the right safety behaviours</p> <p>- Management are sometimes seen to "say one thing but do another"</p>                |                                  |                   |
| 4. Risk Awareness          | 4.3 Management of risk             | <p>How are risks identified and priorities associated with each risk assessed?</p>   | <p>+ Structured and systematic approach to identifying risks associated with operations and changes to operations</p> <p>+ Standardised method for ranking and prioritising risk management activities</p> | <p>- Risks not identified</p> <p>- Risks are sometimes identified but no standard &amp; systematic approach</p> <p>- Operational risks understood but changes not assessed well</p> <p>- Risks are identified but not ranked and prioritised</p> |                                  |                   |

| Element                    | Sub-Element                                | Prompting Questions   | Positive Performance Indicators   | Negative Performance Indicators  | Response and Supporting Evidence | Rating (-2 to +2) |
|----------------------------|--|---|---|--|----------------------------------|-------------------|
| 4. Risk Awareness          | 4.1 Employee understanding of safety risks | To what extent do management understand the operational risks?<br>To what extent do operational (frontline) staff understand operational risks?   | + Management display a comprehensive understanding of safety risks within the organisation or within their division<br>+ Frontline staff display a comprehensive understanding of the risks within their operational division                             | - Management are not really aware of the safety risks within the organisation or within their division<br>- Frontline staff do not display a comprehensive understanding of the risks that they face within their operational division<br>- Personnel have become complacent over time and "blind" to the dangers of the job |                                  |                   |
| 1. Management & Leadership | 1.5 Decisions                              | How are decisions made about when to address safety risks and issues?<br>Is money best spent where it should be?<br>Do decisions about schedules and priorities take into account safety?<br>How? | + Decisions made about safety issues are made promptly<br>+ Decisions are made based on risk assessments<br>+ Appropriate personnel are involved in the decision making process<br>+ Decisions about schedules and operational priorities consider safety | - Decisions are not made promptly<br>- Decisions are not based on risk assessments<br>- Personnel are not consulted in the decision making process<br>- Decisions about schedules and operational priorities rarely consider safety impacts  |                                  |                   |

| Element                    | Sub-Element       | Prompting Questions  | Positive Performance Indicators   | Negative Performance Indicators   | Response and Supporting Evidence | Rating (-2 to +2) |
|----------------------------|-------------------|--|---|---|----------------------------------|-------------------|
| 1. Management & Leadership | 1.6 Actions       | Are actions taken when safety issues are raised?   | <ul style="list-style-type: none"> <li>+ Actions are taken to address known safety issues</li> <li>+ The timeliness of actions are appropriate given the level of risk</li> </ul>   | <ul style="list-style-type: none"> <li>- Actions are not taken to address known safety issues</li> <li>- Actions are slow to be taken, given the level of risk</li> </ul>   |                                  |                   |
| 1. Management & Leadership | 1.7 Encouragement | <p>Do management encourage safe behaviour?</p> <p>Are short-cuts permitted sometimes in order to get the job done?</p> | <ul style="list-style-type: none"> <li>+ Management actively encourage safe behaviour at every opportunity</li> <li>+ Management make efforts to observe operations and commend safe behaviour and correct unsafe behaviour</li> <li>+ Short-cuts are never condoned and this message is reinforced at every opportunity</li> </ul> | <ul style="list-style-type: none"> <li>- Management do not actively encourage safe behaviour</li> <li>- Management do not get involved in operations and provide feedback to operational staff (e.g. commending safe behaviour and correcting unsafe behaviour)</li> <li>- Shortcuts are sometimes condoned. Management might not be consciously aware that they do this</li> </ul> |                                  |                   |

| Element              | Sub-Element  | Prompting Questions  | Positive Performance Indicators  | Negative Performance Indicators   | Response and Supporting Evidence | Rating (-2 to +2) |
|----------------------|--|--|--|---|----------------------------------|-------------------|
| 6. Staff Involvement | 6.2 Staff involvement in development of policies, systems and procedures | Are personnel at all levels involved in making decisions about safety?<br>How do they get to have input? | <p>+ Operational personnel as well as management provide input to safety decisions</p> <p>+ Operational staff get input in a variety of ways including formal (e.g. Risk assessments, safety meetings) and informal methods (e.g. Conversations with managers)</p> | <p>- Operational personnel are not usually involved in making decisions</p> <p>- Decisions are usually made by the same key managers</p> <p>- Operational staff do not often get an opportunity to provide input to decisions</p> <p>- Input is sometimes given informally, but there are limited formal mechanisms</p> |                                  |                   |



| Element             | Sub-Element            | Prompting Questions  | Positive Performance Indicators  | Negative Performance Indicators   | Response and Supporting Evidence | Rating (-2 to +2) |
|---------------------|------------------------|--|--|---|----------------------------------|-------------------|
| 3. Information flow | 3.4 Communication flow | How do management and frontline personnel communicate with one another? How do messages get through? | <ul style="list-style-type: none"> <li>+ Management and frontline personnel have many and varied opportunities for communication (both informal and formal)</li> <li>+ Management and operational staff report that there are good two-way communications</li> <li>+ Operational staff feel well informed</li> <li>+ Multiple channels are usually used to deliver messages across the organisation</li> </ul> | <ul style="list-style-type: none"> <li>- There are limited opportunities for communication between management and frontline staff</li> <li>- Management and / or operational staff report that communications are poor</li> <li>- Operational staff do not feel well informed</li> <li>- Communications are often delivered only via one channel</li> </ul> |                                  |                   |

| Element                    | Sub-Element                            | Prompting Questions  | Positive Performance Indicators   | Negative Performance Indicators  | Response and Supporting Evidence | Rating (-2 to +2) |
|----------------------------|--|--|---|--|----------------------------------|-------------------|
| 1. Management & Leadership | 1.1 Safety message                     | <p>Is there a clear message about the importance of safety?</p> <p>Is this message consistent?</p> <p>Is this message strong and reinforced?</p>   | <p>+ The safety message is clear across the organisation</p> <p>+ Safety is considered important at all levels of the organisation</p> <p>+ The message about safety is consistent across and up/down the organisation</p> <p>+ The safety message is reinforced in numerous ways</p> | <p>- The safety message is not clearly communicated or understood across the organisation</p> <p>- The safety message is not considered important at all levels of the organisation</p> <p>- There are inconsistencies in terms of the safety message across the organisation</p>                |                                  |                   |
| 5. Learning culture        | 5.1 Internal monitoring and evaluating | <p>How are changes monitored and the success of them evaluated?</p> <p>If new equipment is introduced or a new system, is it monitored?</p> <p>How are improvement opportunities identified and addressed?</p> | <p>+ Changes are made and a clear process is in place for post implementation review</p> <p>+ Close monitoring occurs during the introduction of changes, e.g. New equipment, new processes</p> <p>+ Improvement opportunities are identified and addressed</p>                       | <p>- There is no systematic way of monitoring changes when they are introduced</p> <p>- The success of changes is not reviewed</p> <p>- Improvement opportunities are not identified</p> <p>- Improvement opportunities are identified, but no action is taken to introduce the improvements</p> |                                  |                   |

| Element             | Sub-Element             | Prompting Questions  | Positive Performance Indicators   | Negative Performance Indicators   | Response and Supporting Evidence | Rating (-2 to +2) |
|---------------------|-------------------------|--|---|---|----------------------------------|-------------------|
| 5. Learning culture | 5.3 External Monitoring | <p>Does the organisation look to other organisations or industry leaders for ideas for safety improvements?</p> <p>Is the organisation focused on continuously keeping informed of improvements in safety management and implementing these within the organisation?</p> <p>Does the organisation strive for continuous improvement?</p> | <p>+ The organisation looks to other organisations for ideas on leading practice</p> <p>+ The organisation looks at its own industry as well as other leading industries in safety management</p> <p>+ The organisation identifies and implements leading practice improvements</p> <p>+ The organisation strives for continuous improvement through demonstrated monitoring of trends and implementation of improvements</p> | <p>- The organisation tends to be insular and does not actively seek leading practice ideas</p> <p>- The organisation may look towards local organisations in the same industry but rarely looks outside its own local area or at other industries</p> <p>- The organisation does not identify leading practice improvements</p> <p>- The organisation identifies leading practice ideas for improvement but does not apply them</p> <p>- The organisation does not display evidence that it strives for continuous improvement</p> |                                  |                   |

| Element             | Sub-Element            | Prompting Questions   | Positive Performance Indicators   | Negative Performance Indicators  | Response and Supporting Evidence | Rating (-2 to +2) |
|---------------------|------------------------|---|---|--|----------------------------------|-------------------|
| 5. Learning culture | 5.4 Safety Measurement | <p>How is safety measured?</p> <p>What parameters are regularly measured to reflect safety performance?</p> <p>Are these communicated across the organisation?</p> <p>Are successes celebrated? How is success measured?</p> <p>Do management consistently monitor and review employee thoughts, opinions and feelings concerning the effectiveness of safety management within the organisation?</p> | <p>+ A range of parameters are used to measure safety</p> <p>+ These parameters are positive as well as negative indicators</p> <p>+ Parameters reflect true safety performance and not statistically insignificant fluctuations</p> <p>+ Success is celebrated, but only if it can be truly measured to be an improvement in safety</p> <p>+ Safety efforts are rewarded, not just outcomes</p> <p>+ Management consistently measure employee opinions (e.g. Via safety climate / culture surveys)</p> | <p>- Safety is only measured by typical indicators such as SPADs and Lost time injuries</p> <p>- Positive parameters (such as strength and quality of risk management controls) are not measured</p> <p>- Safety parameters that are measured are not considered in terms of the statistical significance of fluctuations</p> <p>- Safety outcomes are rewarded but often these don't reflect safety effort</p> <p>- Employee opinions are not consistently measured (e.g. Via safety climate / culture surveys)</p> |                                  |                   |