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A way out of the impasse

Assessing the company culture instead of the safety culture

In a first opinion piece (*Tribune de la sécurité insdustrielle* n°2015-04) which discussed safety culture, René Amalberti, Director of FonCSI, presented the opposing trends in this area. Today, in this follow-on opinion piece, René Amalberti suggests a new approach: assess the company culture instead of the safety culture.

Adapting values or changing behaviour: as discussed in the previous opinion piece, academics disagree on the best way to make progress through a safety culture. But isn't this debate simply outdated? Let's shift the analysis to three essential questions instead.

Is it right to keep focusing on the same set of values and behaviours in order to optimise safety?

Currently, where behaviour is concerned, we want people to follow procedures and comply with best practices; in terms of values, we seek commitment from management, transparency, and avoidance of a blame culture. This is not a rhetorical question, but one which asks us to consider what safety really is: is it living without serious accidents, without incidents, or following optimal procedures? Almost all existing approaches to safety culture and human and organisational factors corroborate choices that have already been made for years so that they are adopted and monitored in the field. In a way, they introduce safety culture as a final means of optimisation, while taking care to remain compatible with the solutions already chosen. To put it another way, we think of safety culture when we have exhausted the more technical, organisational and rational solutions.

In this context, the recurring idea about safety culture is that of a continuity between failure to follow procedures, errors, incidents and avoidance of serious accidents. It makes sense to everyone and has been considered self-evident ever since the famous Bird pyramid. And yet, this idea of continuity of causes has been largely debunked by academics, who easily demonstrate its lack of scientific basis: depending on the context, the same causes do not trigger the same effects. There is little chance then that a taxonomy of common causes will predict a major accident. A better predictor would be a taxonomy of common contexts and no one has really written one yet (Dekker, Pariès).

Worse still, in the end this appealing idea of a continuity between errors, incidents and accidents serves primarily to achieve a performance with as few problems and as little waste as possible. The problems which can be identified by the usually-available indicators and then corrected are those that are the most repetitive and heavily influence the achievement of peak performance, as well as points monitored and penalised by the regulatory bodies — the industry's TRIR (Total Recordable Injury Rate), for example. However, these aren't necessarily

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the problems that lead to serious accidents. Indeed, this is actually the core principle — along with some degree of honesty — behind Lean Management, which focuses less on the impact on safety culture and more on improving performance and quality through the work atmosphere.

In a way, the values that we favour in (nearly) all current safety culture approaches are in fact only values that are compatible with optimising the technical choices already made. Had we introduced the idea of culture into the history of system safety improvement first, before optimising safety via technique and organisation, our current choice of practices might have been different.

This debate is not new. Franck Guldenmund broached the subject in 2010 by pointing out the industrial sector's recurrent misunderstanding of the initial concept underpinning the introduction of the term "safety culture". Safety culture has become a normative tool, whereas the INSAG (International Nuclear Safety Advisory Group), which coined the term just after Chernobyl, saw in it a system of tacit values shared within the company to give it added strength, coherence and collective resistance to accidents, without there necessarily being visible manifestations of it at all times, particularly in terms of ideal behaviour.

"To use a medical metaphor, a good safety culture would result in a healthy body that is more robust against illnesses, but not the suppression of illnesses"

This is also the position of high-reliability organisations (HRO), and notably John Carroll and Karl Weick, who advocate adaptation as the primary value for collective intelligence capable of straying from procedures, and Gudela Grote, who speaks of "management of uncertainty"; it is even more the case of Erik Hollnagel's "Safety I-Safety II" approach, which recommends completely abandoning compliance in favour of enhancing only the intelligence of adaptation for true safety, usually obtained under non-standard conditions. And actually it is worth noting that these last two approaches do not really use the term 'safety culture' in their vocabulary; they refer instead to 'resilience'. Note also that the innovative nature of these approaches is far from being easily adopted in the field.

The HROs were careful to emphasise a capacity needed to detect the unexpected (sensemaking), while also embracing the industrial sector's classic values: protocols, roles, commitment from management, transparency, and avoidance of a blame culture. As for the extreme vision of Hollnagel's "Safety II", although it is appealing, to date it has not directly penetrated any industry.

What can we expect to gain?

This is the natural continuation of the previous point. The concern for safety culture is rather like a process for optimising choices that have already been made and that have already greatly contributed to safety. As a concern for safety culture is the lowest priority in optimisation processes, it remains restricted by previous choices with regards to the values it encourages. As a result, the potential for gains and the impact on safety are inevitably minimal. You have to invest over the long term, without really knowing where to start to tackle the problem — values first or behaviour first? —, in order to make very little progress in the end. As it is difficult not to measure, we naturally measure the easiest aspects (visible and repeated problems) and in the end, we reap what we sow: mostly improvements in performance — particularly in industries where ironing out problems quickly leads to better product quality —, but not necessarily a higher rate of avoidance of the rarest, most serious accidents.

One culture or several?

There is no such thing as a cultureless company. The question is rather: which culture is best? Remember that a company can die of several causes: products/organisation incompatible with market demand, financial problems, poor quality production, and inadequate safety.

Each of these aspects is combined with favourable and unfavourable cultural aspects (values to be shared): positive change culture, quality culture, culture of relevance and efficiency, safety culture.

Thus, a company that has a strong culture of change and adaptation will be able to successfully weather crises that would destroy other companies.

When assessing such a company, one would no doubt note shared values such as confidence in the management team, a true participative approach for all decision making, a real capacity to challenge routines, and true social flexibility. Each day's problems would be viewed with a relative priority, since they would be understood as the temporary price to pay for change. Obviously, this (good) change culture can conflict with a (good) quality and safety culture. The values can even be relatively at odds. For example, oncology, and chemotherapy in particular, is a typical health sector where the culture of change and innovation is very strong, at the cost of a rather poor safety culture (high number of accidents). Paradoxically, the incessant changes in these innovative sectors are today associated with significant non-compliance issues but are supposed to be building "safer tomorrows". Kodak, on the other hand, had a strong quality culture and no culture of adaptation and change. This killed the company.

It must also be said that in the usual triangulation between the cultures of change (flexibility), production (product performance and quality) and safety (transparency, reporting, compliance), companies continually adjust their cursor based on their context. This adjustment rarely causes a radical shift of the cursor towards safety — unless there has been a recent accident. The company's culture is reflected first in the room available for adjusting between the three cultures (the values in the three cultures), and next the art of adjusting the cursor dynamically. It rests on all of the values shared within the company and not merely the values that would only be positive for safety.

That is another reason that explains the gaps between the HSE (Health, Safety and Environment) slogans — which describe the ideal when it comes to safety, as though it were possible to strive for this without giving up something else — and the arbitration that sometimes positions the real result far from this ideal, without this necessarily being an error in management or something that requires immediate correcting.

> **"The company culture [...] must sometimes give priority to aspects and values that are different to those advocated by the safety culture"**

Escape the trap, assess the company culture

To summarise, it might be more strategic to leave behind the clichés in the domain, reassess what safety means, accept that the company culture, which governs its success and allows it to stay afloat — we could call this a "survival culture" — must sometimes give priority to aspects and values that are different to those advocated by the safety culture. Consequently, an in-context assessment of the company culture seems like an important first step, rather than a

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limited assessment of safety culture.The critical phase in this assessment is the identification of values, the evaluation of the maturity of the governance and management in acknowledging this assessment and the adjustment margins, to then perform revisable arbitrations on the positioning of this company culture, which necessarily includes, but is not limited to, some safety aspects.

By broadening the approach, we could then escape the trap created by simply striving for a final means of optimising safety which, besides easing the industrial sector's conscience by demonstrating that it is still trying, keeps us trapped in an impasse and, worse, is tantamount to making a rod for our own back because the gains are uncertain. In substance, this new direction retains one principle that is identical to the current approach: a broader initial assessment that tests the values and the aspects of change and adaptation, production and safety. However, in addition, it contains an assessment of arbitration management between these three aspects and, ultimately, training in the managerial approach for carrying out this arbitration in context while avoiding sacrifices to the safety culture which are too great or unnecessary. In this context, if we had to choose between Reason's five safety culture components, there is no doubt that the flexible culture would be the most important.

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