Just Culture development at Irish Rail

Dr. Nora Balfe

Head of Human Factors

Iarnród Éireann
Irish Rail

Why we started this…

EVOLUTION OF RESPONSES TO SPADs

Traditionally: written warning + 6 months on jobs confined to depots

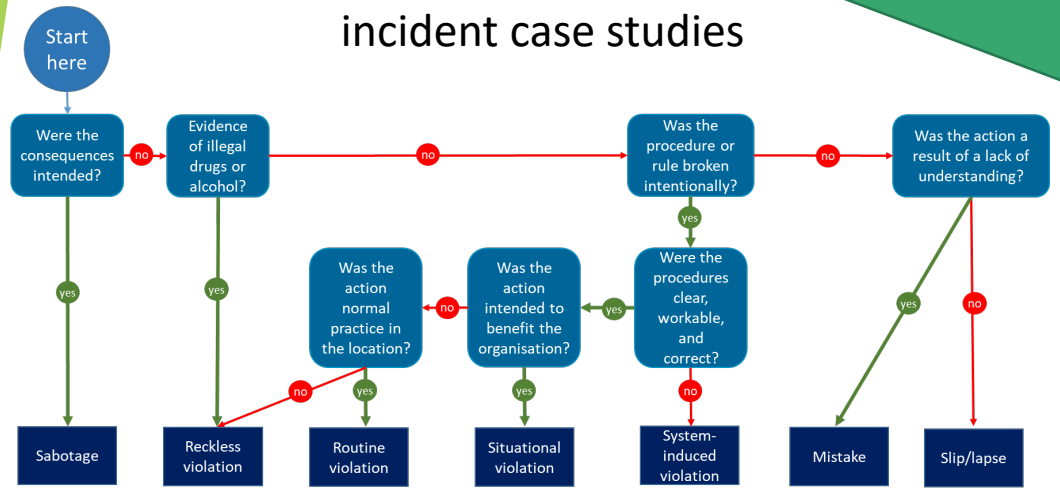
Currently: medical appointment + mandatory 2 year training plan + excluded from career progression

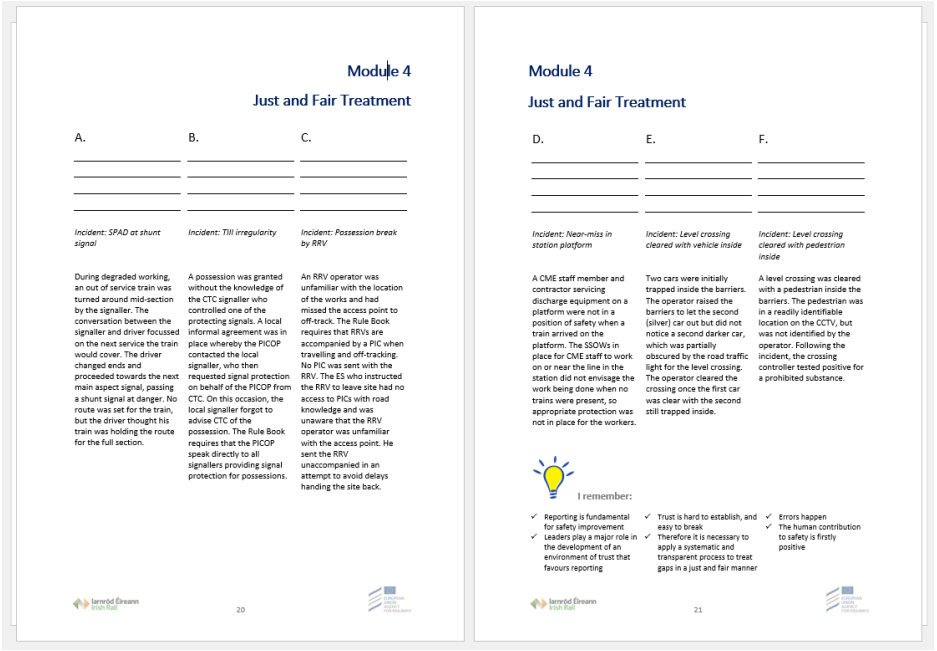
Drivers don't feel fairly treated following a safety incident – and are not inclined to report them

How we started…

HR-led working group

Decision tree and incident case studies





Module 4

Just and Fair Treatment

A. B. C.

Incident: SPAD at shunt signal

During degraded working, an out of service train was turned around mid-section by the signaller. The conversation between the signaller and driver focussed on the next service the train would cover. The driver changed ends and proceeded towards the next main aspect signal, passing a shunt signal at danger. No route was set for the train, but the driver thought his train was holding the route for the full section.

Incident: TIII irregularity

A possession was granted without the knowledge of the CTC signaller who controlled one of the protecting signals. A local informal agreement was in place whereby the PICOP contacted the local signaller, who then requested signal protection on behalf of the PICOP from CTC. On this occasion, the local signaller forgot to advise CTC of the possession. The Rule Book requires that the PICOP speak directly to all signallers providing signal protection for possessions.

Incident: Possession break by RRV

An RRV operator was unfamiliar with the location of the works and had missed the access point to off-track. The Rule Book requires that RRVs are accompanied by a PIC when travelling and off-tracking. No PIC was sent with the RRV. The ES who instructed the RRV to leave site had no access to PICs with road knowledge and was unaware that the RRV operator was unfamiliar with the access point. He sent the RRV unaccompanied in an attempt to avoid delays handing the site back.

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Module 4

Just and Fair Treatment

D. E. F.

Incident: Near-miss in station platform

A CME staff member and contractor servicing discharge equipment on a platform were not in a position of safety when a train arrived on the platform. The SSOWs in place for CME staff to work on or near the line in the station did not envisage the work being done when no trains were present, so appropriate protection was not in place for the workers.

Incident: Level crossing cleared with vehicle inside

Two cars were initially trapped inside the barriers. The operator raised the barriers to let the second (silver) car out but did not notice a second darker car, which was partially obscured by the road traffic light for the level crossing. The operator cleared the crossing once the first car was clear with the second still trapped inside.

Incident: Level crossing cleared with pedestrian inside

A level crossing was cleared with a pedestrian inside the barriers. The pedestrian was in a readily identifiable location on the CCTV, but was not identified by the operator. Following the incident, the crossing controller tested positive for a prohibited substance.

I remember:

- ✓ Reporting is fundamental for safety improvement
- ✓ Leaders play a major role in the development of an environment of trust that favours reporting
- ✓ Trust is hard to establish, and easy to break
- ✓ Therefore it is necessary to apply a systematic and transparent process to treat gaps in a just and fair manner
- ✓ Errors happen
- ✓ The human contribution to safety is firstly positive

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Incorporate case studies in safety leadership training

Externally facilitated workshop with executive team

Current position

- Concept has gained traction, particularly with frontline staff
- Hired a full-time Safety Culture Coordinator to drive the initiative forward
- Set up a senior level steering group
- Holding consultations with different manager groups
- ‘Drip feeding’ the concept at different organisational forums
- Started making changes to some of the SMS standards and processes

Some of the issues raised

Legal challenge – not removing someone from a grade could leave the manager open to challenge if they are later involved in an accident	Legal advice: removing them from the grade for an error could leave the company open to an unfair dismissal case
Legal challenge – identifying systems issues in an accident where a staff member was injured could reinforce their compensation claim	Legal advice: not identifying and addressing systems issues which resulted in an accident leaves the company open to a larger claim if someone else is injured
Perception of what the next level of management wants	All levels feel like the level above them want to hear action taken after an incident
Feeling exposed – managers need to feel supported in the event of making a wrong decision	

Errors so far…

System improvement was too implicit

Account for organisation churn

Focus on frontline behaviours

Too little early senior management engagement

Not acknowledging where we have come from

What's worked

Stories and scenarios

- Worked examples, from simple and straightforward to complex and difficult

Changing the SMS

- Formalise the expectations of manager behaviours post-incident, providing them support

Consulting widely

- Reassurances from legal and regulatory agencies that they see no major issues with this approach

Word of mouth

- Staff who have been treated under a (semi) Just Culture approach are giving positive feedback to their colleagues

Next steps

1. Set of HF and systems-thinking tools for investigators
2. Adapt incident templates to focus more on learning
3. Progress workshop with the exec team
4. Comms and training
5. Launch event?

Thank You

Nora.Balfe@irishrail.ie