

**SAFETEC**

## Culture – the key to safe operations

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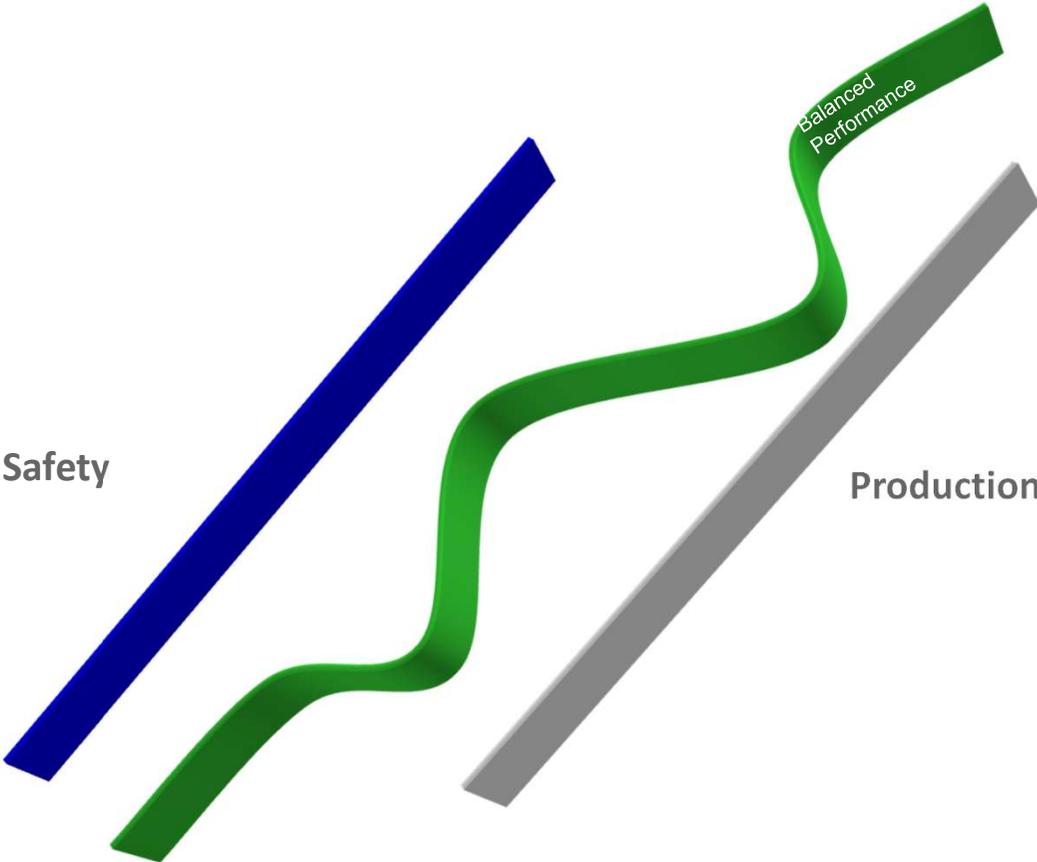
**Safetec** is one of Norway's leading consultancies within risk- and safety management, assisting organisations with a wide range of services, including assessment and development of organisational culture to achieve business goals.

**Blå** has a more than 20-year history of delivering organisational development programmes towards ship-owners, management companies and organisations within the oil- and gas industry.

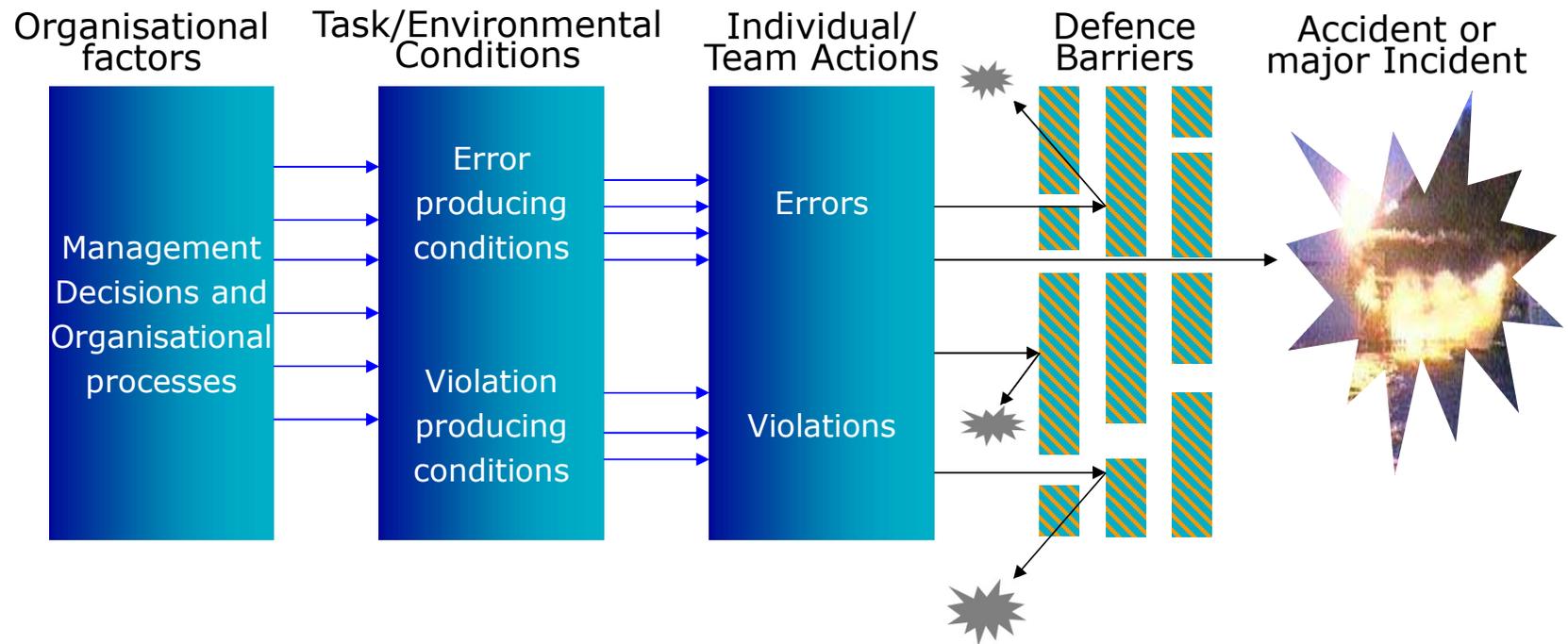
**Safetec** acquired **Blå** in 2022, strengthening our ability to assist companies with safety management. We provide valuable insights into organisational strengths and weaknesses and develop strategies with targeted measures for improvements.



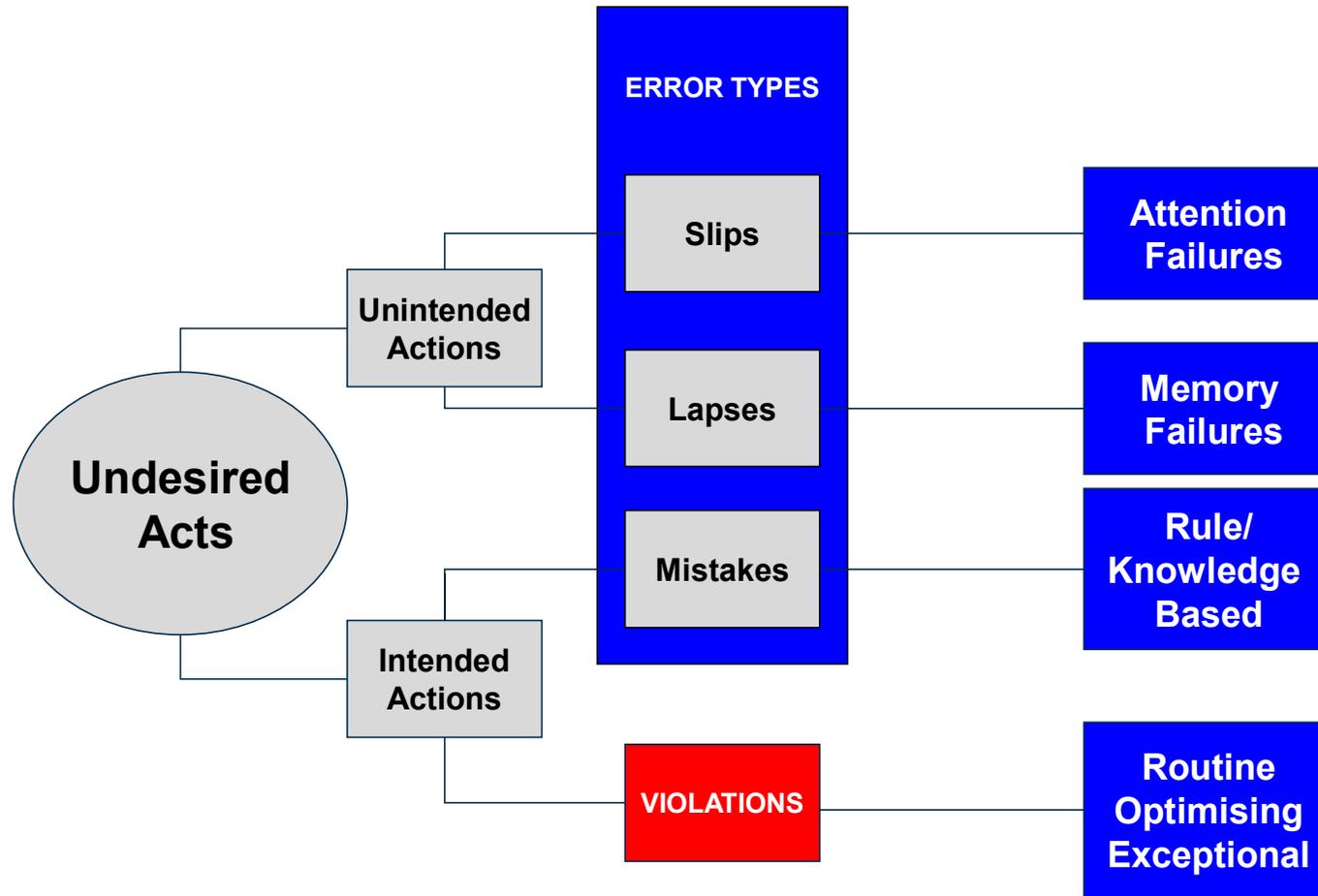
# Perspectives on safety



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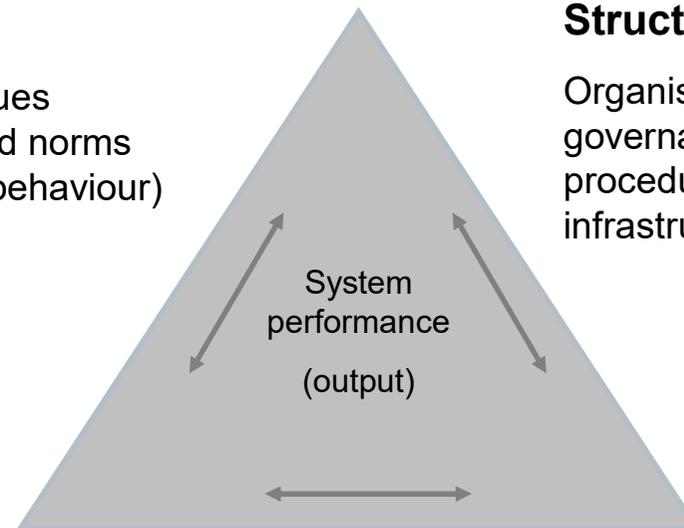
## Safety culture: Three interacting main concepts

### **Culture:**

*Shared values*  
(beliefs) and norms  
(accepted behaviour)

### **Structure:**

Organisational map,  
governance,  
procedures, technical  
infrastructure, etc.



### **Co-operation:**

Processes within/between organisational units;  
teamwork/collaboration, information  
flow/communication, conflict levels, etc.



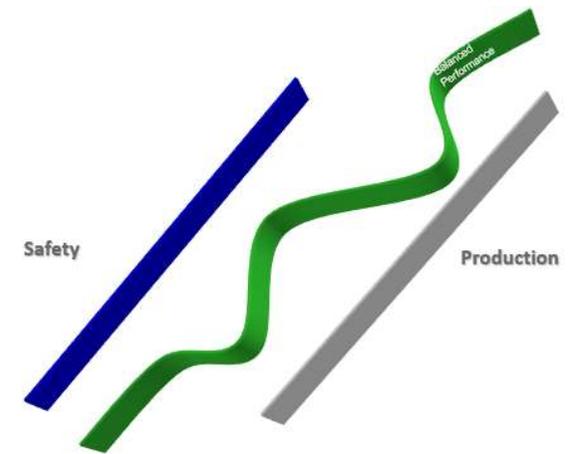
## Safety culture indicators

- Information flow
- Leadership / teamwork
- Management of deviations
- Management of conflicting goals
- Safety / risk awareness
- Suitability of procedure – Accessible, relevant, accepted
- Organisational learning



## What should we do?

- Acknowledge and accept that any decision, change and measure can influence safety
- Communicate honestly and trustworthily about the balance between safety and other important organisational goals
- Set operational limits when feasible – and reward following them, both formally and informally



Figur 9: LN-WIKs stopposisjon mellom TWY B og C.

## Operational limits

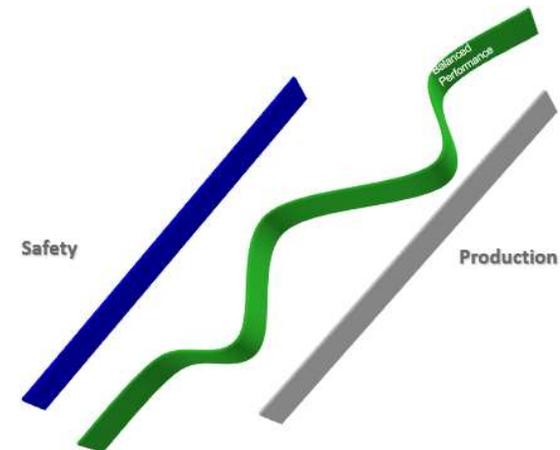


Figur 9: LN-WIKs stopposisjon mellom TWY B og C.



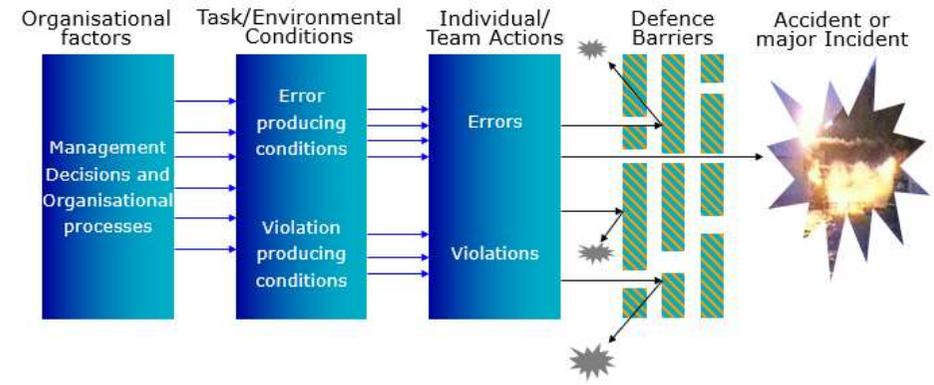
«Decisions taken in advance»

- Based on the risk picture
- Acknowledging that we sometimes take wrong decisions
- An example of how to strengthen a safety culture



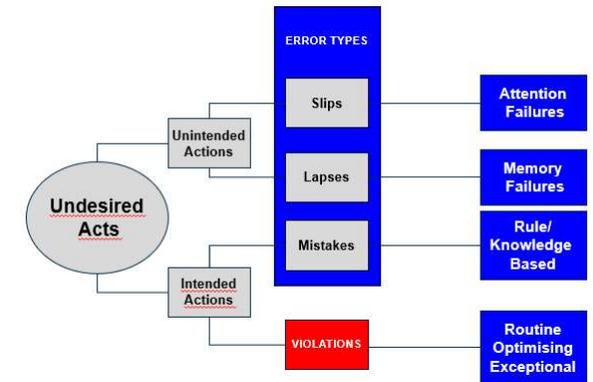
## What should we do?

- Maintain that safety management is complex
  - Ensure competence on safety management
  - Avoid jumping to simple conclusions
- Continuously work on raising awareness about the need for barriers, especially in the sharp end of operations
- Learn across industries – and learn from the numerous examples of things that go well
  - Ensure that the learning circle is completed – resulting in changing practices
- Acknowledge that «maintenance can seriously damage your vessel»



## What should we do?

- Accept that mistakes are made – every day, by everyone. Efforts should be on “fail safely”
- Creep into the head of people involved and try to understand – «Why did you think that this was the correct action / decision?»
- Look upon mistakes as learning opportunities and not something that should be punished
- Understand the concept of just culture
  - Understand the difference between error and unique wilful violations
- Be aware of the fact that campaigns targeted at employees in the sharp end has limited effect
- Ensure that new technology is adapted to people – and not the other way around



## Human and Organisational Performance: Six principles

- People are fallible, and even the best make mistakes
- Seafarers are masters at adaptive problem solving
- Context drives worker actions and behaviours
- Leadership's response to failure matters
- Blame fixes nothing
- Improvement happens through learning



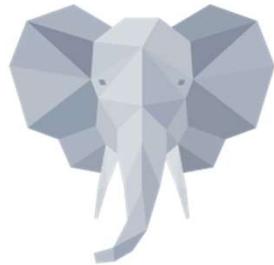
## HOP in investigations – Safety culture in practice

You are doing it!	You are not quite there
Your investigation report:	Your investigation report:
1. Provide insight on error traps	1. States that there was one root cause
2. Provide insight on organisational factors	2. Claims that the cause was: <ul style="list-style-type: none"> <li>• Human error</li> <li>• Human behaviour</li> <li>• Procedural non-compliance</li> </ul>
3. Show dependencies between individuals and teams	3. Use judgemental labels, e.g. <ul style="list-style-type: none"> <li>• Complacency</li> <li>• Recklessness</li> <li>• Laziness</li> </ul>
4. Provide insight on implications of alternative choices	4. Focuses only on what the person did not do or should have done
5. Gives rich descriptions allowing the reader to appreciate the context and situation	5. Contains corrective actions that are mainly behavioural or administrative
6. Describes behaviour / decisions of multiple people explained, including supervisors, engineers	Source: 
7. Contains corrective actions that are mainly engineering / process focused	

**SAFETEC**

## What we can offer

- Safety culture assessment and development
- Accident / incident investigations
- MCRM training
- Leadership training
- A wide range of technical safety services



**ANYTHING CAN BE CHANGED**