



A Guide to using the Fair Culture Flowchart

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Purpose of this Guide

This guide is intended to provide an explanation of the Fair Culture Flowchart, how it should be used and how this fits in with the accident investigation process.

Who the Fair Culture Flowchart can be used for

The Fair Culture Flowchart can be used for any employee involved in a safety incident. The Fair Culture Flowchart is specifically for use following a safety accident or incident. The flowchart should be applied to the immediate cause identified by the investigation where it is an unsafe act and any other unsafe acts identified by the investigation. Although it promotes good management practice, it is not designed for use in other situations, such as poor general performance or absenteeism.

If more than one employee is involved, it is essential to work through the Fair Culture Flowchart separately for each person.

Who the Fair Culture Flowchart can be used by

- Investigation team
- DCP
- Independent review panel
- Line managers

When to use the Fair Culture Flowchart

It is important to see the use of the flowchart as part of the investigation and not the investigation. The normal investigation process should be followed, including using the Investigator Prompts for the 10 Incident Factors to plan for the interview(s), with the flowchart being used once the evidence has been reviewed.

If new information comes to light, it can be worked through afresh and may or may not indicate a different conclusion.

The 10 Incident Factors and associated Investigator Prompts are available in the Investigators' Handbook. These have been updated (to version 2.1) and are available in a separate Guide to the 10 Incident Factors.

How the Fair Culture Flowchart works

The Fair Culture Flowchart guides you through a series of structured questions about the individual's actions, motives and behaviour at the time of the incident.

These questions move through four sequential 'tests' (the four columns of the flowchart):

- The Deliberate Harm Test
- The Foresight Test
- The Substitution Test
- The Personal History Test

Working through each test in turn, possible reasons for the individual's actions are reviewed and the most likely explanation identified. Your responses lead to a behaviour type which aligns with a list of recommended actions in the 'consequences matrix' for both the individual and their manager.

The Deliberate Harm Test

In the overwhelming majority of safety accidents and incidents the individual did not intend the bad outcome. However in rare cases the intent was to cause harm or for personal gain where no concern was given to the consequences for safety. The Deliberate Harm Test asks questions to help identify or eliminate this possibility at the earliest possible stage.

The Foresight Test

If malicious intent or recklessness has been discounted, the Foresight Test examines whether procedures and safe working practices were adhered to and whether it was practicable to do so.

The Substitution Test

If procedures were not in place or proved ineffective, the Substitution Test helps to assess how a peer would have been likely to deal with the situation.

The Personal History Test

Finally, if peers were determined to have been likely to have acted differently then the Personal History Test seeks to determine whether this was a situation the individual often found themselves in.

Consulting the individual

With some of the questions in the fair Culture Flowchart, the only person who can answer the question accurately is the individual. It is therefore important to try and discuss the matter with them. However, there may be circumstances where:

- this is not possible (for example, the individual has been arrested); or
- you simply do not believe their answer.

In these cases, you will have to form a view based on the balance of probability using the information before you.

If new facts come to light you can work through the Fair Culture Flowchart afresh.

Individual denies involvement

If the individual says they were not involved in the incident the questions can be difficult to answer. It is possible that the individual:

- really was not involved;
- is traumatised and confused about what happened; or
- is lying to cover up malicious intent.

Bear in mind that in a 'blame culture' individuals sometimes feel pushed into denying mistakes through fear of punishment.

What to do if you're unable to answer a question

If you cannot answer a question it is important to pause and try to establish the facts. Do not make assumptions.

The Fair Culture Flowchart can be worked through stage by stage. The questions do not have to be answered in one go.

Gather as much evidence as you can, but recognise that there could be situations where information proves patchy or inadequate. In these circumstances you may have to answer the question based on your best judgement.

The Deliberate Harm Test

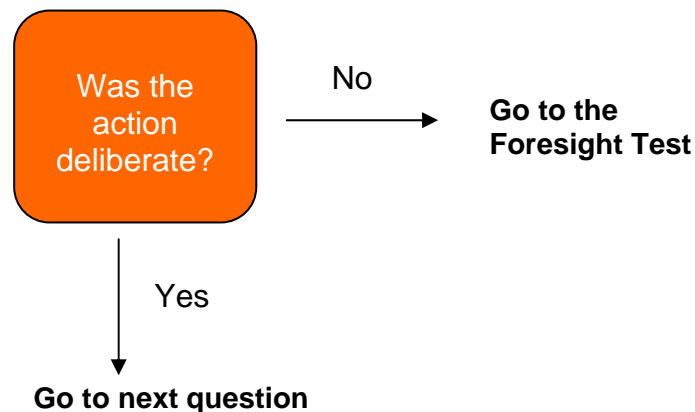
Guidance

In the overwhelming majority of safety incidents the individual has decided to behave in a particular way but without the intent of causing harm or any other bad outcome. Sometimes people knowingly take risks, not necessarily with the intent of causing harm, but because they think they can do it better, or simply because it is more convenient for them or they get a thrill from deliberately not following the rules.

However in rare cases the intent was to cause harm or for personal gain where no concern was given to the consequences for safety.

The Deliberate Harm Test asks questions to help identify or eliminate these possibilities at the earliest possible stage.

Was the action deliberate?



This question asks whether the actions were as intended, not whether the outcome was as intended. This is an important distinction.

10 Incident Factors

If individuals are unaware of the correct course of action then investigation using the questions in the **Knowledge, Skills and Experience** Incident Factor will help with understanding why.

When people forget steps in a process it is useful to consider what might had led them to forget and the extent to which they might have been distracted or overloaded. **Personal** and **Workload** Incident Factors will help identify these issues.

Deliberate acts

Consider whether the individual:

- decided to take the action
- decided not to take the action
- refused to carry out an instruction

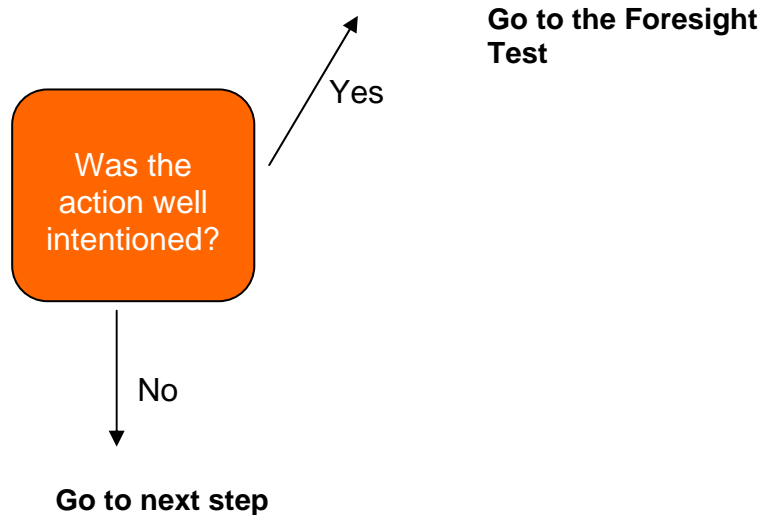
Non-deliberate acts

Consider whether the individual:

- forgot to take the action
- was prevented from taking the action

- didn't know they had to take that particular course of action

Was the action well intentioned?



This question tries to identify the individual's motives for taking the action they did and will help identify those who deliberately tried to cause harm or sought personal gain where no concern was given to the consequences for safety.

Well intended actions

In most cases where the actions were as intended the individual's actions were well intentioned and they did not mean the harm that resulted. There are other reasons why the correct course of action was not followed. For example, the individual may not have been aware of the correct course of action, got confused, didn't know how to apply the correct course of action or thought they were doing the right thing but just hadn't appreciated the risks of their course of action.

Malicious or reckless acts

Deliberate acts of sabotage such as placing scrap rail across a running line or setting fire to lineside equipment where the intention was to cause disruption and in doing so put life at risk would require a 'No' answer.

Also, in a very small number of cases individuals deliberately ignore safety procedures without thinking or caring about the consequences. These are reckless acts.

There are individuals who knowingly break rules for their own personal benefit. Examples include cutting corners to leave work early or to get longer breaks, or because they get a thrill from deliberately not following the rules. It is likely that in cases of conscious, deliberate harm there will be a criminal investigation.

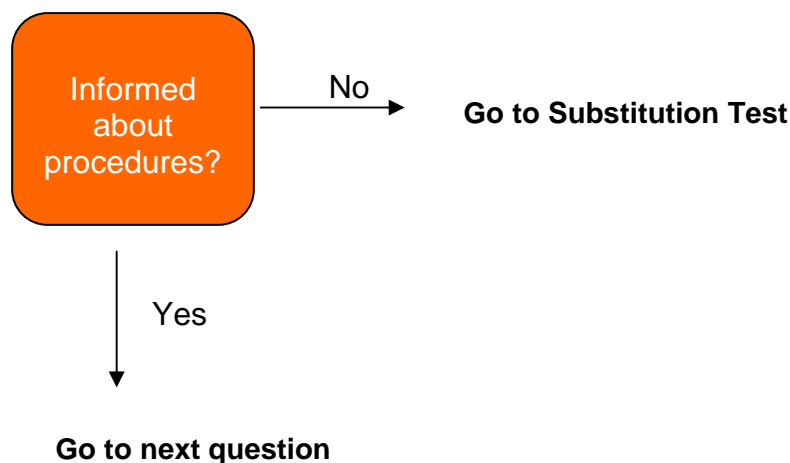
Sabotage,
malicious intention
or Reckless
contravention for
personal benefit

Finally, using the criteria above decide whether the behaviour was:

- Sabotage or malicious intention; or
- Reckless contravention for personal benefit.

The Foresight Test

Was the individual informed about the procedures?



Guidance

If intent to harm has been discounted, apply the Foresight Test to determine whether procedures and safe working practices were properly adhered to. The Foresight Test does not try to remove an individual's personal responsibility for their actions, but sets it in the context of potential problems with procedures.

First clarify whether the action was governed by an agreed procedure or procedure. Do not simply assume this to be the case – check the documentation yourself. It is impossible to proceduralise every eventuality.

Likewise, it is dangerous to apply procedures slavishly, without using judgement or taking into account particular circumstances. Failure to react to unusual circumstances can be as dangerous as routine contravention of procedures.

The Substitution Test (described later in this document) acts as a safety-net when assessing situations where procedures were inadequate or not in place.

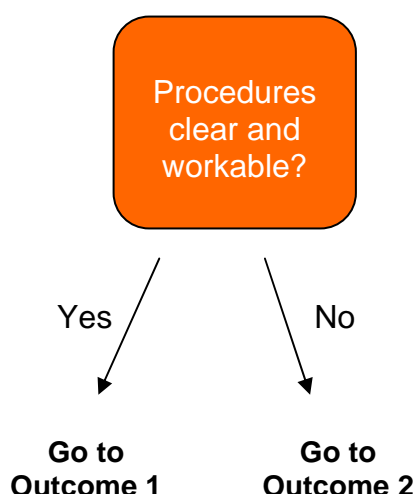
10 Incident Factors

Questions in the **Practices and Processes** and **Knowledge, Skills and Experience** Incident Factors will help answer these questions.

What would make this 'Yes'

When considering this question you need to look at whether procedures or a safe way of working existed in the first instance. If the answer to this question is yes then you need to consider whether the individual knew about the procedures. This goes beyond looking at whether they have a certificate of competence and looking at the quality of the training and whether it covered this situation and the appropriate actions. If the procedure has recently been changed or introduced, check whether the individual had been briefed and what the quality of the briefing was.

Are the procedures clear and workable?



Guidance

Do not automatically assume that procedures were workable and in routine use.

Remember to establish the situation at the time of the incident; working practices may have been revised subsequently.

Was the procedure clear?

A procedure was only 'clear' if the individual had ready access to it. For example, if a procedure could only be accessed via the intranet but there was no computer in the work vicinity, the procedure could not be considered 'clear'.

Was the procedure workable?

What at first sight appears to be a workable procedure may be problematic in practice:

- Did the individual misinterpret an ambiguous or badly-written procedure?
- Was the individual unwittingly applying an outdated procedure?
- Were conflicting procedures in circulation?
- Was the procedure technically accurate but too laborious to apply routinely? (If the procedure was technically accurate, but too time-consuming or complex to apply the individual may have had to disregard it in order to get the job done)
- Did the procedure promote correct and sensible action?

If the procedure was badly written or unworkable the individual may have made a professional judgement to disregard it.

A procedure that is workable in routine situations might have failed in unusual circumstances, such as when there is degraded working or equipment failure.

Was the procedure in routine use?

It is unrealistic to assume that because a procedure existed staff were using it routinely. There are a variety of reasons why it might not be, some of which you may already have uncovered:

- People weren't aware they had to use it;
- The activity/context the procedure applies to just doesn't happen that often ;
- Local custom and practice means there are alternative ways of working.

It is important to examine what the custom and practice is and why this might be different to the documented procedure.

Did the individual decide not to apply the procedure?

If the individual was aware of the procedure but decided not to apply it you need to establish their reason for doing this. For example, on establishing the underlying reason you may find that the individual was faced with an emergency situation and contravened a rule in order to avert immediate danger.

If their action stemmed from difficulties applying the procedure, you would normally answer 'no' to the question, consider the consequences for 'mistake caused by system' and go on to apply the Substitution Test.

If there was another reason, you would normally answer 'yes' to the question and move down the flowchart to the next box in the Foresight Test to consider whether the action was a contravention or a slip/lapse.

Did the individual cut corners because they knew the procedure so well?

Sometimes the individual was so familiar with the procedure they felt over-confident about cutting corners. Corner-cutting usually causes problems where the case concerned turns out to be atypical.

The individual may be alone in cutting corners, or may work in an environment where this is routine.

Sometimes the individual was so used to applying a familiar procedure that they acted instinctively and forgot there had been a change in practice. This may happen when:

- an old procedure is replaced;
- an individual changes departments or locations; or
- an individual changes organisations.

In this instance, as long as the new procedure was clear and workable, then this is a case of an attentional slip. The consequence for slip/lapse should therefore be applied.

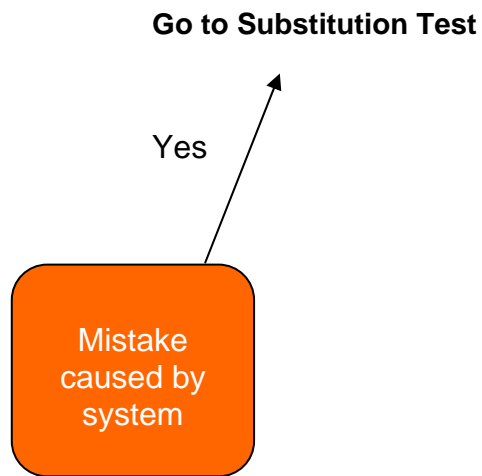
Outcome 1



If you have arrived here from a situation where the action was deliberate and well intentioned then the behaviour is a contravention and the consequences for this should be applied.

If you have arrived here from a situation where the action was not deliberate then the behaviour is a slip/lapse and the consequences for this should be applied.

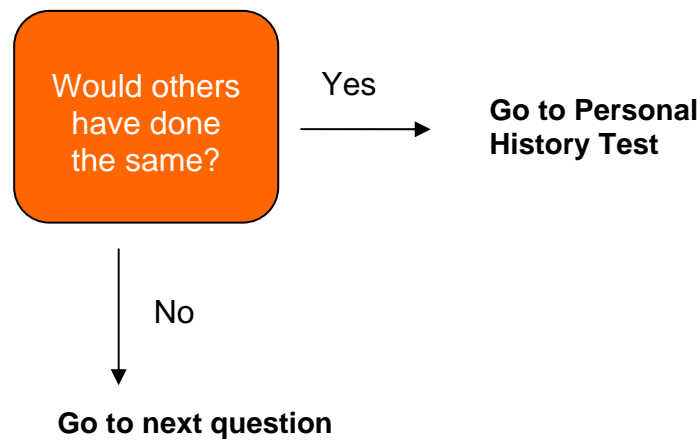
Outcome 2



Having arrived here you should consider the consequences for 'mistake caused by system' and then go on to apply the Substitution Test.

The Substitution Test

Would others have done the same thing?



Guidance

If procedures were not in place or proved ineffective, apply the Substitution Test to assess how a peer would have been likely to deal with the situation.

This test also highlights any deficiencies in the following that may have been involved in the safety incident:

- training
- experience
- supervision

10 Incident Factors

Questions in the **Knowledge, Skills and Experience, Supervision and Management** and **Personal** Incident Factors will help answer these questions.

Questions to consider:

Consider what a 'reasonable' peer acting sensibly would have done.

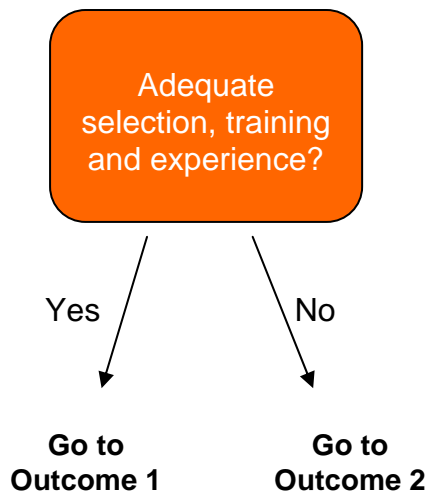
Consider whether breaking the rule or not following the procedure has become the normal way of working. This way of working often remains invisible until there is an accident (or sometimes as the result of an audit). Routine rule violations are promoted by a relatively indifferent environment, i.e. one that rarely addresses rule breaking or rewards compliance: "we do it like this all the time and nobody even notices."

When considering what the norm is and how others would have behaved it is important not to deduce the norm from blanket judgements and prejudices. For example:

- Contractor COSS's never have good local knowledge;
- Signallers never want to help maintenance;
- Possession support staff tend to be easily confused.

The chances that other people would have done the same thing are increased if there is little checking that procedures are being adhered to and if managers turn a blind eye to those not following the rules.

Selection, training and experience



Guidance

Consider whether the individual was properly equipped to deal with the situation. If not, a system failure is indicated. Do not make automatic assumptions about the standards of training or supervision received.

Sometimes a lack of training or supervision can affect an individual's ability to apply common sense and 'think on their feet'. If this is the case, additional coaching or support may be necessary.

10 Incident Factors

Questions in the **Knowledge, Skills and Experience, Supervision and Management** and **Personal** Incident Factors will help answer these questions.

When answering this question:

Carefully check the following possibilities:

- Gaps or deficiencies in the individual's training;
- Being 'thrown in at the deep end', with insufficient experience to handle the situation;
- Inadequate competence assessment and supervision.

Selection

Look into how the individual has progressed into the role which led them to be undertaking the activity where the error was made:

- Has the progression provided sufficient and relevant experience?
- How was a decision made to appoint this individual to this role?
- What evidence is there to suggest that the individual has the appropriate non-technical skills for this role?

Training

Look into any training the individual had received and make sure it was:

- comprehensive;
- well-designed; and
- effectively delivered.

Supervision

Check that supervision was both active and supportive.

Outcome 1



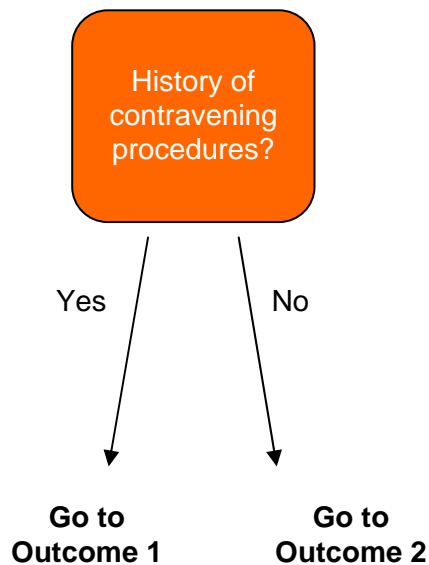
Having arrived here you should consider the consequences for 'poor judgment'.

Outcome 2



Having arrived here you should consider the consequences for 'mistake caused by system'.

The Personal History Test



Guidance

This question is concerned with finding out whether the individual had a history of contravening procedures or whether there was a history of contravening this procedure at this location or within the team. The latter contraventions are sometimes referred to as routine violations where the contravention has become the norm.

In order to help you establish whether this is the case consider:

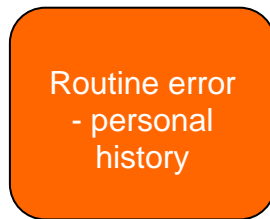
- Whether the contravention has been condoned by managers (i.e. have managers been turning a blind eye)?;
- How long this way of working has been in existence and whether it's so established that it's only the incident that has brought it to light;
- Management priorities and how they are communicated to staff – quite often routine rule violations are promoted by a relatively indifferent environment, i.e. one that rarely addresses rule breaking or rewards compliance: "we do it like this all the time and nobody even notices."

Where the history of contraventions is associated with the individual this is an indication that they present an additional risk. Consideration needs to be given as to whether this is an issue of training and competence or capability.

10 Incident Factors

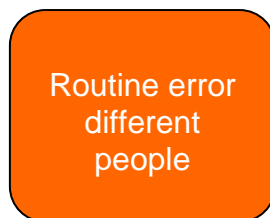
The questions in the **Supervision and Management, Knowledge, Skills and Experience** and **Personal** Incident Factors with help answer this question.

Outcome 1



Having arrived here you should consider the consequences for 'routine error – personal history'.

Outcome 2



Having arrived here you should consider the consequences for 'routine error – different people'.

Recording the outcome

It is the role of the investigation team to:

- identify the behavioural cause of all unsafe acts identified during the investigation;
- record local actions for the fair consequences to be applied by the individual's line manager and their line manager (two separate actions).

Unsafe acts form the majority of the immediate causes identified during our investigations, but you may identify others too.

It is important that the actions are phrased in an impartial way that directs the line managers to consult the consequences matrix and apply this appropriately; it is not the role of the investigation team to interpret the matrix.

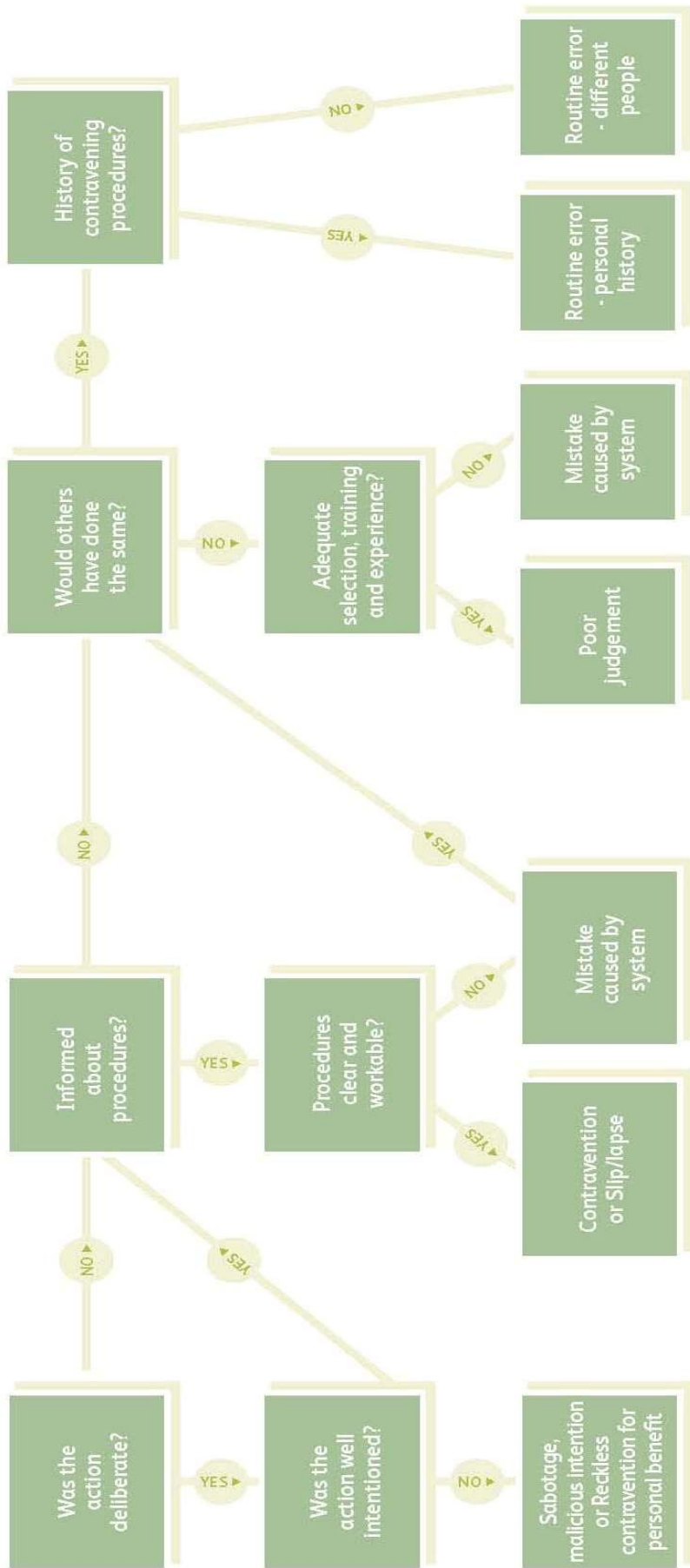
Here is an example of the wording that could be used:

Behavioural cause (using fair culture flowchart)

- The IWA was in breach of the Lifesaving Rule: Always have a valid safe system of work in place before going on or near the line. In accordance with the 'fair culture flowchart' the investigation team concluded that this was a 'contravention' (see section G3 of this report).

Local actions

- The section manager should consider the behavioural cause of the identified breach of the lifesaving rule by the IWA in accordance with the consequences table and take appropriate action (see section A4.1 of this report).
- The IME should review the behavioural cause of the identified breach of the lifesaving rule with the section manager (as the IWA's line manager) and take appropriate action in accordance with the consequences table (see section A4.1 of this report).



Possible disciplinary action



Increasing individual responsibility

Decreasing individual responsibility

Coaching, retraining etc.

This table is a guide for deciding on the appropriate positive consequences to recognise those who behave positively around the Rules.

Behaviour	Description	Outcome for the Person	Outcome for the Person's Managers
Excellent risk identification, planning and management	Risk identification, planning or management has reduced the risk of human error or situations that lead to breaches. The person has stepped back to reflect on how the risks could be better managed. For example, effective contractor management, and job hazard analysis.	Recognition or reward as the line manager sees fit, in line with local HR policy and with HR manager's agreement. Examples: ▶ Praise ▶ Public recognition ▶ Special Recognition Awards (SRA) ▶ Individual Performance Factor (IPF) ▶ Positive performance appraisal ▶ Opportunity to coach others	If the whole team behaves like this, or team members do it regularly, then their supervisor or manager should also be recognised or rewarded. Examples: ▶ Praise ▶ Public recognition ▶ Recognition for development of their people ▶ Special Recognition Awards (SRA) ▶ Individual Performance Factor (IPF) ▶ Positive performance appraisal ▶ Opportunity to coach others
Creating a more effective working environment	Creating trust, good communication and clear expectations in a team.	Recognition from line manager and supervisor's management.	Encouragement and recognition from line manager and senior managers if the whole team is working this way.
Effective sharing of lessons learned	Sharing experiences in a way that really benefits others, e.g. highly effective communication, using lessons learned to improve a working practice. Able to demonstrate a tangible impact in other areas of the business.	Recognition from line manager and supervisor's management.	Encouragement and recognition from line manager and senior managers if the whole team is working this way.
Effective intervention	Recognising and intervening in a potentially problematic situation. For example, stopping your own or someone else's job, catching errors, preventing someone from breaking a Rule. Also includes being receptive to others' interventions.	Recognition from line manager and supervisor's management.	Encouragement and recognition from line manager and senior managers if the whole team is working this way.
Compliant behaviour	Doing what the job requires.	Recognition from line manager and supervisor's management.	Encouragement and recognition from line manager and senior managers if the whole team is working this way.

This table is a guide for deciding on the appropriate consequences for rule breaking. The lead investigator will recommend action from the independent review flowchart.

Behaviour	Description	Action for Person/s Directly Involved	Action for Manager of Person/s
Routine error – personal history	It is not the first time that this type of error has been made by this person. Other people in similar situations do not make this error.	Assessment of fitness to work (abilities and suitability for this type of job). If appropriate, competence development and coaching, if not, consider assigning alternative, more appropriate type of work.	Coaching on fitness to work.
Poor judgement	The person demonstrates poor risk awareness and/or understanding of the impact their actions have.	Assessment of fitness to work (abilities and suitability for this type of job). If appropriate, competence development and coaching, if not, consider assigning alternative, more appropriate type of work.	Coaching on fitness to work.
Slips and lapses	Actions that did not proceed as planned, e.g. something was done twice, the wrong way or a step is forgotten.	Coaching conversation on how to spot, report and prevent errors.	Coaching conversation in how to manage errors. Identify alternative work methods that make better use of reminders, checklists and other job aids.
Routine error – different people	Other people would have done or do it the same way. It has become the accepted way of working.	Whole team to receive coaching conversation in the importance of meeting the required standard or following the appropriate procedure.	Coaching conversation on how to manage rule breaking together with team. If this type of violation has occurred before, a formal discussion must be held to explain the implications of condoning a violation or not taking action, and to set the required performance standard.
Mistake caused by system	The mistake is the result of inadequate information, training or support. Workload and equipment factors may also have contributed to this error.	Possible competence development/coaching conversation.	Coaching conversation in how to manage errors and ensure team is competent. Further investigation of workload and equipment issues.
Contravention	The person committing the violation thought it was better for the company to do it that way or considered the job could not be done if the procedures were followed. The violation was committed to improve performance or to please the supervisor.	Coaching conversation and encouragement on the need to speak up when Rules cannot be followed and to stop the job until it can be done safely.	Coaching conversation on how to manage this example of 'rule breaking', as well as how to support and encourage employees who speak up.
Reckless contravention for personal benefit	The person thought it was better for them personally to do it that way because they will derive a personal benefit, at the risk of safety standards, e.g. getting a longer work break, getting away earlier, etc.	Formal disciplinary procedure to commence.	Coaching conversation on how to manage Rule breaking. If this type of violation has occurred before, a formal discussion must be held to explain the implications of condoning a violation or not taking action, and to set the required performance standard. As part of such a discussion the reason for condoning unacceptable behaviour must be investigated, which will determine whether further action is required.
Sabotage or malicious intention	The person committing the violation did not think or care about the consequences. Gross negligence can be considered a part of this type of violation.	Formal disciplinary procedure to commence.	Managers coached to develop skills in objective, non-confrontational challenge. If this type of violation has occurred before, a formal discussion must be held to explain the implications of condoning a violation or not taking action, and to set the required performance standard. As part of such a discussion on the reason for condoning unacceptable behaviour must be investigated, which will determine whether further action is required.