CAPSafety Beacon

September 2021

The Safety Beacon is for informational purposes. Unit Safety Officers are encouraged to use the articles in the Beacon as topics for their monthly safety briefings and discussions. Members may go to eservices Learning Management System, click on "Go to AXIS," search for this month's Safety Beacon, take the quiz, and receive safety education credit.

Just Culture and Safety

An effective safety culture depends on everyone valuing the behaviors, attitudes, and best practices that make it work well. In part, that means everyone is fully participating in discovering the contributing factors that lead to, or could lead to, negative safety outcomes. This focus on discovery is not about assigning responsibility or fault but is about learning everything we can so everyone goes home safely, and our resources are mission ready.

One of the biggest derailers to members fully participating in safety programs is blame. As a verb, blame means "to assign responsibility for a fault or a wrong," and is the antithesis to many key principles of our safety culture. Specifically, when we focus our discovery efforts on who is responsible, we set the stage for mistrust, disengagement, and withholding of critical safety information.

Bottom line: Looking for "who" caused a negative safety outcome does not address the root cause of a problem. Blame is detrimental to the safety culture we need in CAP and leads to fear of making mistakes and covering up errors instead of openly sharing and learning from them.

Does CAP have a "blame" culture? Some might say yes, but it's not a question of whether we do or we don't - there are definitely instances of blame occurring across the organization; it's a question of whether or not members and member-leaders are embracing the mindset and practices of our safety culture (see August's CAPSafety

Beacon on Mindsets and Safety for more on mindset), specifically, the attributes of a just culture.

The opposite of blame culture is just culture. In a just culture, the focus is on, "What went wrong?" not on "Who's at fault?" This shift in focus is centered on learning from human errors rather than punishing the person involved (however, even in a just culture, seriously negligent behaviors or willful misconduct may need to be dealt with punitively). By and large, people do not intentionally make errors that lead to negative safety outcomes. Errors usually occur because of an action or inaction that occurs below the level of awareness. For example, when a person misses an important step in a procedure, that person might say, "I'm not sure how I missed that step!" Whatever led to the missed step is often outside the person's awareness in the moment it occurred. That missed step is an error and was likely unintentional.

So, let's embrace Alexander Pope's idea that, "To err is human; to forgive, divine," and go one step further with Doug Larson's, "To err is human; to admit it, superhuman." All of us are prone to err, and all of us are capable of learning from errors so we don't repeat them.

What does blame culture look like?

Whether intentional or unintentional, blame negatively impacts member morale and engagement in safety. As you reflect on blame culture, here's how it might look.

Beliefs

- People are the problem
- Problems are headaches
- Admitting error is a sign of weakness

Focus

- Who is wrong?
- Fault-finding
- Punishment as deterrent

Results

- Acting on untested assumptions
- Withholding of relevant information
- Less communication
- Hiding problems
- Finger-pointing
- Distrust

- Turf wars
- Lack of innovation
- Leaders are less aware of unsafe conditions or behaviors
- Continuously reactive (vs. proactive) risk management
- Member disengagement

What does just culture look like?

When we shift from the mindset, behaviors, and actions of blame culture to just culture, here's what might be different.

Beliefs

- There are many contributing factors to negative safety outcomes
- Problems are opportunities from which everyone to learn
- Acknowledging an error occurred is a step toward personal growth

Focus

- Contributing factors
- Fact-finding
- Learning

Results

- Increased openness and information sharing
- Increased reporting of safety issues before a negative outcome occurs
- Improved engagement from members to help solve the problem
- Readiness to acknowledge error and to share learning
- Improved reliability in assuring safety
- Increased proactive focus on safety issues and risk management
- Increased trust
- Innovative solutions to safety issues emerge more often

An Example for Shifting from Blame Culture to Just Culture

A January 2020 blog post at SAFESTART.com, "How Do You Avoid Blaming When it Comes to Human Error?" states, "When human error is found to be the cause, there's a misapprehension that it will be used as grounds to punish the human involved in the error." One of the ways this misapprehension manifests is in how we state contributing factors in our mishap reviews and discussions about mishaps.

When we use phrases like, "The person involved failed to…," we are assigning fault to an individual and referencing "failure" as the cause. We need to rethink the language we use. Granted, the reason we put policies and procedures in place is to avoid negative safety impacts, however, a "failure" to follow those policies or procedures is only a factor and not the cause of a mishap. Using the word "failure" to describe contributing factors automatically assigns fault to the person as having done the wrong thing or having failed to do the right thing - which may be true, but still doesn't lead to preventing the reason it occurred. The question that must be asked is, "What led to the individual not following the procedure or policy?" That question, asked as often as needed, helps in discovering underlying factors where not following existing requirements is a factor.

How questions are asked of people involved in mishaps is just as important as what you ask. Try this: ask the following question using two different tones of voice, "What led to not using a spotter?" First, ask the question as if you are angry that the person didn't use spotter in the first place (blame mindset). Second, ask the question as if you are genuinely curious about all the possible the factors involved that led to not using a spotter (just mindset). There should be a difference in how the question comes across and is received by the individual answering the question. This single shift in tone could make the difference between defensiveness and openness in mishap reviews.

One final thought…

Be open about your intent for asking questions. The intent is not to assign fault, but to see what we can learn from what happened so we can all do our part in preventing it. Don't assume that the responsibility belongs to one person. There are often multiple contributing factors, many of which may not be centered on an individual's actions or inactions. The responsibility for preventing belongs to us all, not just to one individual or group. Above all, check your mindset going in - are you learning or blaming?