Just & Fair approach Implementation Guide

SNCF
SAFETY

PRISME

SNCF

THE JUST & FAIR APPROACH

GOALS OF THE APPROACH

The Just & Fair approach aims to create a climate of trust that encourage feedback. By promoting freedom to speak, this approach provides **a better understanding of system strengths and weaknesses.**

Following a safety event, this approach allows a processing of both:

Just: by distinguishing the causes induced by the system and those related to the actors.

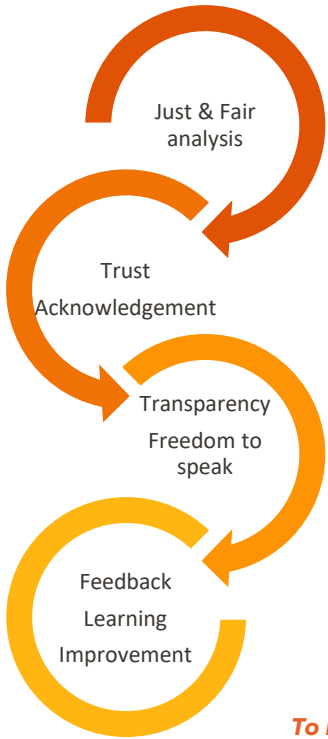
& Fair: by providing a homogeneous handling to similar situations.

The approach also aims to recognise and promote exemplary behaviours that contribute to strengthen the safety level.

Ultimately, the approach aims **to take appropriate measures to prevent such event from recurring** and, in doing so, to contribute to enhance the Safety Culture.

THIS BOOKLET...

... is a tool dedicated to the Just & Fair approach. Its purpose is to guide you in the processing of safety events in order to determine the appropriate actions to prevent similar event from occurring.



THE JUST & FAIR APPROACH...

...IS:

- a complete approach, guided by a methodology and tools to assist management in taking the right decision.
- a guide to analyse the facts with goodwill yet with no complacency.
- a complementary approach linked to the analysis of Human and Organisational Factors (HOF) carried out following a safety event.
- an approach promoted by management that contributes to the development of Safety Leadership.

...IS NOT:

- a penalty scale.
- a search for culprits.
- a moral judgment.
- a substitute for the HOF analysis of an event
- a screening approach for psychoactive substances.
- an approach limited solely to this guide.

To learn more about the process and the associated tools, scan the QR code (available in French language only):

5 KEY STEPS REQUIRED

1. COLLECT FACTS AND ANALYSE ROOT CAUSES
2. IDENTIFY THE BEHAVIOUR OR ACT
3. EVALUATE THE ACCEPTABILITY OR UNACCEPTABILITY OF THE BEHAVIOUR OR ACT
4. TAKE APPROPRIATE MEASURES REGARDING THE ACTORS, THE TEAM AND THE SYSTEM
5. PROVIDING FEEDBACK TO ALL PARTIES INVOLVED

Best practice
Identify a J&F referent to ensure the implementation of the approach.

about WHAT?
The approach applies to:
- **All behaviours or acts that have had or may have an impact on safety and are not expected or planned.**
- All areas of Global Safety (rail safety, occupational health safety, security, fire safety, environmental safety and cybersecurity).

WHEN?
- The gathering of facts is done as quickly as possible after the event.
- The other steps are carried out by taking the time necessary to conduct an exhaustive analysis of the situation.

HOW?
- With a goodwill and listening posture.
- Giving the benefit of doubt to the people involved.
- By being objective and open to everyone's points of view.
- **By not anticipating the result** during the analysis.

by WHOM?
- The process is carried out **collectively**.
- With the contribution of a **HOF specialist**.
- As much as possible, with the people involved in the safety event at all stages of the process.

1 COLLECT FACTS AND ANALYSE ROOT CAUSES
DISTINGUISH BETWEEN SYSTEM-INDUCED AND OPERATOR-INDUCED CAUSES

SYSTEM-INDUCED CAUSES

Negative factors		Positive factors
☑ **Rules / Procedures / Documentation**		
Unavailable	← – – →	Available
Unenforceable	← – – →	Enforceable
Inappropriate for the situation	← – – →	Appropriate for the situation
Not understandable	← – – →	Understandable
Not up-to-date / Obsolete	← – – →	Up-to-date
Inconsistent to each other	← – – →	Compatible with each other
☑ **Equipment / technical installations**		
Unavailable	← – – →	Available
Bugged or out of order	← – – →	Fully functional
Unsuitable for the activity	← – – →	Suitable for the activity
☑ **Resources available**		
Insufficient time for the activity	← – – →	Sufficient time for the activity
Unavailable staff	← – – →	Available staff
Insufficient staff	← – – →	Sufficient staff
Inadequate skills (training, qualification, authorisation)	← – – →	Adequate skills (training, qualification, authorisation)
☑ **Organisation**		
Unsuitable for the activity	← – – →	Suitable for the activity
Not compliant with the plan	← – – →	Compliant with the plan
☑ **Environment and working conditions (mood, atmosphere...)**		
Uncomfortable (noise, weather...)	← – – →	Comfortable
Group pressure	← – – →	Collaborative helping
Unsafe local practices	← – – →	Safe group practices
Hierarchical pressure	← – – →	Hierarchical support

OPERATOR-INDUCED CAUSES

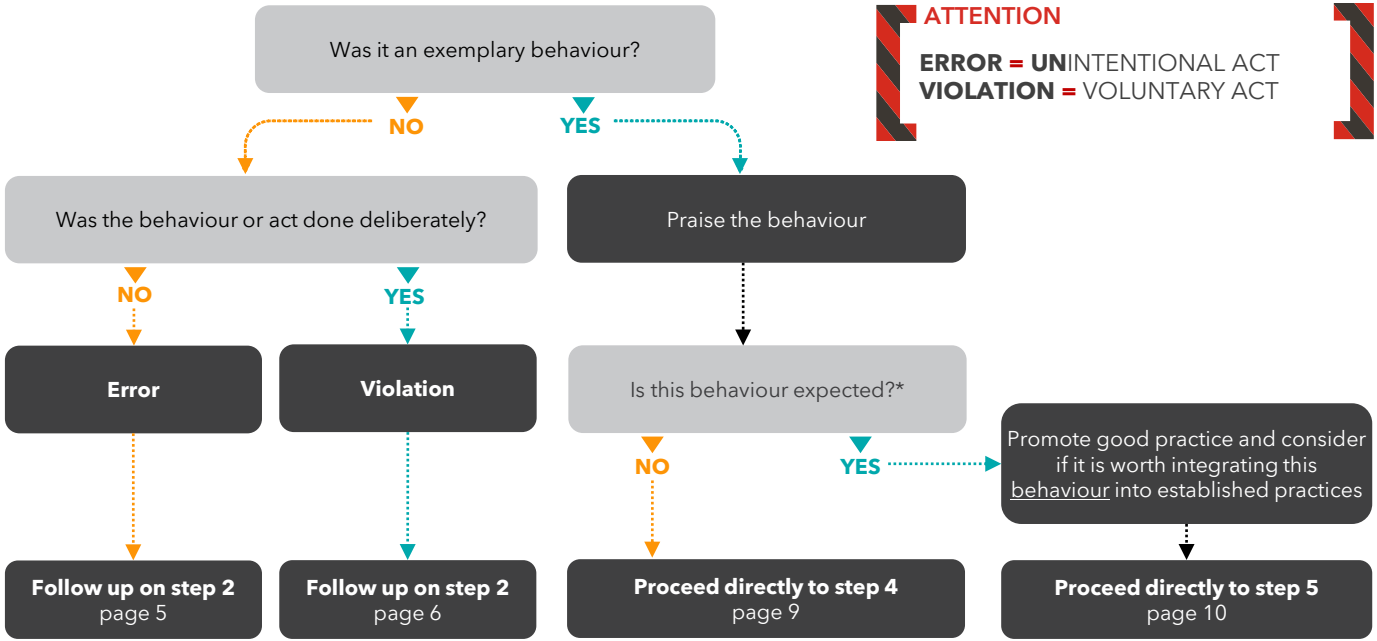
Negative factors		Positive factors
☑ **Knowledge**		
☑ **Technical skills**		
☑ **Non Technical Skills (NTS)**		
Lack of knowledge	← – – →	Adequate knowledge
Training gap	← – – →	Adequate training
Inadequate training received	← – – →	Appropriate training received
Lack of experience	← – – →	Appropriate level of experience
Inadequate soft skills	← – – →	Adapted soft skills
Technical skills gap	← – – →	Sufficient technical skills
Non technical skills gap	← – – →	Sufficient non technical skills

Best practices

- *Challenge the system and managerial practices.*
- *Identify root causes based on the HOF analysis of the safety event.*

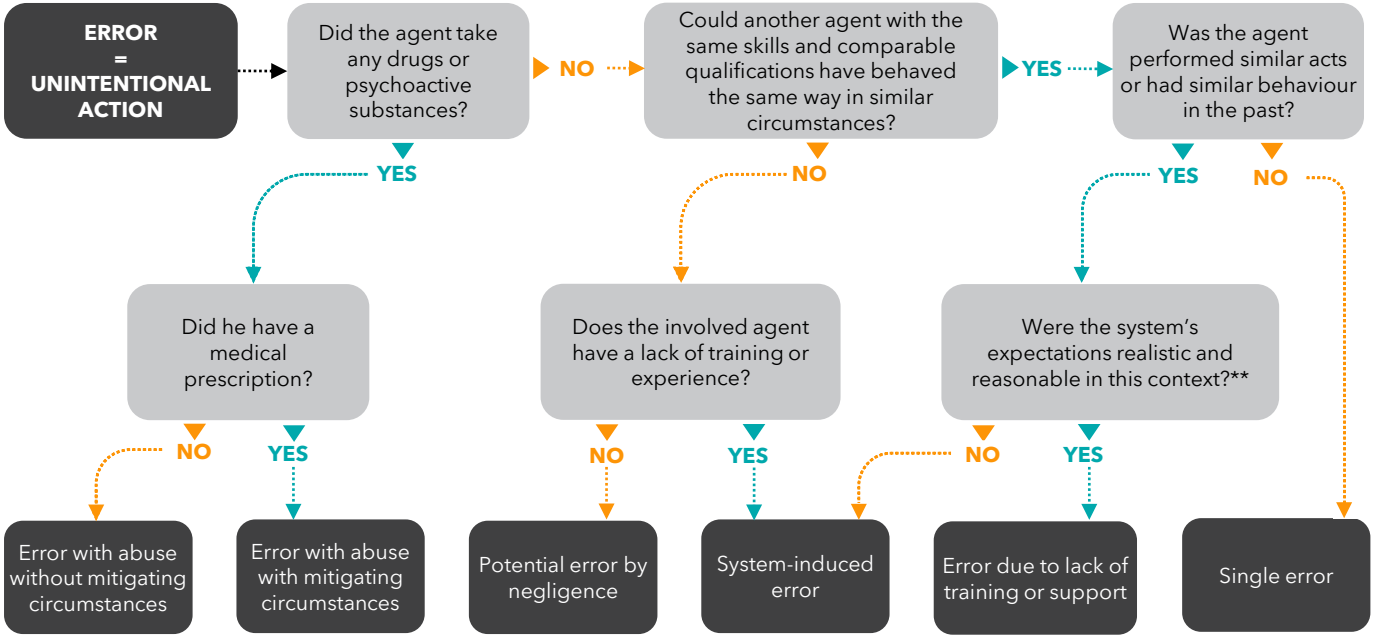
2 INDENTIFY THE BEHAVIOUR OR ACT
DISTINGUISH BETWEEN ERROR, VIOLATION AND EXEMPLARY BEHAVIOUR

WAT IS AN EXEMPLARY BEHAVIOUR?
It is a good practice, a behaviour or an act performed to guarantee a higher level of safety, even if it means breaking some rules.
Example: Airplane pilot Sully landing on the Hudson River in New York on January the 15th 2009.



** A behaviour can be considered exemplary because it has allowed a situation to be remedied, but can also be considered as undesirable given the fact that it is not the agent's but the system's responsibility to prevent or remedy this situation. Such exemplary behaviour is hence evaluated as undesirable when we want to avoid putting other agents in a similar situation.*

2 IDENTIFY THE BEHAVIOUR OR ACT
QUALIFY THE NATURE OF THE ERROR

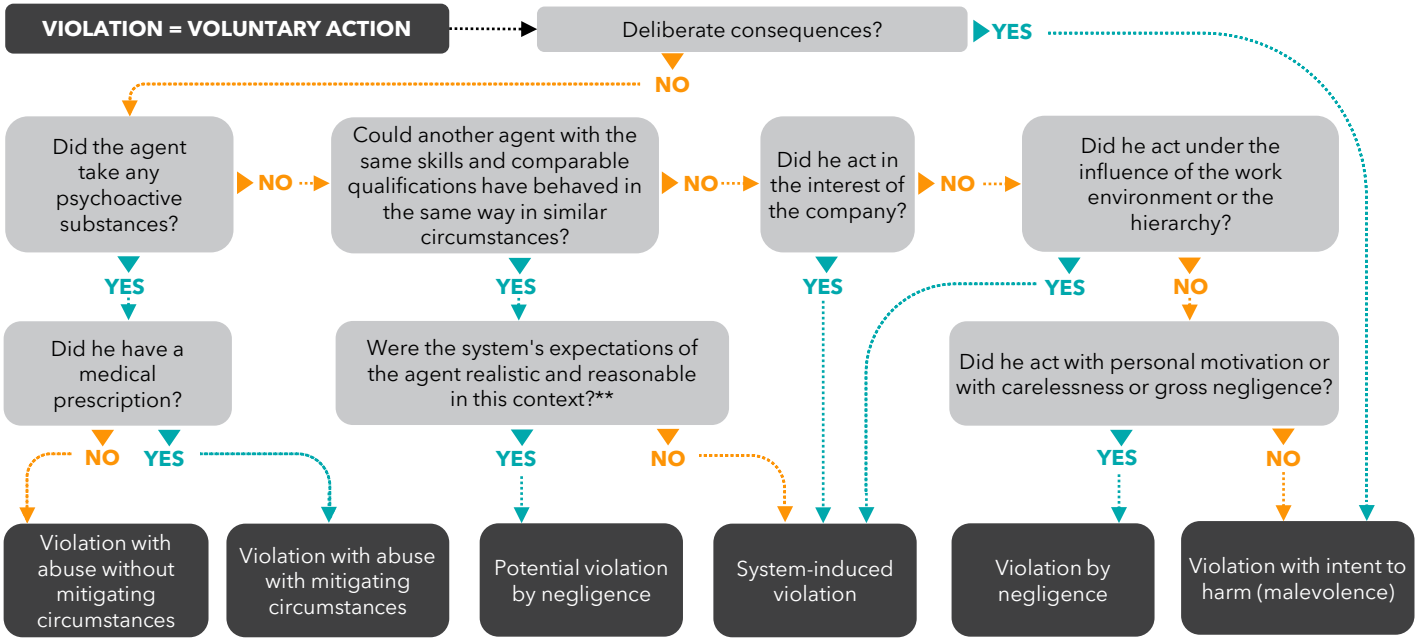


** If necessary, describe the situation with peers including any contextual factors and then raise the question: ' **How would you have acted in a similar context? Could you have made the same error?** '. Assess the work habits and any factors that might have 'trapped' the agent.*

*** Review the negative factors identified in step 1 and enquire about the causes induced by the system with the following questions:*

- Were the procedures available, understandable, applicable, and appropriate to the activity?
- Did the environment or context (atmosphere, disrupted situation) favour the observed behaviour?
- Was the technical equipment fully functional?
- Was the organisation adapted and were the resources adequate?

2 IDENTIFY THE BEHAVIOUR OR ACT
QUALIFY THE NATURE OF THE VIOLATION



** If necessary, describe the situation with peers including context and then raise the question: '* ***How would you have acted in a similar context? Could you possibly have committed the same violation?****'. Assess the work habits and factors that could have 'trapped' the agent.*

*** Review the unfavourable factors identified in step 1 and enquire the causes induced by the system with the following questions:*

- Were the procedures available, understandable, applicable, and appropriate to the activity?
- Did the environment or context (atmosphere, disrupted situation) influence the observed behaviour?
- Was the technical equipment fully functional?
- Is it the system that forced the agent to choose between several conflicting demands (double binding)?
- Was the organisation appropriate and the means sufficient?

3 EVALUATE THE ACCEPTABILITY OR UNACCEPTABILITY OF THE BEHAVIOUR OR ACT
DEFINE THE LEVEL OF ACCEPTABILITY RELATED TO THE OPERATORS

If the result of step 2 is:

Violation with intent to harm (malevolence)	Use of psychoactive substances without mitigating circumstances	Use of psychoactive substances with mitigating circumstances	Violation by negligence	Error by negligence	Single error

Review the causes collected in Step 1 and use the following questions to evaluate the acceptability of the behaviour or act from the operator's perspective:

- Could another agent have acted in the same way in similar circumstances? Do peers consider this behaviour appropriate for a professional in the industry?
- Does the safety event reveal a latent 'trap' in which other agents could fall too?
- Did the organisation put in place contribute to the occurrence of the safety event?
- Was the agent aware of the potential impact on safety or other possible impacts (on reputation, regularity, etc.)?
- Was the agent being transparent? Did he/she spontaneously report the information?
- Was the agent collaborative during the investigation and analysis?
- Does the agent show any guilt or remorse?
- Is this safety event a source of learning for the group or the system?
- Did the agent have a duty to be exemplary? The more influential an agent is, the more he / she should be exemplary. (Raise this question in the case of a violation by a manager, trainer, person with safety duties, etc.)

Best practice
Do not let consequences influence your assessment.

UNACCEPTABLE ◄ ····· ► **ACCEPTABLE**

3 EVALUATE THE ACCEPTABILITY OR UNACCEPTABILITY OF THE BEHAVIOUR OR ACT
DEFINE THE LEVEL OF ACCEPTABILITY OF THE SYSTEM

If the result of step 2 is:

System-induced violation

System-induced error

Error due to lack of training or support

Review the causes collected in Step 1 and use the following questions to evaluate the acceptability of the agent's behaviour or act from the system's standpoint:

- Could the safety event have had more serious consequences or other more significant impacts?
- Is the organisation, the context, the situation exceptional or recurrent?
- Does the safety event reveal a latent "trap" in which other agents could fall too?
- Was it possible to work differently in this situation / context / environment / working conditions?
- Was the safety event predictable? Could it have been anticipated or is it surprising?
- Were the system's expectations of the people involved realistic and reasonable (i.e., sufficient and appropriate training, available resources, available staff, available time, applicable procedures, etc.)?
- Were the working conditions acceptable?
- Did the organisation put in place generate significant or unconsidered risks? Risks for which no protective barriers are provided?
- Could the people involved have warned, avoided or remedied the situation?

Best practice
Do not let consequences influence your assessment.

UNACCEPTABLE ◄ ····· ► **ACCEPTABLE**

4 TAKE APPROPRIATE MEASURES REGARDING THE ACTORS, THE TEAM AND THE SYSTEM
PREVENT THE EVENT FROM RECURRING

ATTENTION
It is up to the analysis team to identify the measures needed to prevent the event from happening again. Make sure that every decision is compared with similar cases to ensure a fair process.

Undesirable exemplary behaviour

The error or violation is assessed as acceptable

The error or violation is assessed as unacceptable

Assess whether measures are necessary to ensure that the safety event does not recur

Take measures to prevent the event from happening again

Assess whether the sanction is useful in addition to other actions

Context

☑ **Environment, working conditions:** lighting environment, noise exposure,...

☑ **Equipment, tools, technical equipment**: available, in good working order, suitable for the activity,...

☑ **Resources available:** available time, staff, equipment...

Operational management

☑ **Organisation** adapted to reality

☑ **Managerial practices:** safety leadership, on-site presence, exemplarity,...

☑ **Rules, documentation, procedures**: available, appropriate, understandable, up to date, applicable and coherent

Operational activity / the protagonist(s)

☑ **Work experience, training:** knowledge, technical and non-technical skills, qualification, authorization,...

☑ **Psychological and physiological condition:** support, planning,...

Strategic management

☑ **Orientations, decisions, arbitrations at the entity level:** risk analysis, Common Safety Method (CSM),...

☑ **Feedback and alert on strategic business choices**

J. Reason's model

Sanction is necessary if it is the only way to:

❑ solve the problem

❑ prevent the event from happening again

❑ enforce the fundamentals

❑ discourage overt cover-ups

If a checkbox is ticked, consider the sanction and possibly initiate the disciplinary procedure

5 PROVIDING FEEDBACK TO ALL PARTIES INVOLVED

PROVIDING FEEDBACK AND EXPLAINING TO BUILD TRUST

ATTENTION

Building trust is based on understanding and adherence to treatment outcomes.

1

Review the facts and information collected **from all parties involved** in the event.

2

Explain the decision taken. Using the provided tools, **explain the path of questions** which has led to the conclusion whether the observed behaviour or action is acceptable or unacceptable.

3

Present **the measures taken** and **the associated action plan**.

4

Explain what these measures **have prevented, are preventing and will prevent**.

Best practice

Give feedback to the larger team by explaining the decision and measures taken.

Best practice

Explaining the decision is an essential step for the success of the process.

ITEMS TO BE PRESENTED

- Synthesis of the facts collected in Step 1.
- Main organisational factors identified in step 1.
- Main Human Factors identified in step 1.
- Result of the behaviour or action analysis from the flowchart in step 2.
- Results and evaluation criteria for assessing the acceptability of the behaviour or action (step 3).
- Actions taken and lessons learned for the system (step 4).

In case of a safety event, the appropriate question to ask is not:
'What penalty should I apply?' but
'What actions do I need to take, at system level and for the operators, to ensure that the event does not happen again?'
This is the only way we can improve to ensure a high level of safety.

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