A culture of safety
or the secret organisation of process and protocol

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Oil & Gas

In 1988, **the Piper Alpha oil rig exploded** into a horrible fire. The disaster cost many lives. The investigation revealed critical **Human Errors**: errors and **violations of protocol** that showed commitment to safety was compromised. The industry became acutely aware that it had to **manage human errors**. Shell took the lead, developing the Reason Model of Accidents to **diagnose latent errors** that might one day cause disaster. From this model a **Safety Management System** was developed that organisations can use to manage their risks better. As industry leader, Shell now prides itself with its **uncompromising safety culture**.

How do **reliability-seeking organisations** construct **images of safety culture** and how are these constructions **exchanged** between and across industries?

The concept of 'safety culture' raises expectations that it cannot fulfil.

It suggests a 'strong culture' which somehow enables participants to know when to stick to procedure, and what situations are so extraordinary that improvising is allowed.

This image masks the benign uncertainties and routine improvisations that occur in daily practice. They usually go right, but sometimes they go wrong.

Societal responses to accidents are fierce, harming carefully constructed safety cultures with familiar politics of blaming.

Aviation

In 1977, **Human Error** caused the worst aircraft accident in history. On the foggy runway of **Tenerife Airport**, a KLM B747 and Pan Am B747 **crashed, killing 583** people. The investigation revealed that **the KLM Captain had violated a procedure and ignored his crewmembers**' correct reservations to commence takeoff. The industry realised it had to **flatten cockpit hierarchy** and create an **open atmosphere** towards errors. **Crew Resource Management** courses and training schemes since taught generations of pilots about the dangers of **complacency and hubris**. Aviation developed a **unique safety culture.** The majority of pilots will admit they are **only human**, make mistakes, and need others to correct them. Organisations also began to adopt and integrate explicit **Safety Management Systems**. They diligently update and apply **Standard Operating Procedures** to keep air transport safe.

Health Care

In 2001, an inquiry was completed on the **needless deaths** of many dozens of children in the **Bristol Royal Infirmary**. It was yet another shocking case of a **bad organisational culture** contributing to lethal **Human Errors** in a hospital. These findings contributed to putting **patient safety** on the agenda. Some health care organisations are now beginning to **adopt aviation's Crew Resource Management training** methods to improve cooperation in medical teams. Yet reports keep accumulating that medical staff are **not complying with the protocols** that are devised to keep patients safe. Whereas pilots believe in their own fallibility, **surgeons are still prone to complacency and hubris** because they do not as readily admit that they are fallible. They are under mounting pressure to **change their organisational structures**.

This project aims to create an empirically supported *framework for safety culture* that explicitly acknowledges ambiguous aspects of practice.

The project is an *interdisciplinary* effort, uniting an *organisational anthropology* approach to culture with a *linguistic* approach to discourse.

Models, images and particularly *metaphors* are believed to play a central role in the (re)production of meanings like safety culture.

Textual, social network and observational data are collected and analysed with an innovative combination of methods.