The essentials

FOR A JUST AND FAIR CULTURE

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ICSI
Institute for an Industrial Safety Culture

THE ESSENTIALS OF INDUSTRIAL SAFETY COLLECTION

Editorial

You have no doubt already heard phrases such as 'I knew it' or 'That doesn't surprise me' when an incident or accident occurs. They are typical in environments where organisational silence has taken hold. The information is there and readily available, but it is not reported upwards through the chain of command. How can an organisation improve safety when decision-makers do not (really) know what is happening at the sharp end?
A just and fair culture is, among other things, a lever for improving an organisation's culture of transparency, a core attribute of an effective safety culture. We have been working on the topic for several years, and we regularly support our members in their related efforts. Our focus on this is no coincidence: the safety culture assessments we have been conducting for over 15 years show that this area often requires significant improvement.
A just and fair culture may seem straightforward on paper, but it is complex to implement. It requires work on the fundamentals of the organisation's culture, its values and its continuous improvement processes. With these Essentials, we aim to provide practical keys to understanding, along with a synthesis of our knowledge and experience. We hope you will find them valuable.

Ivan Boissières,
General Manager of ICSI

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What is a just and fair culture?

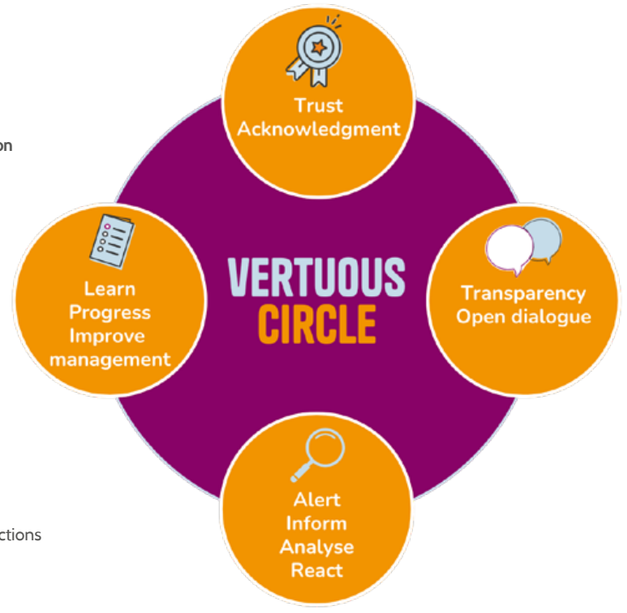
What is it?

A just and fair culture encourages the reporting of information important for safety, by creating a climate of trust and transparency that is necessary to foster open dialogue and speak-up behaviour.

To encourage speaking up, there must be **a clear framework in place, known and accepted by everyone,** regarding how reported issues and situations will be analysed and handled.

This framework must be:
- **just**, because it sets explicit and shared rules that guide the analysis and handling of reported situations objectively,
- **fair**, because it guarantees identical treatment for all actors, irrespective of their status, position or level in the chain of command.

In a just and fair culture, the reactions of the organisation and management following event reports are predictable. The reactions are just, appropriate and consistent.



What information is useful for safety?

Employees hold key information that is essential for safety and must be identified and taken into account:
- **what is going wrong or 'not as planned'**: high-potential incidents or situations, latent failures, anomalies, suboptimal conditions, errors, rule and procedural violations, improvised adaptations in response to unexpected difficulties, etc. Identifying these situations early on is fundamental to detecting weaknesses in the system and strengthening it.
- **'good news'**: positive and proactive safety behaviours, good practices, successes in situations critical to safety, etc. Understanding why and how things went right is just as important as understanding why and how they went wrong.

How does this relate to safety culture?

Fostering open dialogue strengthens one of the key attributes of an effective safety culture: **a culture of transparency**. It ensures a smooth flow of information throughout the organisation and helps combat a well-known problem in companies: organisational silence. The information reported is then analysed and handled. This triggers an operational experience feedback and learning loop, which contributes to the development of another essential component of a safety culture: **a learning culture**. The ultimate objective is improved control of the risks of serious injuries, fatalities and major technological accidents.

A just and fair culture is also closely tied to:
- **managerial leadership**, expressed through changes in attitudes and practices,
- a **shared awareness of the most significant risks**, supported by strong discipline around the fundamental rules relating to major hazards,
- **everyone mobilising** to report information that is useful for safety and to maintain a climate of trust.

The benefits of a just and fair culture

- A **reporting dynamic**, with an increase in spontaneous reporting and early, transparent event reports. This triggers one of the main tools of continuous safety improvement: the event analysis process and the implementation of corrective actions;
- **Greater safety proactiveness**, with more safety-focused initiatives in at-risk situations, as well as improved engagement and motivation among teams and a stronger sense of usefulness among employees;
- **Greater rigour and discipline** with regard to the organisation's fundamental rules, to protect people, facilities and the environment;
- A more constructive **climate of trust** between managers and their teams, resulting from consistent managerial reactions when events are reported.

Historical milestones

A just and fair culture is not a recent concept. It is the fruit of extensive academic research.

1970s: reporting

The aviation sector was a pioneer in promoting the idea that encouraging spontaneous event reporting is more effective for safety than punishing the professionals involved.
Aviation Safety Reporting System, 1976 (USA)

1980s–1990s: systemic analysis

James Reason's work shows that too many analyses focus on identifying an immediate culprit, rather than examining the underlying systemic causes (management, context).

1990s: operational experience feedback and a non-punitive approach to mistakes and error

The 1990s were marked by limited operational experience feedback and under-reporting. This highlighted the need for a safety culture that builds trust, fosters open dialogue and is based on a non-punitive approach to mistakes and error (but not to rule violations). David Marx introduced the term 'just culture' in 1997.

2000s: organisational silence

Sidney Dekker further developed the concept of just culture, notably addressing the excessive 'criminalisation' of human error and the need for proportionality in organisational reactions.

2010s: the just culture in companies

'Just culture' initiatives emerged within companies as an objective in their own right. The focus was often placed on appropriate managerial reactions, sometimes at the expense of the initial objective: combating organisational silence.

Fostering open dialogue to improve safety

Combating organisational silence

Organisational silence is a situation in which information that is useful for safety is not reported. As a result, it can neither be analysed nor handled at the appropriate decision-making levels, and is therefore not taken into account in prevention strategies, leading to multiple and critical consequences for risk control.

The consequences of organisational silence

- **At-risk situations accumulate without management being aware of them**, because anomalies or problems have not been reported. When an accident occurs, it is common to hear those at the sharp end say, 'I knew it' or 'I'm not surprised';
- **An illusion of control:** 'if nothing is being reported, everything must be fine'. The chain of command continues to operate under the false belief that its models are appropriate, and therefore fails to make the necessary adjustments;
- **Similar events occur repeatedly**, because the root causes have not been identified or corrective actions have not been communicated to employees;
- **Employees become demotivated and disengage from prevention activities:** little or no safety proactiveness;
- **Management is unable to recognise exemplary actions or ensure they are shared** with everyone;
- **A deteriorated workplace climate**, particularly between managers and those they manage.

Besides safety, organisational silence can also have harmful effects on health, psychosocial risks and work quality, for example.

HOW DOES ORGANISATIONAL SILENCE DEVELOP?

There are **individual defence mechanisms** that can hinder reporting, including risk minimisation, denial, or a sense of fatalism that leads people to think that 'speaking up won't change anything'.

Within a **work group**, being the first to report information can be tough. Concern about **how peers will react** weighs heavily. Individuals may fear generating conflict or being seen as 'telling' on others. More broadly, this raises questions about **the shared understanding of what makes a 'good worker': someone with no problems, or someone who reports problems?**

There are also many **organisational mechanisms**:

- **Systematic disciplinary measures:** reporting a problem or an error systematically exposes employees to disciplinary action. They remain silent and withhold information to protect themselves.
- **An impression of tacit tolerance:** sharp-end workers feel that the most dangerous behaviours are tolerated or even normalised. Managers turn a blind eye... so why report something?
- **Arbitrary and inconsistent reactions:** when an error or anomaly is reported, managerial reactions are perceived as unpredictable, arbitrary and lacking clear guidelines. When there is doubt or uncertainty about how management will react, employees prefer not to report.
- **A focus on human error in event analysis:** there is a deep-rooted feeling that blame always falls on the sharp-end worker, without any in-depth examination of how the organisation itself functions.
- **A lack of follow-up or feedback on reports:** employees who have reported information feel that 'nothing comes of it' and see no concrete action.
- **A lack of recognition for positive safety behaviours:** initiatives and good practices are not valued or recognised by the organisation or by colleagues, so why bother?

> 'No news is bad news'

24%

This is the proportion of respondents who answered 'often' or 'very often' to the statement: 'Incidents that could have led to a serious injury sometimes go unreported by employees'.

Source: ICSI safety culture assessments (2020–2025, 80,000 respondents)

A CLOSER LOOK AT SILENCE AMONG MANAGERS AND CONTRACTOR COMPANIES

As information moves up the chain of command, it is filtered. This is a normal process, but it becomes problematic when **organisational silence operates at every managerial level**. According to ergonomist François Daniellou, 'a manager may find themselves caught between contradictory information coming down from senior management and information coming up from the sharp end. To protect themselves, they will tend to restrict the upward flow of information, whether consciously or not'.

Other factors may also come into play. **Distance from the sharp end** can lead some managers to downplay alerts they do not fully understand. There may also be a **'good performer' culture**: under pressure from indicators or zero-accident targets, a good manager is expected to keep their area of responsibility accident-free, even when conditions are difficult. In companies, this is reflected, for example, in the widely-known 'watermelon indicators': they are always green on the outside, but they can be hiding red on the inside!

Important note: the point is not to report everything – that would be unrealistic and unnecessary. What matters is that high-potential safety events are escalated smoothly through every layer of the chain of command so that they can be handled at the appropriate decision-making levels.

Contractor companies are economically dependent on the client companies they work for. This asymmetry in the relationship makes them particularly exposed to organisational silence: fear of losing a contract, limited access to the client's reporting channels, contractual pressures such as 'zero accidents' or 'zero delays' (which encourage problems to be concealed rather than risking a work stoppage), differing standards and practices, blurred legal responsibilities, etc. Including contractor companies in the development of a just and fair culture approach is a powerful lever for progress.

Key points

No news = bad news. Organisational silence is profoundly harmful to safety: **it renders the organisation 'blind and deaf' to what is really happening**. It is like navigating in fog.

Combating organisational silence **is everyone's responsibility, from sharp-end workers to top management**. The chain of command must fully play its part and be convinced of its essential role.

The more bad news you receive, the better: it is a sign of a culture that confronts reality. Receiving more reports of incidents, problems and anomalies is not something to be feared. What matters is that they are handled. **Over time the numbers will fall, and this will represent real and sustainable progress.**

Are organisations eager for bad news?

'Bad news is generally not welcome at the highest levels of large organisations. In practice, reporting it may even be actively discouraged. Leaders sometimes seek to make their employees more autonomous by telling them, 'Don't bring me your problems, bring me your solutions.' Bad news is actually good news, because it means that reporting systems are allowing the bad news to reach the decision-making level where action can be taken before it is too late.'
Andrew Hopkins, sociologist at Australian National University (ANU) in Canberra.

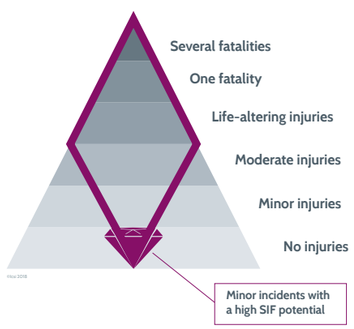
Reporting information and learning from it

Identifying learning opportunities

Among the large volume of information reported, focus your in-depth analysis efforts on **high-potential incidents and situations** (sometimes even called 'high learning-potential' events). These are situations where (fortunately) nothing happened... but where slightly different circumstances could have been disastrous. A good way to identify these is to ask a simple question: 'Would I have been surprised if this situation had led to something serious?' If the answer is yes, there is only one appropriate course of action: analyse the root causes (technical, organisational and human) and address them. By doing so, you are acting on your accident precursors and weak signals, and thus contributing to the genuine prevention of serious injuries, fatalities and major technological accidents.

Tip: to improve the quality of reporting, train teams on the type of information that should be reported. They will be far more likely to engage if expectations are clear and specific.

▼ The prevention diamond



To combat organisational silence, a reporting system must be put in place. But this is not enough in itself: information is only useful if something is done with it. It must be analysed, handled and used to initiate an operational experience feedback and learning loop that benefits the entire organisation.

ORGANISING EVENT REPORTING

An event reporting system comprises **a range of channels that are more or less formal and interconnected:**

- reporting systems: digital tools used to collect, organise and analyse data,
- communication and discussion rituals: toolbox talks, safety walks, coordination meetings, etc.,
- informal interactions: everyone knows, for example, what a goldmine of information the coffee break area can be,
- interactions with external stakeholders (clients, contractor companies, authorities, etc.),
- employee-management dialogue: employee representatives act as 'sentinels of work-as-done' and are recognised as contributors to the identification and handling of hazardous situations.

A distinction must be made between:

- everyday minor issues and irritants (minor failures, recurring inconveniences, poorly designed procedures, etc.). These require short-loop handling: rapid, visible responses with direct corrective actions and feedback within 48 hours;
- high-potential incidents and situations, which require in-depth analysis in order to identify their root causes.

The larger the organisation, the greater the risk that information will become siloed by department, occupational group, type of risk or reporting channel. The challenge is to create bridges between them.

TRIAGING INFORMATION

There is a real risk of becoming overwhelmed by the volume of information. **It is not possible to analyse and handle everything. Prioritising is key!**

ANALYSING AND USING THE INFORMATION: TOWARDS A LEARNING CULTURE

The quality of the analysis performed is critical. It must be objective and neutral, and aim to understand how things actually functioned, identify the nature of the problems, and **explain 'how' and 'why' the situation arose**. In other words, it is not intended to assign individual responsibility, and even less to impose disciplinary measures. Ideally, the analysis is not carried out by managers, but by analysts who have no hierarchical link with the people who submit the reports.

There are different levels and methods of analysis. An in-depth **root cause analysis** is required in cases involving high-potential incidents or situations, repeated events of a similar nature, or crossing the organisation's red lines (for example, failure to comply with a life-saving rule).

Analysis should lead to:

- the handling of technical and organisational root causes,
- a strengthening of preventive, recovery and mitigation barriers,
- just and fair handling by management, based on a clear framework known and shared by all.

Each level of the chain of command has a responsibility to take an interest in hazardous situations which the level below cannot deal with alone, and to escalate to the appropriate decision-makers any situations beyond its own decision-making authority.

FEEDBACK

Keep teams informed about the follow-up to their reports. This is essential to sustain employees' motivation to report information. It enables them to feel useful and to see how they contribute to improving safety for everyone.

Some good practices to encourage reporting

- show approval and give recognition to those who report information,
- put simple, accessible reporting tools in place, tailored to the needs of users,
- opt for reporting options that preserve anonymity where relevant,
- promote a participative bureaucratic culture: managerial approaches and attitudes that encourage reporting and a willingness to listen, as well as practices embedded in existing rituals (toolbox talks, briefings, presence at the sharp end, etc.),
- communicate on the purpose and importance of reporting, and train employees to identify at-risk situations and information that is useful for safety,
- provide visible and rapid feedback and implement short handling loops,
- involve employees in the analysis and handling of reported situations.

Key points

Encouraging speak-up behaviour provides **a more detailed picture of what is happening** at the sharp end than accident and incident indicators can provide (KNOW). The information is then analysed and handled, **feeding a continuous improvement loop** (LEARN). Learning has only truly taken place when a positive change has been implemented.

Analysis of reported information must explain 'how' and 'why' things happened, rather than assigning responsibility. A culture of transparency requires acceptance of the need **to trace problems back to their root causes**, which are often managerial and organisational.

High-potential incidents and situations must be identified and analysed, in order to focus organisational efforts on preventing serious injuries, fatalities and major technological accidents.

Building a just and fair culture

Key point

To foster the trust needed for open dialogue, organisational actors must agree on a clear framework **for analysing and handling reported information and situations**. This is essential for achieving **an appropriate, consistent and fair organisational and managerial response.** Co-constructing a framework that sets out the rules of the game, and is shared and applied by all, lays solid foundations for a just and fair culture.

Understanding different behaviours and acknowledging the right to make mistakes

The first building block in establishing a just and fair culture is developing a shared lexicon and a common understanding of the different human contributions to safety. This is necessarily a collective process.

There are three broad categories of behaviour when it comes to safety: positive contributions, mistakes, and rule violations.

POSITIVE CONTRIBUTIONS

These are by far the **most common**: employees generally strive to do their job as well as possible. Shared vigilance, rule compliance, proactive attitudes, initiatives, appropriate adaptations to situations, event reporting... all these behaviours should be **encouraged and recognised.**

Team successes should be analysed, good practices captured and shared. Understanding why and how things went right is an invaluable source of learning... and yet it remains underutilised!

HOW TO DISTINGUISH BETWEEN MISTAKES AND RULE VIOLATIONS

Organisations establish rules and procedures to ensure safety: this is rule-based safety, which values rule compliance. But sometimes activities do not go as planned. This is referred to as a deviation, a departure from standard operating procedures. A deviation may be intentional or not! This is what distinguishes a mistake from a rule violation:

- **mistakes are always unintentional**: no one starts the day thinking 'Today I'm going to make a mistake'.
- **rule violations are intentional:** the rule is knowingly broken, often as a result of contextual factors, performance pressures, personal interest, etc. The situation must be analysed carefully.

Note: the term 'fault' belongs to the legal lexicon and carries an implication of liability. It is not part of the language of prevention.

ACKNOWLEDGING THE RIGHT TO MAKE MISTAKES

According to neuroscience, human beings make **between two and five mistakes per hour**. Mistakes made during work activities may be due to human behavioural characteristics (routine errors, for example) and/or latent factors such as design choices, the configuration of the work environment, organisational failures, and certain managerial decisions. Most often, mistakes are the consequence of the conditions in which individuals are placed. The question, therefore, is not whether mistakes will occur, but when.

A just and fair culture is based on the principle that the organisation **acknowledges the right to make mistakes.** Human beings contribute significantly to overall safety performance in organisations, and it is necessary to accept that mistakes will occur from time to time. Technical, organisational and human measures can be put in place to limit their occurrence, but their effect will be limited. The key issue is determining what **the organisation has put in place to detect mistakes, recover from them and mitigate their consequences**. As René Amalberti, Director of FonCSI, puts it: 'The most effective systems are not those that make the fewest mistakes, but rather those that catch the most.'

Acknowledging the right to make mistakes demonstrates the importance of reporting these mistakes spontaneously rather than concealing them. A reported mistake helps safety improve.

RULE VIOLATIONS

Rule violations are intentional, but they may have many possible explanations. They must be analysed carefully: was a different course of action possible? Would someone else have done the same thing in that situation? What were the person's intentions? The answers to these questions will determine how the situation is handled. Among the range of possible violations, some will fall within the organisation's **red lines**: it is up to each organisation to define these through dialogue and internal co-construction.

> **Acknowledging the right to make mistakes does not mean that anything goes.**

Key points

It is essential to distinguish between positive contributions, mistakes and rule violations. This is a matter of semantics that requires alignment and a shared understanding of terms and situations. The central question is: how will the organisation respond in the different situations encountered?

A just and fair culture requires acknowledging the right to make mistakes, which are by definition unintentional. Punishing individuals for mistakes makes no sense: it neither reduces mistakes nor prevents their recurrence. Worse still, it will demotivate teams and limit people's positive contributions to safety.

A rule violation is not necessarily blameworthy. It must be analysed to understand its causes and the intent. Some violations do, however, cross the organisation's red lines and may legitimately expose individuals to disciplinary action.

How should mistakes be dealt with?

The concept of 'right to make mistakes' is extremely sensitive: lives may be at stake... and what if a mistake leads to a serious injury or fatality? Given the emotional impact, it can sometimes be very tempting to respond with exemplary severity and to punish the individual concerned. This is understandable, but it often gets in the way of asking the real questions and drawing lessons from the event. Ultimately, is it not more important to put measures in place to prevent a serious accident from happening again? According to Sidney Dekker, 'You can either learn from an accident or punish the individuals involved, but not both at the same time.'

POSITIVE CONTRIBUTIONS

- Compliance and exemplary behaviour: adopting attitudes and practices that meet expectations, and holding oneself to the same standards expected of others.
- Positive and proactive contributions: taking initiatives beyond what is expected, with the aim of improving the safety system or protecting one's own life or that of others.
- Consistent and noticeable engagement: sustained involvement in safety-related matters.

MISTAKES

- Routine mistakes: errors made through now-automatic behaviours in familiar and frequently repeated situations (lack of attention, bad reflex).
- Errors in applying rules: mistakes in implementing a rule, or misidentifying a situation, leading to the application of an inappropriate rule or the failure to apply a relevant one.
- Errors in assessing a situation: difficulties arising from a lack of knowledge or skills in new or complex situations.
- Mistakes due to latent failures: errors resulting from design flaws, organisational failures, etc.

RULE VIOLATIONS

- Context-driven violations: contradictory rules, inappropriate procedures, etc., making strict compliance impossible.
- Normalised violations: the work group violates the rule with tacit managerial tolerance. This occurs in situations where the cost of abiding by the rule is perceived as too high, or where the rule has lost its meaning.
- Violations driven by performance objectives: without being driven by personal gain, individuals may feel compelled to bypass the rule in order to meet performance objectives influenced by the context (economic pressure, customer satisfaction, cost and schedule constraints, etc.). This is an individual decision.
- Violations for personal gain: personal interest or gain is prioritised over collective safety. This may involve negligent, reckless or careless behaviour.

Recognise, reinforce and promote

Acknowledge the right to make mistakes, support, assist

Remobilize, realign expectations, impose disciplinary action

Sabotage or malicious intent involves an intention to cause harm. It is very rare, but it constitutes such a serious offence that it falls under criminal law.

Recognising and reinforcing positive contributions

In the vast majority of their day-to-day work practices, employees make positive and proactive contributions to safety, through rule compliance, initiatives, cautious behaviour, appropriate adaptations to suboptimal conditions, helping one another, and spontaneous event reporting. Most of the time, work is carried out safely.

MAKING THE INVISIBLE VISIBLE

In terms of safety, when work is done well, nothing happens: no accident, no workplace fatality, no evening news report about a disaster. In other words: it is invisible. And yet, this absence of events is the result of skills, investment, initiatives, team commitment, daily trade-offs, etc.

It is precisely these **positive and proactive contributions to safety that need to be reinforced and recognised.**

Key points

Recognition is the 'poor relation' of prevention policies, and yet it is an extremely powerful driver of safety. It fosters engagement, motivation and proactiveness, and it improves the quality of relationships between managers and their teams.

Everyone needs recognition, from sharp-end workers to top management. Recognition should be directed not only at individuals but also at work groups!

Recognition is not the sole responsibility of managers; it should also come from the organisation or its representatives, from peers, and from external stakeholders (clients, suppliers, etc.).

FORMS OF RECOGNITION* at the individual or group levels

RECOGNITION OF THE PERSON/THE WORK GROUP

Recognise individuals or work groups for what they are (and not just what they do or produce).

Examples:
- *aware of risks,*
- *vigilant for themselves and others,*
- *acts with care.*

RECOGNITION OF WORK PRACTICES

Acknowledge the quality, methods, organisation and effectiveness of work.

Examples:
- *taking initiatives,*
- *working as a team,*
- *challenging a co-worker,*
- *helping one another,*
- *reporting information that is critical for safety.*

RECOGNITION OF INVESTMENT IN WORK

Focus on employees' commitment, dedication and personal effort.

Examples:
- *consistently demonstrates exemplary safety behaviour over time,*
- *shows a particularly high level of engagement in safety rituals.*

RECOGNITION OF OUTCOMES

Focus on the outcomes achieved and the objectives reached.

Examples:
- *zero serious injuries*

*Based on the work of Jean-Pierre Brun, a professor at Université Laval (Canada) and the co-author of Le pouvoir de la reconnaissance au travail (2018)

THE EFFECTS OF RECOGNITION

Recognition at work may be given to individuals or to groups. It helps to:
- increase motivation, engagement, creativity and proactiveness among teams,
- foster a sense of usefulness and purpose at work,
- embed good practices,
- improve the quality of relationships between managers and their teams, etc.

Recognition is an **extremely powerful driver** of safety. And yet, it is **often overlooked** in prevention strategies.

RECOGNITION: FOR EVERYONE, BY EVERYONE

Everyone needs recognition, from sharp-end workers through all levels of management to the very top of the organisation. **Acknowledging and recognising the safety-related decisions and trade-offs made by managers at all levels** is a powerful lever for improving safety performance. However, recognition practices **are not the sole responsibility of managers**. Recognition may come from the organisation itself or its representatives, from **co-workers**, or from **external stakeholders** (clients, suppliers, authorities, etc.). The more numerous the sources and the more regular the recognition, the more effective it will be.

RECOGNITION PRACTICES

Recognition practices can be:
- **Formal**: employee-of-the-month schemes, skills development, promotions, financial rewards (bonuses), features in internal communications, letters of thanks from the organisation, etc.
- **Informal**: everyday encouragement and expressions of appreciation, genuine interest in employees' actual work (site visits, questions, discussions), being consulted and heard, being given autonomy, etc.

The power of informal, day-to-day recognition by line managers and peers should not be underestimated: it conveys genuine consideration and fosters trust in individuals. It requires authenticity, sincerity and consistency.

48%

This is the proportion of respondents who answered 'sometimes' or 'almost never' to the statement: 'Management knows how to recognise and acknowledge those who work safely.'

Source: ICSI safety culture assessments (2020-2025; 80,000 respondents)

Learning from what goes right, too

'An alternative view of safety focuses on understanding how positive outcomes are achieved, in order to increase them. This requires understanding work-as-done and striving to increase successful outcomes rather than merely preventing failures.'
Erik Hollnagel, Emeritus Professor at Linköping University (Sweden)

Establishing fundamental rules and enforcing red lines

Clarifying red lines means defining what all actors within the organisation consider unacceptable from a safety standpoint. This includes practices, behaviours, attitudes and decisions that put the health and lives of others at risk. These red lines are closely linked with the organisation's fundamental rules.

Implementing a just and fair culture does not in any way mean promoting a permissive culture where 'anything goes', including the most dangerous behaviours. Such an approach would signal that safety is not a fundamental priority; it would lead to a decline in engagement and vigilance with regard to at-risk situations, and encourage the normalisation of deviation through the repeated acceptance of deviations from rules.

ESTABLISHING AND EMBEDDING FUNDAMENTAL RULES

Organisations have **fundamental rules** that must be complied with 'at all costs'. The health and safety of people, facilities and the environment depend on them. Their legitimacy stems from the fact that **they address the risks of serious injuries, fatalities and major technological accidents** already identified. These rules must be clearly set out, co-constructed and shared within the organisation, as well as with external stakeholders (contractor companies, clients, etc.).

Simply setting rules is not enough; they must be embedded through key communication opportunities (onboarding, briefings, toolbox talks, coordination meetings, etc.) and through managerial support (safety visits, supervision, etc.).

It is also essential to encourage teams to identify technical or organisational obstacles preventing strict compliance with the rules, and to propose adjustments. Finally, the rules must be kept up to date. Organisations evolve, activities change, and new or significant risks emerge. Organisations must therefore ensure that their fundamental rules continue to address the risks of serious injuries, fatalities and major technological accidents.

ENSURING COMPLIANCE: AN ORGANISATIONAL RESPONSIBILITY

The organisation must **put in place the conditions, means and resources that enable employees to comply with these fundamental rules** of safety. Rules should therefore be rolled out progressively, with an initial phase during which the teams verify their applicability in real-world conditions. Once implemented, the organisation must regularly ensure that they remain applicable. Where all reasonable efforts have been made to enable compliance, violating one of these fundamental rules constitutes the crossing of a red line. It represents a collectively recognised boundary, an inviolable limit, a form of conduct considered unacceptable by all. Compliance with the fundamental safety rules contributes to the sense of fairness within the organisation: no one would understand if management and the organisation allowed such rules to be disregarded. This is deeply embedded in the culture: when someone violates these rules, it is shocking to other employees.

A DEVIATION FROM A FUNDAMENTAL RULE = A HIGH-POTENTIAL SAFETY EVENT

Failure to comply with one of the organisation's fundamental rules must be regarded as a high-potential safety event and systematically trigger an in-depth analysis to identify the causes. This analysis should explain 'why' and 'how' the situation arose, without judgement or preconceptions, and provide factual elements to determine how to handle the situation. It is essential to resist the urge to take systematic disciplinary measures against the individual concerned: the analysis could show that a mistake was made, that the individual did not have the means to do otherwise, or that they were influenced by contextual factors (for example, pressure from management or peers).

In such cases, the root causes must be addressed: working conditions, work groups, management practices, or organisational factors.

Conversely, the analysis could also show that the individual was in a position to carry out their work safely but deliberately chose to violate a fundamental safety rule. This is rare, but it constitutes the crossing of a red line. In such cases, the individual may legitimately be exposed to disciplinary action, which could be severe depending on the circumstances.

A word of caution, however. Disciplinary measures are only legitimate if they are applied to all involved, regardless of their position in the chain of command. The crossing of a red line can therefore involve a sharp-end worker (dangerous behaviour, proven and repeated negligence, concealment, malicious intent, sabotage, etc.), but also a manager if, through their decisions, attitudes or conduct, they have pushed their teams to take risks (turning a blind eye to safety issues, tolerating violations of fundamental rules, systematically prioritising performance over safety in their messaging, etc.).

Golden rules or life-saving rules

Fundamental organisational rules are often complemented by 'life-saving rules', sometimes called 'golden rules'. These are a concise set of non-negotiable rules that:

- aim to save lives if strictly followed,
- are formulated in a short, clear and, where possible, positive manner,
- are known to everyone,
- apply without exception. Where an exceptional exemption is required, it must be formally authorised in writing by a member of senior management or their representative, and compensatory measures must be put in place,
- are binding in both directions: the organisation may require employees to comply with them, but employees may, with full confidence, refuse to carry out a task if the conditions required to comply with a life-saving rule are not met.

> **A strong safety culture relies on strict discipline with regard to the fundamental rules associated with major hazards.**

Good practices

No-go or stop-work situations
At the sharp end, the fundamental rules make it possible to identify 'no-go' situations: suboptimal work situations in which the conditions do not allow these rules to be applied. In such cases, anyone may legitimately say 'stop' and halt the activity until safe conditions are restored. Solutions are then sought collectively to return to a controlled situation.

Exceptional exemption arrangements
No employee may unilaterally decide to depart from a fundamental rule set by the organisation. In exceptional cases, a formal exemption system may be put in place, monitored and overseen at the highest level of the organisation. However, particular care must be taken to avoid the normalisation of exemptions, a toxic situation in which rules ultimately lose all meaning.

Key points

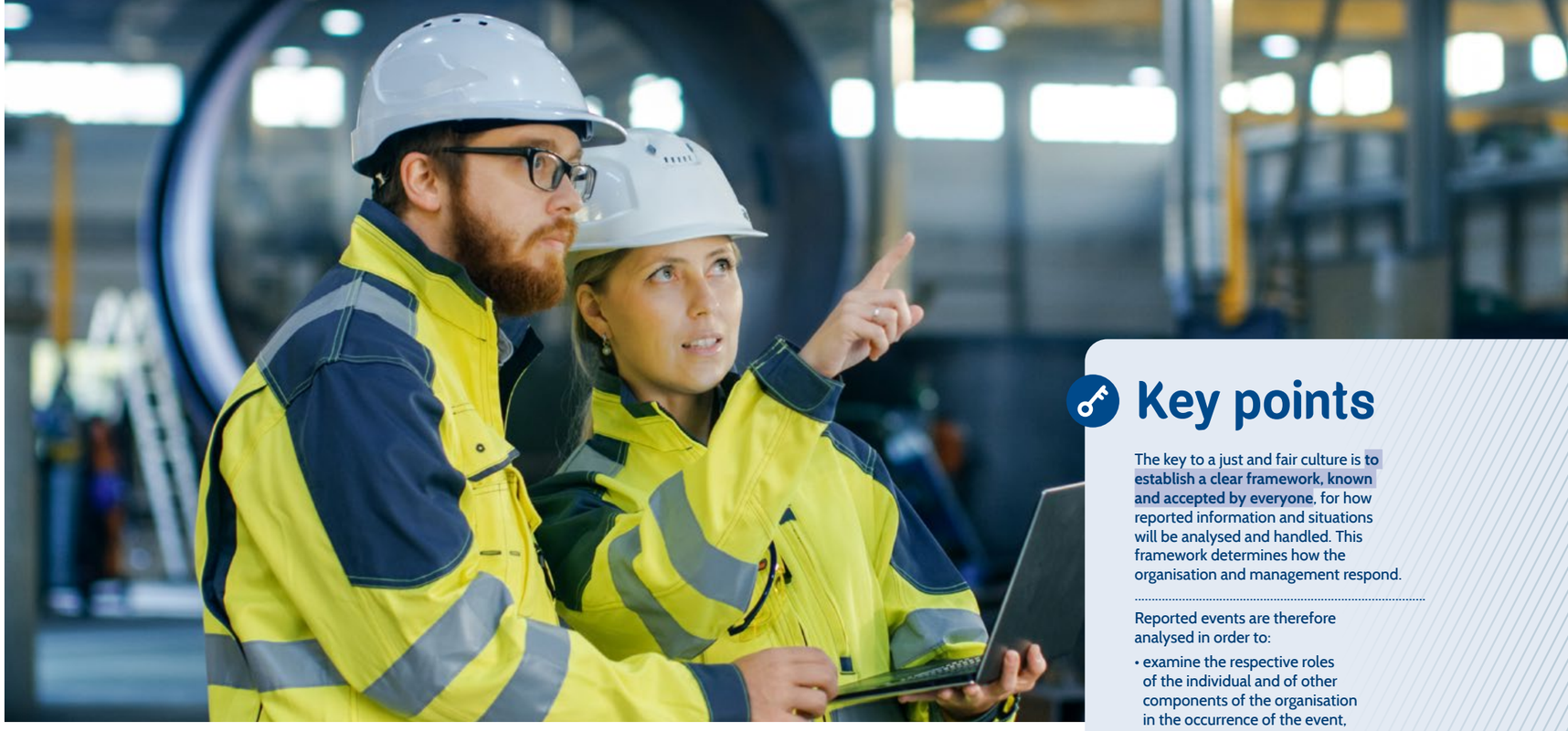
Organisations must establish fundamental safety rules relating **to the most critical risks**. They must **put in place the necessary conditions, means and resources to enable employees to comply with them.** At the sharp end, these rules serve as reference points for identifying 'no-go' and stop-work situations where safety conditions are not met.

A deviation from a fundamental rule must be regarded as a **high-potential safety event** and systematically give rise to an **in-depth analysis to identify its causes.** Where all reasonable efforts have been made to enable compliance, **violating one of these fundamental rules constitutes the crossing of a red line.** This applies to all behaviours, decisions and trade-offs that put the health and lives of others at risk.

Crossing a red line may **expose employees to disciplinary action.** Such action is only legitimate if it is identical for all involved in the event.

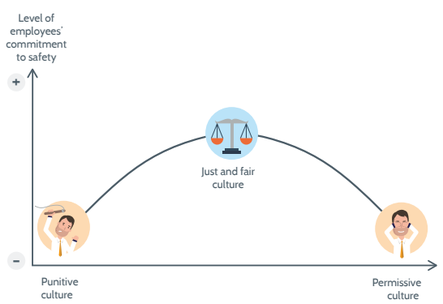
Responding appropriately and consistently to undesirable events

In a just and fair culture, the responses of the organisation and management following reports are predictable, because they are based on explicit, shared rules that frame the analysis and handling of undesirable events.



Permissive culture vs punitive culture

A permissive culture is a culture of 'tacit tolerance' in which even the most dangerous behaviours are allowed to continue. Patterns of normalisation of deviation begin to emerge in such environments, posing serious risks to safety. However, the opposite extreme should also be avoided: a punitive culture, characterised by systematic disciplinary action, is equally detrimental to safety. Such a culture undermines trust in reporting mechanisms and reinforces organisational silence. Employees limit what they report and focus on protecting themselves.



▲ Permissive culture vs punitive culture, adapted from David Marx

To build trust and encourage speak-up behaviour, **employees' concerns about how the organisation and management will respond when an at-risk situation, an undesirable event or a deviation from rules or standard operating procedures is reported must be addressed...** 'What will happen to me if I speak up?' Uncertainty is one of the most frequent causes of organisational silence. These concerns are exacerbated when managerial responses are perceived as arbitrary, dependent on mood, or on individual management style.

To this end, explicit, clear and shared rules must be established, enabling the organisation and management to respond in a manner that is:

- **just:** appropriate to the situation and context, measured and proportionate;
- **consistent:** the same irrespective of who is responsible for responding (often the manager);
- **fair:** all involved receive identical treatment, irrespective of their status, position, level in the chain of command, etc.

ANALYSIS: A CRITICAL STEP

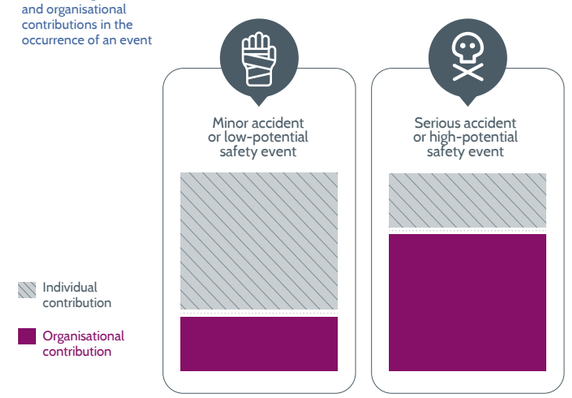
Reporting an undesirable event (including deviations from rules) is invaluable in helping to improve safety, provided the objective is not to assign blame, but to understand and address weaknesses in the system.

The first step is therefore **to examine the respective contributions of the individual and of other components of the organisation to the occurrence of the event.**

In the case of a minor accident, the individual's contribution may be significant (e.g. Matilda sprains an ankle while walking, because she was focused on her phone). However, the greater the actual or potential severity of an event, **the more the organisational contribution outweighs the individual contribution in its occurrence**. Indeed, the organisation should have put in place **defence-in-depth barriers** (prevention, recovery and mitigation). If these barriers are weakened, it is essential to understand why and how this occurred.

The main objective of the analysis is to prevent a similar event from recurring, by identifying and addressing its **root causes,** independently of the individual(s) involved. An **in-depth analysis** must then be carried out to determine the technical causes (condition of equipment and tools, design choices, clarity of available information, etc.), organisational causes (work organisation, training, human resources management, interactions between actors, etc.), and managerial causes (conflicting instructions, poorly defined objectives, inadequate communication, limited presence in the field, etc.).

▼ Relative weight of individual and organisational contributions in the occurrence of an event



Key points

The key to a just and fair culture is **to establish a clear framework, known and accepted by everyone**, for how reported information and situations will be analysed and handled. This framework determines how the organisation and management respond.

Reported events are therefore analysed in order to:

- examine the respective roles of the individual and of other components of the organisation in the occurrence of the event,
- identify the technical, managerial and organisational root causes, and strengthen defence-in-depth measures.

The managerial response is based on a systematic line of questioning, using tools such as the SPV method (savoir–pouvoir–vouloir) to determine knowledge, means and intent. The objective is to clarify the situation and its context and to determine **the most appropriate response** (support, training, guidance, disciplinary action, etc). This requires a managerial culture that is neither punitive nor permissive.

Good practices

Analysis vs managerial response: different roles
Analysis is carried out by safety specialists, whereas the response is the responsibility of managers. The right balance must be struck between these two spheres, and that is rather complex. Two extremes must be avoided:

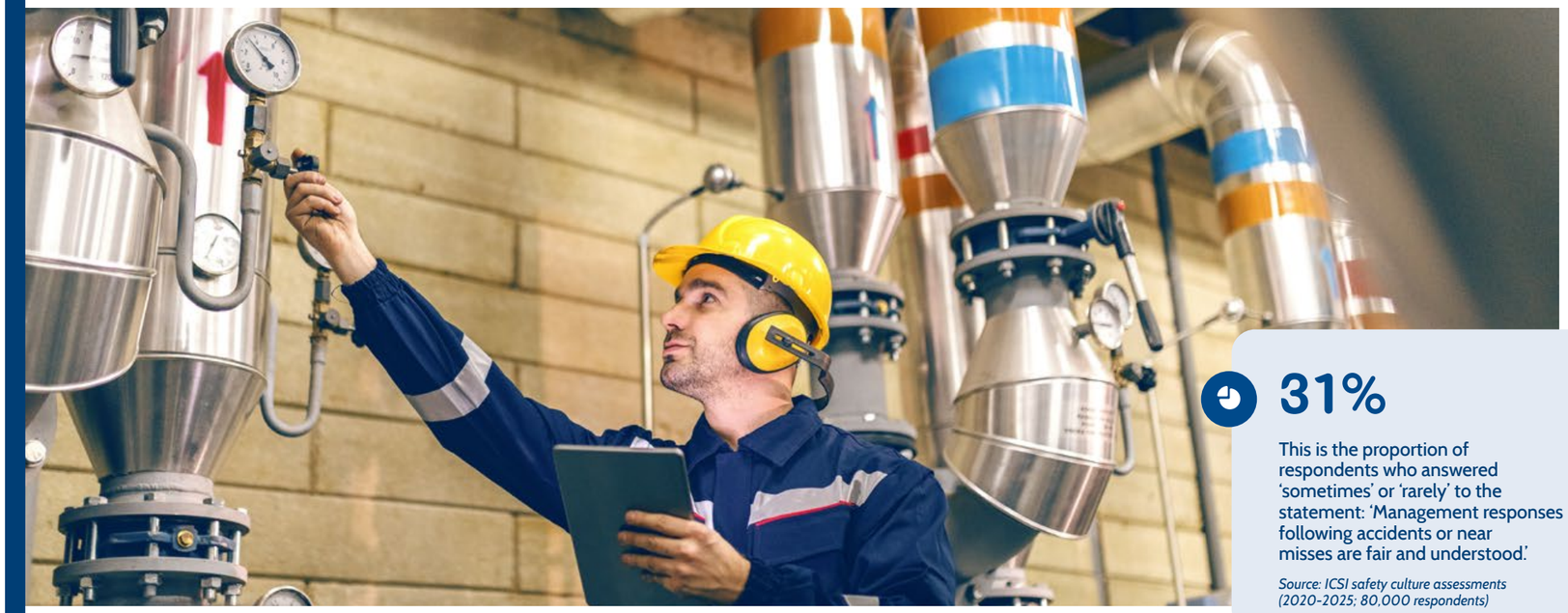
- a situation where management is systematically prevented from taking action, for fear of discouraging reporting or weakening employee engagement,
- a situation where the managerial response (particularly the desire to take disciplinary action) takes precedence over a prior in-depth analysis.

The SPV method (*savoir-pouvoir-vouloir*)

This is a tool designed to help ensure just and fair responses. It is based on three lines of questioning:

- KNOWLEDGE (*SAVOIR*): did the employee have the necessary knowledge? Were they sufficiently qualified and trained? Was this the first time they were performing this task? Were the risks known? Was the rule clear?
- MEANS (*POUVOIR*): did the employee have access to the means, resources and conditions required to comply with the rule? Did the situation involve ambiguities, productivity pressures or time constraints? Was the rule applicable in practice? Would other employees have behaved the same way in that situation?
- INTENT (*VOULOIR*): is this rule violation common among employees? Have there been previous cases where violations of the rule were tolerated or even encouraged by management? Was the employee dealing with conflicting instructions? Had the employee already been involved in similar cases? Did the employee violate the rule for personal gain?

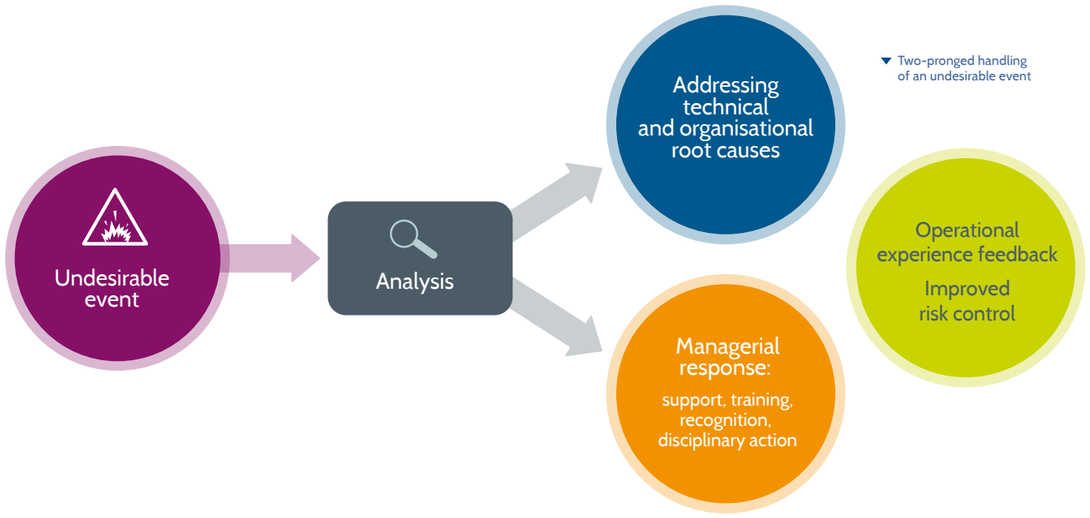
It is also useful to examine the influence of work groups and management on the individual and the situation: did the group encourage the employee's behaviour? Does the group regularly bypass this rule? Does the manager usually ensure that employees have the appropriate conditions to carry out the task? Does the manager routinely check with their teams that all rules can be properly applied when carrying out the work? Does the manager implicitly tolerate bypassing certain rules when there is an opportunity to improve organisational performance?



31%

This is the proportion of respondents who answered 'sometimes' or 'rarely' to the statement: 'Management responses following accidents or near misses are fair and understood.'

Source: ICSI safety culture assessments (2020-2025; 80,000 respondents)



▼ Two-pronged handling of an undesirable event

MANAGERIAL RESPONSE

The analysis may also highlight inappropriate individual or collective behaviours. In such cases, a managerial response is required, based on a **systematic line of questioning to understand the situation and its context** – for example, the French SPV method (Savoir–Pouvoir–Vouloir), used to determine knowledge, means and intent.

This questioning helps to **clarify the situation**: did the employee make a mistake? Or was it a rule violation? For what reasons? In what context?

Certain **mitigating factors** should be taken into account, such as: an isolated deviation, a spontaneous and honest report of the event, a positive attitude after the event, or a strong commitment to safety. Conversely, **aggravating factors** may exist, such as: repeated deviations, concealment, a negative attitude, a weak commitment to safety, or the crossing of a red line.

The answers to these questions determine:

- the respective involvement of the employee and of the organisation (including the influence of other actors),
- whether personalised support is required (additional training, discussion of the event with the team or with other relevant departments, etc.),
- the legitimacy of any disciplinary action, based on a clearly defined scale that is known and shared by all (verbal warning, formal warning, reprimand, withdrawal of authorisation, termination in exceptional cases).

A just and fair managerial response to undesirable events depends to a large extent on the **managerial culture,** which should be neither punitive (with disproportionate recourse to disciplinary measures) nor permissive (tolerating the most dangerous behaviours). Finding the right balance with regard to rules and discipline is a delicate exercise for any organisation. Managers must therefore be trained and equipped to respond appropriately, and supported over time in doing so.

Good practices

Establishing a just and fair culture observatory
Some organisations have set up independent appeal bodies for employees who feel they have been unfairly treated or subject to unjust disciplinary action. These joint committees are tasked with ensuring that the just and fair culture framework has been properly applied. They typically include members of senior management, employee representatives, and subject-matter experts.

Assessing the quality of the managerial response by asking three questions:

- Did the response help prevent the recurrence of a similar event?
- Did it maintain or strengthen trust between the actors involved (particularly between manager and employee)?
- Did it enable all those involved to better understand what happened and to learn from it?

Driving the change

5 levers for success

A just and fair culture may seem simple on paper, but it is complex to implement. It is a cultural transformation that takes time and requires humility, with progress made step by step. Below are five key levers for success.

ENSURING BALANCE ACROSS THE 4 PRIORITY AREAS FOR TRANSFORMATION

In some organisations, attention is paid to a just and fair culture simply because it is seen as the fashionable thing to do: yet another top-down initiative, reduced to a slogan. Meaning must be restored: a just and fair culture approach is not a 'bubble' disconnected from other safety challenges. It is an in-depth, systemic, organisation-wide process to improve risk control. It is structured around four focus areas for transformation: understanding different behaviours and acknowledging the right to make mistakes, reinforcing and recognising positive contributions, establishing fundamental rules and clearly defining red lines, and responding appropriately and consistently to undesirable events.

Maintaining balance across these four focus areas is essential. Focusing too heavily on one at the expense of the others can undermine the entire approach. Common pitfalls include:

- a culture that is too permissive or, on the contrary, overly punitive,
- an excessive focus on managerial responses while neglecting the need for a deeper understanding of organisational dysfunctions and failing to address organisational silence,
- an approach focused solely on handling undesirable events, while forgetting to recognise positive contributions to safety.

CO-CONSTRUCTING A COMMON FRAME OF REFERENCE

Co-construction must underpin the entire project. Operations, safety, human resources, employee representatives and communications teams need to engage in dialogue, align their perspectives and agree on a common frame of reference. A representative group of stakeholders must be formed, at both the central and local levels. At a later stage, certain external stakeholders must also be involved, including supervisory authorities and, of course, contractor companies. This is critical.

SUPPORTING AND ASSISTING MANAGERS

Changing managerial practices is a central part of achieving a just and fair culture. Managers must feel supported and have access to experts who can help them implement the approach and deal with complex cases. In large organisations, a network of specialists in human and organisational factors (HOF) can provide support. In smaller organisations, managers should be able to turn to HSE or prevention teams that have received appropriate training. They can assist with fact-finding and guide managers in analysing and understanding situations, while ensuring that the methodology used is robust and consistent.

ACCEPTING HETEROGENEITY

Within the same organisation, there may be 'several cultures' rather than just the one. Ways of doing and ways of thinking can differ depending on the work group, its history, context, occupation, and so on. As a result, the causes of organisational silence may vary from one group to another. It is therefore important to accept that the common frame of reference will need to be adapted locally, with sufficient leeway and flexibility for local teams. The right balance must be found, and it will be specific to each organisation.

COMBINING LONG AND SHORT CHANGE LOOPS

The change process involves a long loop. This is a marathon: it takes place over several years. Alongside this, it is advisable to integrate phases of testing and experimentation on a limited scale throughout the change process: these are short loops. These help to ensure that the principles, methods and tools that make up the common frame of reference are aligned with operational realities and their varying contexts. They allow for adjustments to be made before a broader rollout.
One final important point: it would be a mistake to think that most of the work is done once a managerial guide and a decision-support tool have been developed. A just and fair culture cannot be reduced to the deployment of tools alone. This is not sufficient to change practices and may even have adverse effects, for example by undermining the overall purpose of the approach.

Steps to get started

Some symptoms of organisational silence:
- few or poor-quality reports
- declining safety proactiveness
- rules bypassed, deviations normalised
- recurring accidents, causes left unaddressed

1. BUILD CONSENSUS AROUND THE NEED FOR CHANGE
Build consensus around the need and the determination to shift the organisational culture towards a just and fair culture that fosters trust and speak-up behaviour, by involving senior management and employee representatives. The process may be initiated at the level of a group, site, department, subsidiary, etc. Commitment from the management of the relevant entity is essential.

2. ASSESS THE CURRENT SITUATION
Identify the most critical causes of organisational silence, particularly by examining organisational barriers, managerial attitudes and practices, and the way work groups function. Share this assessment with the key actors involved in the process.

Some questions to ask:
What is the level of transparency surrounding hazardous situations? What is the approach to error? To disciplinary action? To positive contributions?

3. BUILD A CHANGE STRATEGY
Develop a change strategy tailored to the organisation's context (vision, key milestones, indicators, etc.). Choose the priority areas for transformation and establish an action plan.

4. CO-CONSTRUCT THE POLICY AND TOOLS
Clearly establish the objectives and principles of a just and fair culture. Develop a practical guide for managers, to support them in operational deployment. This guide should set out the managerial attitudes and practices expected, as well as the methods and tools to be used for handling undesirable events and recognising positive contributions to safety.

Remember:
Ensure consistency between existing key processes (handling of reports, in-depth analysis, etc.).

5. ORGANISE SKILLS DEVELOPMENT
Train key actors (prevention teams, managers, HR, communications, employee representatives, etc.). Training for managers must include case studies to allow them to practise the expected managerial responses to undesirable events and positive contributions. Post-training follow-up and coaching are recommended.

Remember:
- Raise awareness among sharp-end workers and keep them informed.
- Mobilise a network of HOF specialists to support and assist managers.

6. DEPLOY PROGRESSIVELY
The conditions are now in place for a general deployment, for example through the signing of a commitment charter by senior management and its dissemination across the organisation.

Ongoing monitoring
- Conduct regular reviews to measure the impact of the changes on organisational silence (for example: using indicators relating to the number and quality of reports of high-potential safety events),
- Check for any drift in the implementation of just and fair culture principles,
- Ensure progress towards the harmonisation of practices,
- Set up a body that can be consulted in the event of complex situations.

Find out more

Visit www.icsi-eu.org to explore our page dedicated to just and fair culture.

A few minutes of animated videos on our key topics
Visit our YouTube channel

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The essentials

for a just and fair culture

ICSI
Institute for an Industrial Safety Culture

Objectives

Combating organisational silence

No news = bad news. Organisational silence is profoundly harmful to safety: **it renders the organisation 'blind and deaf' to what is really happening**. It is like navigating in fog.

Combating organisational silence **is everyone's responsibility, from sharp-end workers to top management.** The chain of command must fully play its part and be convinced of its essential role.

The more bad news you receive, the better: it is a sign of a culture that confronts reality. Receiving more reports of incidents, problems and anomalies is not something to be feared. What matters is that they are handled. **Over time the numbers will fall, and this will represent real and sustainable progress.**

Reporting information and learning from it

Encouraging speak-up behaviour provides **a more detailed picture of what is happening** at the sharp end than accident and incident indicators can provide (KNOW). The information is then analysed and handled, **feeding a continuous improvement loop** (LEARN). Learning has only truly taken place when a positive change has been implemented.

Analysis of reported information must explain 'how' and 'why' things happened, rather than assigning responsibility. A culture of transparency requires acceptance of the need **to trace problems back to their root causes**, which are often managerial and organisational.

High-potential incidents and situations must be identified and analysed, in order to focus organisational efforts on preventing serious injuries, fatalities and major technological accidents.

Building a just and fair culture

Understanding different behaviours and acknowledging the right to make mistakes

It is essential to **distinguish between positive contributions, mistakes and rule violations.** This is a matter of semantics that requires alignment and a shared understanding of terms and situations. The central question is: how will the organisation respond in the different situations encountered?

A just and fair culture requires acknowledging the **right to make mistakes,** which are by definition unintentional. Punishing individuals for mistakes makes no sense: it neither reduces mistakes nor prevents their recurrence. Worse still, it will demotivate teams and limit people's positive contributions to safety.

A rule violation is not necessarily blameworthy. It must be analysed to understand its causes and the intent. Some violations do, however, cross the organisation's red lines and may legitimately expose individuals to disciplinary action.

Recognising and reinforcing positive contributions

Recognition is the 'poor relation' of prevention policies, and yet it is an extremely powerful driver of safety. **It fosters engagement, motivation** and proactiveness, and it improves the quality of relationships between managers and their teams.

Everyone needs recognition, from sharp-end workers to top management. Recognition should be directed not only at individuals but also at work groups!

Recognition **is not the sole responsibility of managers;** it should also come from the **organisation** or its representatives, from **peers**, and from **external** stakeholders (clients, suppliers, etc.).

Establishing fundamental rules and enforcing red lines

Organisations must establish fundamental safety rules relating **to the most critical risks.** They must **put in place the necessary conditions, means and resources to enable employees to comply with them**. At the sharp end, these rules serve as reference points for identifying 'no-go' and stop-work situations where safety conditions are not met.

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Just and fair CULTURE

ORGANISATIONAL *silence*

Undesirable event

- I'm going to be exposed to disciplinary action
- We've always done it this way
- I'm going to put my coworkers in difficulty
- Speaking up won't change anything

No **event reporting**

CONSEQUENCES

- At-risk situations accumulate without management being aware of them
- No corrective actions
- Repetition of similar events
- Deterioration of risk control

How to combat organisational silence?

Building a just & fair CULTURE

4 areas for improvement

1 Understanding different behaviours and acknowledging the right to make mistakes

- Shared vocabulary: positive contributions, mistakes, and rule violations
- Acknowledging the right to make mistakes

2 Recognising and reinforcing positive contributions

- Positive and proactive contributions
- Spontaneous event reporting
- Cautious behaviour
- Helping one another and working as a team

3 Establishing fundamental rules and enforcing red lines

- Shared awareness of the most significant risks
- Life-saving rules applicable and applied
- A deviation from a fundamental rule = a high-potential safety event
- Systematic analysis
- Legitimate disciplinary action in the event of crossing a red line

4 Responding appropriately and consistently to undesirable events

- Event analysis
- Examine the respective contributions of the individual and the organization
- Addressing root causes
- Managerial response based on a systematic line of questioning
- Fair and consistent treatment

The benefits of A JUST AND FAIR CULTURE

A just and fair culture encourages the reporting of information important for safety, by creating a climate of trust and transparency that is necessary to foster open dialogue and speak-up behaviour.