

# **Moving toward a Just Culture in the U.S. Railroad Industry through Development of a Confidential Reporting System**

Jordan Multer

18<sup>th</sup> International Railway Safety Conference, Denver, Colorado  
October 5-8, 2008

## **Abstract**

As railroad operations grow more complex, teasing out the factors that contribute to accidents and developing successful countermeasures becomes more difficult. Within the U.S. Federal Railroad Administration (FRA), the Office of Research and Development is seeking innovative methods to tackle this challenge. One of these methods is the use of close call reports to learn about hazardous conditions and activity before they result in harm. A close call is “an opportunity to improve safety practices in a situation or incident that has a potential for more serious consequences.” The FRA is supporting the development, implementation, and evaluation of a Confidential Close Call Reporting System (C<sup>3</sup>RS) to learn how to successfully operate this kind of safety intervention in the railroad industry. This demonstration project represents a movement toward a just culture in which employees can disclose information about safety without blame and the organization can learn from these events. A key element in developing a successful reporting system is building trust among the partners so that they feel comfortable sharing safety related information. The paper describes some of the challenges to overcome in building trust and how they were addressed.

## **Introduction**

To complement its traditional approach to safety enforcement and compliance, the Federal Railroad Administration (FRA) has embarked on several safety initiatives that strives for excellence within the railroad industry by going beyond minimum safety standards. This initiative represents a new approach to safety that will enable both the FRA and the railroad industry to better manage safety through proactive non-regulatory methods. When failures occur, individuals and organizations are held to account in a different way from the past.

In the past, holding people accountable often meant punishing the employee closest to the event. In a just culture, accountability means identifying the factors that contribute to the problem and using these failures as learning opportunities to correct them. A just culture seeks openness and transparency, but does not tolerate all behavior. The stakeholders strive for consensus based upon what is within the boundaries of acceptable behavior and what is outside after open discussion of all perspectives. As Sidney Dekker suggests, creating a just culture requires building relationships between people<sup>1</sup>.

One of the initiatives is the creation of close call reporting system to learn about hazardous conditions and activity before they result in harm. Analyzing close calls represents a proactive way to manage safety. A close call is “an opportunity to improve safety practices in a situation or incident that has a potential for more serious consequences.” When individual events are analyzed collectively, railroads can identify safety hazards and develop solutions to these threats. The Federal Railroad Administration’s Office of Research and Development is supporting the

development, implementation, and evaluation of a confidential close call reporting system to learn how to successfully operate this kind of safety intervention in the railroad industry.

The development of successful close call reporting systems shares several features that are representative of a just culture. These features involve building trust to encourage disclosure of close call information and sharing information in an open and transparent way. In the current environment, building trust involved using a third party to collect and store the information, confidential reporting, and limited protection for employees and employers from liability or enforcement.

This paper describes how the Confidential Close Call Reporting System (C<sup>3</sup>RS) was built and implemented using just culture principles.

### **Development and Implementation of The Reporting System**

At the request of the FRA, the Volpe Center initiated this effort by forming a steering committee to represent the key industry stakeholders from the labor unions, carrier management and the regulator (FRA), as well as railroad industry associations and government agencies. Table 1 lists the stakeholders involved.

Table 1. List of C3RS stakeholders

Federal Agencies	Labor Unions	Carriers and Industry Associations
Bureau of Transportation Statistics	Brotherhood of Locomotive Engineers and Trainmen	Association of American Railroads
Federal Railroad Administration	Brotherhood of Railway Signalmen	American Short Line and Regional Railroad Association
National Transportation Safety Board	United Transportation Union	Burlington Northern Santa Fe Railroad
Volpe National Transportation Systems Center		Canadian Pacific Railway
		New Jersey Transit
		Union Pacific Railroad

At the foundation of the process was the idea that participation in a confidential reporting system must be a voluntary process to which all the representative stakeholders agree. The steering committee developed the core principles by which the system would operate and defined each stakeholder's responsibilities. This process took two years of collaboration using a consensus-based approach to reach agreement. These principles were documented in a model memorandum of understanding (MOU) which included general rules for eligibility and a framework for how the system would operate. The model MOU can be viewed at:

[http://www.closecallsrail.org/publications\\_mou.asp](http://www.closecallsrail.org/publications_mou.asp)

The core principles include the following:

- Participation by all parties is voluntary;
- The stakeholders agree to use a consensus based approach to decision making;
- The system is confidential to protect employees from blame, shame and discipline;
- It offers protection from discipline for events that meet the criteria for report acceptance.

The goal of these principles was to provide an environment where employees felt comfortable reporting about themselves and others so that the industry can learn from close call events. The steering committee defined accountability through the general conditions under which a report would be accepted. While the process to reach consensus was time-consuming, the time taken to discuss each of the stakeholder needs and concerns enabled all of the groups to better understand each other and build a workable structure that would accommodate everyone's needs.

Figure 1 shows the organizational structure for C<sup>3</sup>RS. A neutral third party collects and protects the close call reports submitted by the employee. The Bureau of Transportation Statistics (BTS) agreed to accept the close call reports, and provide the statutory and legal authority to keep the reports confidential. BTS interviews the employees who submit close calls and sends the information they collect with direct and indirect identifiers removed to the demonstration sites for analysis by a Peer Review Team (PRT). BTS also analyzes trends in the data within and across sites, and communicates with the demonstrations sites to share lessons learned.

Using the model MOU, railroads volunteering to participate in this demonstration project tailor the document to adapt it to local concerns. This document is referred to as an implementing MOU (IMOU). As before this process takes several months. During this process, stakeholders from each of the three key groups; labor, management, and the regulator, meet to discuss how to adapt the model MOU to address local concerns and needs. The discussions enable the stakeholders to understand how the process will work and to build ownership in the system. In specifying in greater detail what reports will be accepted, the geographical boundary conditions for where reports can be submitted from, the stakeholders build a more complete picture of how the system will operate. They also become champions for the project and communicate how it works to the broader community at the demonstration site.

Following the completion of the IMOU, the PRT, consisting of local stakeholders from each of the three stakeholder groups, is formed. They analyze the close call events with their knowledge of the local conditions to uncover why they occurred and to recommend corrective actions. The PRT is trained in multiple cause incident analysis methods, works on team-building exercises, and develops communication plans to publicize the system for several months prior to the launch of the system at each demonstration site. The PRT evaluates the effectiveness of the corrective actions, and shares responsibility for communicating about the system with employees within the individual demonstration site.

Following the launch of the C<sup>3</sup>RS system at each site, eligible employees can submit reports. Figure 2 shows the process for submitting a report and what happens to it when it enters the system. When an employee sees an event involving him/herself or someone else, the reporter calls a toll-free telephone number to let BTS know that he/she would like submit a report (Step 1). The employee must follow-up by mailing a written report to BTS. BTS takes this report and makes a preliminary decision as to whether it qualifies as an event which falls within the scope of the reporting system and is eligible for protection from discipline (Step 2). For rare events that

do not qualify, BTS notifies the employee that report is ineligible and indicates why the report is ineligible.

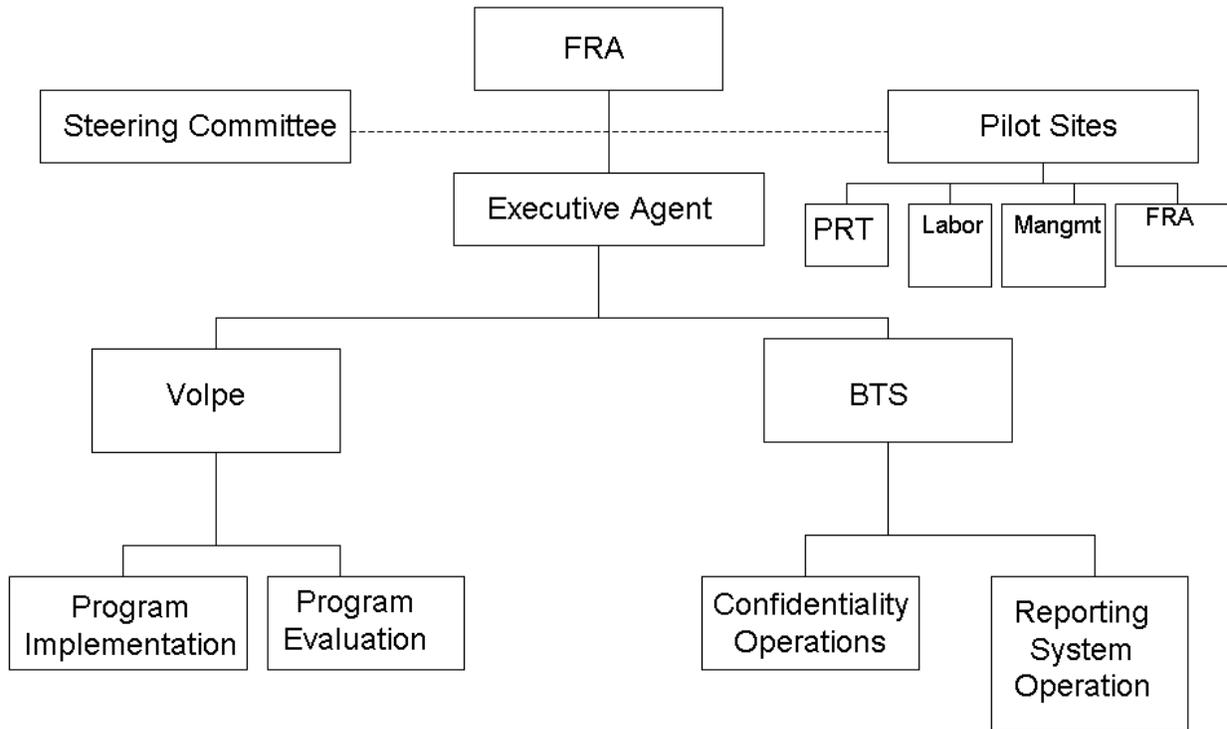


Figure 1. C<sup>3</sup>RS Organizational Structure

### How a Report Moves Through C<sup>3</sup>RS

For all other reports, BTS enters the report into a tracking system (Step 3) and contacts the employee to setup an interview. BTS conducts an interview with the employee to collect more information so it can provide the PRT with the most complete picture of how the event occurred or the unsafe condition that exists (Step 4). BTS creates a de-identified “incident summary report” (Step 5) that describes the event without details that would enable someone to identify the reporting employee. When more than one employee reports on the same event, BTS submits a single incident summary report to the PRT that captures the information from all the reporters (Step 6).

The PRT makes a final determination that the report falls within the scope of acceptable C<sup>3</sup>RS reports. For accepted reports, it analyzes each of the incident summary reports to identify the factors that contributed to the event for the purpose of recommending corrective actions (Step 7). The PRT documents its work and shares this information with BTS, so BTS can share with employees the results of the PRT’s recommendations, if the employees asks BTS what occurred as a result of their reports. The PRT also provides corrective action recommendations to the carrier. The carrier decides which corrective actions to implement and their time frame (Step 8).

Currently, there are two railroads participating in C<sup>3</sup>RS. When three or more railroads participate, BTS will share aggregated data across the sites so that all the sites are aware of the risk trends and emerging risks.

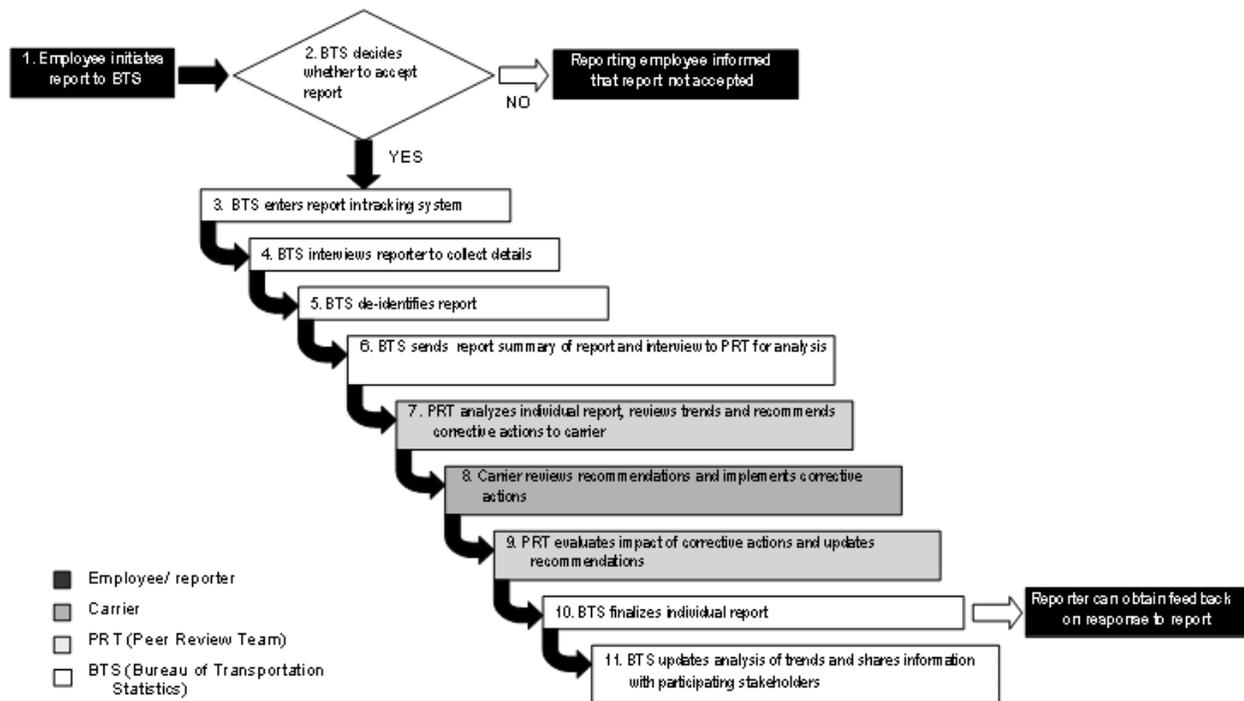


Figure 2. C<sup>3</sup>RS Reporting Process

### Challenges to Creating a Just Culture

In creating the conditions for successful implementation of C<sup>3</sup>RS, the implementation team and local stakeholders faced a significant set of challenges. Moving toward implementation required understanding the obstacles we would face so we could develop strategies to address them.

Perhaps the most important obstacle we faced in implementing C<sup>3</sup>RS, was overcoming the blame-based culture that exists through out the railroad industry. When failures occur that lead to unwanted consequences, the investigation process frequently starts and stops with the front-line employees. These employees are the closest in time and space to the event. Corrective actions often focus on remedial training for the employee who “failed to follow proper procedures”, and adding or modifying operating rules that prescribe employees behavior under the circumstances in question. Failure to follow the appropriate operating rules could result in the employee being subject to discipline.

In this environment, when failures occur, the employee has little if any incentive to talk about what happened and the context in which it took place. For C<sup>3</sup>RS, the outcome of a blame-based culture is an employee’s reluctance to share information that might lead to discipline of themselves or a peer. Within the railroad industry, the Federal Employer’s Liability Act (FELA) exacerbates this reluctance to share information and fosters an adversarial relationship between employees and the carrier. FELA is a fault based system that awards damages to an injured railroad employee when a court determines that the railroad is partly or wholly at fault. For the

employer, FELA increases the motivation to find the employee at fault while also reducing the desire to uncover factors for which management bears responsibility. The desire to assign and deflect blame keeps the organization from learning from mistakes and taking corrective actions that address the multiple factors involved when failures occur.

Another challenge to implementing C<sup>3</sup>RS comes from the uncertainty around change within organizations. Uncertainty in response to change can manifest itself in different ways. Here are three examples from each of the three key stakeholder groups: labor, management and the FRA.

As we have discussions about implementing C<sup>3</sup>RS, employees ask how this safety initiative is different from previous safety initiatives that have come and gone. They ask “how is this initiative different from other “flavor of the month” safety initiatives? The question is prefaced by the comment that they have been inundated with safety initiatives at the railroad. These safety initiatives last for a short time and then they come to an end. The issue underlying this question is why should we trust that this initiative will last any longer than previous failed initiatives? Where will the commitment come from to sustain this initiative? In light of the many safety initiatives in the past, it is a question that we need to answer.

For management, uncertainty in response to change manifests itself in the change in locus of control. The opportunity for the PRT to recommend changes is coming from the bottom of the organization and includes labor and FRA in this group as well as management. The opportunity to identify sources of failure and recommend corrective actions that can have system-wide implications can create anxiety in other parts of the organization. While it empowers employees, managers may perceive a loss of control. Identifying sources of failure and making them visible to the organization creates pressure to respond to these failures when other stakeholders are involved. How will the organization respond to these pressures? Given limited resources, how will it respond to recommendations for corrective actions?

For the FRA, resistance to change arises from the tension between its traditional role in enforcing safety regulations through compliance procedures and civil penalties and this alternative role in which it partners with industry. How does it balance the need to apply civil penalties with the desire to partner with the industry it regulates? Many of its employees are comfortable with the traditional approach to working with industry. How will its employees handle this new role? Can they perform both roles at the same time or do they need to be separated?

### **Creating the Conditions for Change**

To overcome these obstacles and build the trust needed establish a confidential reporting system, the Volpe Center implementation team worked closely with the stakeholders at the national and local levels. The stakeholders took ownership of the process by jointly identifying the principles by which the system would operate. While maintaining these core principles, described earlier, the stakeholders at the local level were given freedom to adapt the system to meet local needs with the limits needed for a neutral third party to operate from a central location. This process took place through the development of the IMOU.

Following the completion and acceptance of the IMOU by the demonstration site stakeholders, we worked with the demonstration site to prepare for the use of the system by site employees. PRT members learned how to work together as a team to identify the factors that contribute to close call events. They established ground rules for working together to model a learning culture and shared leadership roles between stakeholders. The demonstration site identified resources to

support their activities. A dispute resolution committee at the regional and national level was established to address conflicts between the stakeholders that they could not resolve themselves. These conflicts revolved around the determining whether to accept reports that resided at the boundary conditions of report acceptance, where the IMOU did not address it or was ambiguous. We worked with each demonstration site to identify champions to educate employees and managers about the purpose of the reporting system and its benefits. In addition to “formal” champions such as the PRT members, informal champions were identified to help in educating their peers and answering questions about how the process would work. A management support team was established to assist with supporting the case for system-wide corrective actions and educate others within the organization on its benefits.

### **Early Progress**

On February 1, 2007, BTS began accepting reports from the first demonstration site. Currently, two freight railroads participate in C<sup>3</sup>RS. As of June 2008, the system has received over 800 reports. Almost all of the reports are first person reports. The high percentage of first person reports contrasts with other confidential reporting systems which traditionally receive more third party reports in the beginning as users learn to trust the system. This behavior suggests that C<sup>3</sup>RS users trust the system enough to report about themselves. In many cases, more than one crew member has reported on the same event, giving a more complete picture of how and why the event occurred.

The C<sup>3</sup>RS demonstration project continues as a work in progress. As a prototype, the implementation team and the stakeholders continuously search for ways to improve the effective operation of the system. A lessons learned team is collecting information on current operations and providing feedback to improve operations. This improvement process will continue as the system grows and changes.

### **Acknowledgements**

This project was conducted with funding from the FRA’s Office of Research and Development and Office of Safety. The author wishes to thank Dr. Thomas Raslear for his support, direction and guidance on this program.

For more information on C3RS contact:

Jordan Multer

Volpe National Transportation System Center  
55 Broadway; RTV-4G  
Cambridge, MA. 02142

Tel: 617.494.2573

Email: [jordan.multer@dot.gov](mailto:jordan.multer@dot.gov)

---

1 Dekker, S. (2008). Just Culture: Balancing Safety and Accountability. Burlington, VT: Ashgate