



# SMS

— SAFETY —  
MANAGEMENT  
SUMMIT BRAZIL

2024

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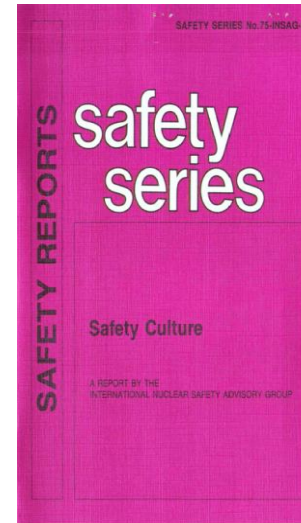
## Safety culture

*Éder Henriqson, PhD. - PUCRS*

# Outline

- Origins and axioms
- Two scientific approaches
- Safety Culture as a politics of organizational practices
- Safety Culture and the constitution of a way of seeing (which is also a way of not seeing)
- Safety Culture and the Disaster Incubation Theory

# Origins



INTERNATIONAL ATOMIC ENERGY AGENCY, VIENNA, 1991

“Safety culture is that **assembly of characteristics and attitudes** in organizations and individuals which establishes that, as an **overriding priority**, nuclear plant safety issues receive the attention warranted by their significance.”

“Safety Culture requires all duties important to safety to be carried out correctly, **with alertness, due thought, and full knowledge, sound judgment, and a proper sense of accountability.**”

## Origins: initial axioms

1. Safety is a guiding **principle**, a core **value**, and an **overriding priority**.
2. Safety requires **management commitment**, planning, and supervision.
3. Safety requires **workers' commitment, engagement, and adherence to policies and procedures**.
4. A culture of safety is an **essential trace of highly reliable organizations**.

# Scientific approaches

## Functionalist

Culture as...

- Something an organization has;
- Top-down;
- fabricated, manageable, measurable.

## Interpretivist

Culture as...

- Something an organization does;
- Bottom-up;
- Emergent, resistant to management and measurement.

## SC and organizational practices

- Culture and practices are collective phenomena.
- Practices unveil collective understandings, rules, and intentions.
- Practices unveil traces of integration, differentiation, and ambiguities of the organizational life.

# Lenses for interpretation of safety

## *Old Safety*

1. Workers are a problem to control and fix. They introduce failures.
2. We must tell workers what to do (and not do).
3. Safety is “the absence” of an accident.

## *New Safety*

1. Workers are problem-solvers. They create safety.
2. We must ask workers what they need to work safely better.
3. Safety is “the presence” of positives.



*The **Challenger** disaster was an accident, the result of a mistake. What is important to remember from this case is not that individuals in organizations make mistakes but that mistakes themselves are socially organized and systematically produced.*

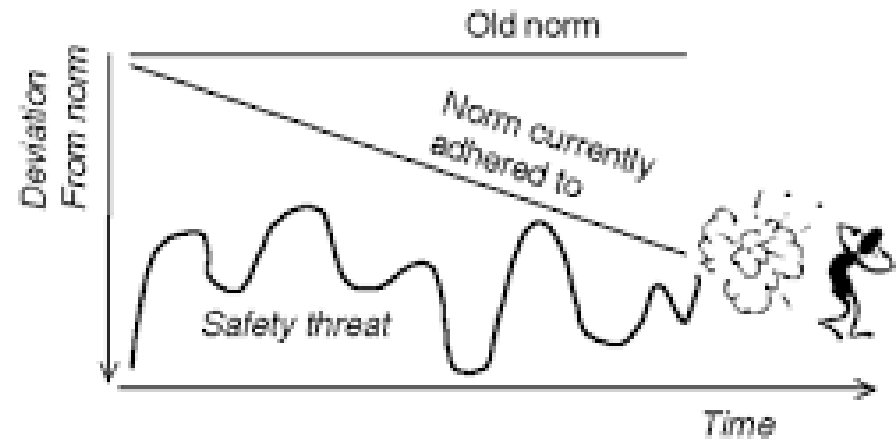
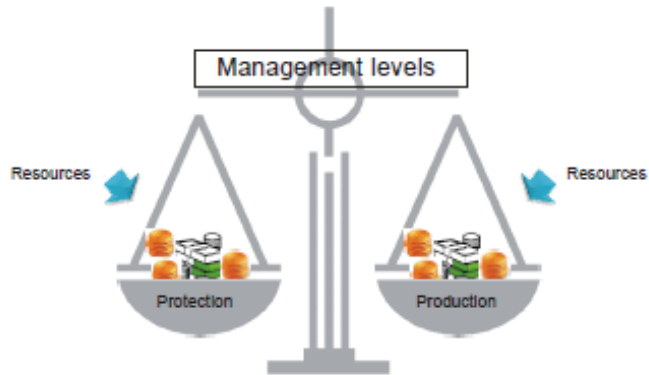
*(...) the tragedy had systemic origins that transcended individuals, organizations, time, and geography. Its sources were neither extraordinary nor necessarily peculiar to **NASA** (...). Instead, its origin was in routine and taken-for-granted aspects of organizational life **that created a way of seeing that was simultaneously a way of not seeing.***

*D. Vaughan, 1996, p.394.*

# Disaster incubation theory

- Initially culturally accepted beliefs about the world and hazards.
- Accumulation of an unnoticed set of events at odds with accepted beliefs about hazards and the norms to control them.
- Precipitating event. Shit hits the fan. Transforms general perception. Surprise. Cultural disruption.
- Full cultural re-adjustment. Beliefs and precautionary norms are adjusted to fit newly gained understanding of the world (“this must never happen again”).

# Silence, Drift, and Incubation...



Sidney Dekker



## Culture is not...

- About individuals
- Brainwash and new slogans
- Another “tag” to blame workers, managers, and organizations.

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