



Assessing the statistical properties and underlying model structure of fifteen safety constructs



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ABSTRACT

Background: Organisations spend a considerable amount of time and effort on diagnosing and analysing risks within their organisation. In the area of occupational and process safety, a myriad of employee survey instruments is available. Many studies show that operational processes play an important role in an organisations overall safety. Yet, so far safety surveys mainly focus on safety measures or operational safety processes. A flexible instrument was developed with which a wide variety of constructs, from different disciplines, can be measured in a consistent and practical way. The resulting survey distinguishes itself from existing safety surveys by extending the scope with the operational processes which are also referred to as the 'Core Business'.

Study: This study reports on the development of a catalogue of constructs which were derived from scientific literature and practice. Each of these constructs has been developed with a view towards measurability in an employee survey. The reliability and validity for fifteen of these constructs was assessed. Five separate projects have been conducted within a range of organisations operating as high risk industries. **Results:** Construct validity and the dimensional structure of the instrument have been established through exploratory factor analysis and confirmed through confirmatory factor analysis. Diverse aspects derived from motivational and ergonomic approaches to safety proved to be distinguishable in this analysis.

Conclusion: The described instrument allows the mapping and quantification of various aspects of the operational process that are, based on existing knowledge, related to the occurrence of incidents.

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1. Introduction

Over the past decades front-running organisations and industries have been successful in reducing the frequency of occupational accidents within their organisation. The combined oil and gas producing organisations for example have managed to reduce the frequency of personal harm year on year since 2004 (OGP, 2013). Although on a broader societal scale accidents and incidents still cause considerable personal harm (Takala et al., 2014) or, in the case of major high impact events, have consequences for business, people and environment (Baker et al., 2007; Onderzoeksraad voor Veiligheid, 2013; GPO, 2011; Powell, 2006a, 2006b, 2006c). The ability to map factors that may contribute to accident causation is therefore of great importance. Safety surveys are a common

tool for this purpose. Here we will first provide a short review of existing safety surveys where we focus on two dominant approaches related to 'motivational aspects of safety' (e.g. Zohar, 2010) and 'workplace conditions and systems' (e.g. Reason, 1990). First, we focus on safety climate research, thereafter we describe surveys related to workplace conditions. Subsequently, we will present a new approach which intends to span domains and enable a more flexible approach to safety surveys. The overall goal of this paper is to introduce a newly developed catalogue of constructs. The resulting survey distinguishes itself from existing safety surveys by extending the scope with the operational processes which are also referred to as the 'Core Business'. Since safety is an integral part of successful business operations (Zwetsloot et al., 2017), this instrument can be starting point for organisations to enhance their operational safety through integral system management. The first findings concerning the reliability and validity of these constructs are provided.

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1.1. Safety climate

Understanding the complex array of factors that may contribute to accident causation is no easy task. One way to gain proactive insight is the study of organisational (safety) culture and safety climate (Guldenmund, 2007; Parker et al., 2006; Zohar, 2010). The concepts of safety culture and safety climate are closely related (see Guldenmund, 2007 for a discussion), generally organisational safety culture is seen as a more generic, overarching concept whereas safety climate refers to attitudinal and more overt manifestations of culture within an organisation. For recent literature reviews concerning safety climate we refer to Griffin and Curcuruto (2016) and Schwatka et al. (2016). In this area the use of questionnaires has been the most popular approach as a 'quick and dirty' method to gain insight into momentary safety attitudes, more accurately referred to as the organisation's safety climate (Guldenmund, 2007). Measuring safety perceptions or safety culture is not only popular in academia but is also used extensively within the wider industry, over 60% of organisations measured safety perceptions or safety culture within their organisation in one survey of Dutch safety professionals (van Kampen et al., 2014).

Extensive research has been conducted on the measurement of safety climate through questionnaires (see for example: Christian et al., 2009; Clarke, 2006; Guldenmund, 2000, 2007; Kines et al., 2011; Zohar, 2010). As a result, a large number of different questionnaires has been designed to measure safety climate, with each questionnaire using (slightly) different operationalisations of the concept, although with a similar goal. In order to use safety climate scores as a valid indicator for safety within organisations it is important to know the extent to which these scores are predictive of safety outcomes. Only a subset of safety climate studies takes the step to correlate the concept with safety outcomes, these have been summarised in several literature reviews and meta-analyses. Clarke (2006) analysed 28 studies which contained measures of safety climate combined with a measure of actual incidents or injuries (occupational accidents). She found that the relationship between safety climate and accident involvement was small and moderated by research design. Nahrgang et al. (2007) also found a small yet significant correlation between safety climate and accidents or injuries based on their meta-analysis of 24 studies. Christian et al. (2009) most recently conducted a systematic review looking not only at relationships between safety climate constructs and outcomes but more broadly at safety knowledge, motivation, performance (compliance and participation), personality and safety climate. Again, they found a modest relationship between safety climate and safety outcomes and identified a broad variety of concepts which were included in safety climate studies and were correlated with some proxy-outcome measure of safety (e.g. safety compliance and participation).

On the basis of these and other studies Zohar concluded in 2010 that recent meta-analytic studies revealed that safety climate offers robust prediction of objective and subjective safety criteria across industries and countries. Zohar, however, also concludes that much work is needed in exploring the relationship between safety climate and its antecedents and mediators. This is also apparent from the meta-analysis from Christian et al. (2009). They show the primary focus of current safety climate literature through a meta-analytic path analysis (Fig. 1) which was by necessity limited to only the factors which were found most consistently in the literature.

As can be seen from Fig. 1 the safety climate literature is currently focused on Safety compliance – the extent to which employees report adherence to obligatory safety behaviours – and Safety participation – the extent to which employees self-report additional positive safety behaviours which are not 'obligatory'. These behaviours are the main hypothetical mediators used in some form

within most of the studies and they are grouped by Christian et al. (2009) as 'safety performance'. These factors are observed to relate negatively to (self-reported) accident and injury involvement and seen to be positively shaped by 'safety knowledge' and 'safety motivation' and in turn by 'safety climate'. The model shows the person-oriented (behavioural) focus of safety climate research in current practice with main pathways through individual motivation, individual knowledge and rule following behaviour.

1.2. Workplace conditions and systems orientation

Whilst intentional behaviour is evidently relevant for safety, other studies suggest that behaviours which can be influenced by knowledge and motivation are only a subset of those which are relevant. Aspects of the situation in which the work is conducted are seen to be at least, as if not more, relevant (Wagenaar and Groeneweg, 1987). Winsemius for example in 1965 writes that: *It is too easily forgotten that a 'human factor' as a direct causal element in the genesis of an accident can only mean some form of human behaviour which is not only determined by the individual's personal traits, but also by the situation the individual has to cope with (p. 151)*. It therefore seems to be especially useful to expand on the role of human error probability and latent conditions in relation to safety climate (Dekker, 2014, 2015). In his influential book 'Human Error' Reason (1990) identified particular types of cognitive error and combined it with earlier work on levels of cognitive processing (Rasmussen, 1980). Groeneweg (2002) reported on the development of basic risk factors or 'general failure types' and their assessment using a questionnaire instrument called TRIPOD Delta. The importance of systemic and organisational performance shaping conditions has been clearly established (e.g., Groeneweg, 2002; Hollnagel, 1998; Reason, 1990, 1997).

The findings of the investigation into the explosion of Piper Alpha (Cullen, 1990) lead to increased attention for organisational factors and the development of safety management systems. Organisational factors which are thought to influence worker conditions have been classified in many ways. The concept of basic risk factors (Groeneweg, 2002; Wagenaar et al., 1994) was developed by starting from the latent failure 'Swiss cheese' model of accident causation (Reason, 1990). At a similar point in time Hollnagel (1998) identified nine 'common performance conditions'. Guldenmund et al. (2006) identified nine elements of so-called management delivery systems which are primary safety management processes. Zacharatos et al. (2005) looked at High-Performance work systems and management practices in relation to occupational safety outcomes. Ale et al. (2008) used seven delivery systems or 'components of working safely'. Finally, Sklet et al. (2010) identified seven risk influencing factors. An overview of the themes these authors identified is included in Table 1.

As can be seen from Table 1 some similar concepts are included in most of these approaches though with different labels and level of detail. A questionnaire was central to the development of the 'basic risk factors'. The TRIPOD Delta checklist which was developed in the nineties uses a questionnaire-based approach to measure performance on these aspects (Hudson et al., 1991, 1998; Groeneweg, 2002). The instrument consists of a broad database of binary questions on observable characteristics of latent failures grouped into the factors. The instrument was used extensively in practice and was shown to provide additional insight into the performance of safety management systems over a purely audit based approach (Cambon et al., 2006) and was adapted to a healthcare setting (van Schoten et al., 2014). For the other taxonomies, quantification of organisational contributions to 'human error' has instead been focused on methods such as systematic interviews (Vinnem et al., 2012) and expert judgement (Ale et al., 2008;

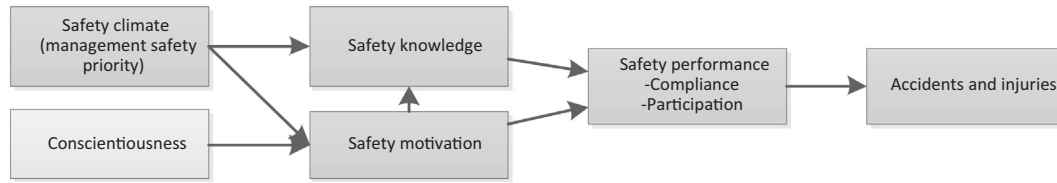


Fig. 1. Model of safety climate (adapted from Christian et al., 2009). The dark grey aspects have most support from Christian's meta-analysis. Christian added conscientiousness as well but the estimates were partly on generic rather than safety specific data (see Christian et al., 2009, p. 11).

Table 1
Risk factors and delivery systems.

| Basic risk factors (Reason, 1990; Groeneweg, 2002; Wagenaar et al., 1994) | Common performance conditions (Hollnagel, 1998) | Delivery systems (Guldenmund et al., 2006; Duijm and Goossens, 2006) | Risk influencing factors (Sklet et al., 2010; Vinnem et al., 2012) | Delivery systems (Ale et al., 2008) | Zacharatos et al. (2005) |
|---------------------------------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|-------------------------------------|-------------------------------------------|
| - Design | - Adequacy of man-machine interface and operational support | - Design specification, purchase, construction, installation, interface design/layout and spares | - | - Interface | - |
| - Hardware | - | - Inspection, testing, performance monitoring, maintenance and repair | - | - Technology | - |
| - Maintenance management | - | - | - | - | - |
| - Housekeeping | - | - | - | - | - |
| - Error enforcing conditions | - Working conditions | - | - Workload and physical working environment | - | - |
| | - Time of day (circadian rhythm) | | - Work practice | | |
| - Procedures | - Available time | - Procedures, plans, rules and goals | - Procedures and documentation | - Procedures | - |
| - Training | - Availability of procedures/plans | - Competence, suitability | - Competence | - Competence | - Employment security |
| | - Adequacy of training and expertise | | | | - Selective hiring |
| - Communication | - | - Coordination, communication | - Communication | - | - Training |
| | | | | Communication | - Information sharing |
| - Incompatible goals | - Number of simultaneous goals | - Commitment, conflict resolution | - | - Motivation | - Contingent compensation |
| | | | | | - |
| - Organisation | - Adequacy of organisation | - Availability, manpower planning | - Management | - Availability | - Transformational leadership |
| | - Crew collaboration quality | | - Management of change | | - Teams and decentralized decision making |
| - Defences | - | - Risk (scenario) identification, barrier selection and specification | - | - | - |
| - | - | - Monitoring, feedback, learning and change management | - | - | - Measurement |
| - | - | - | - | - | - Reduced status distinctions |
| - | - | - | - | - | - Job quality |

Note: The aspects in this table have been sorted in such a way that broadly similar concepts are aligned in the same rows. A more precise matching of concepts is beyond the scope of this article.

Hollnagel, 1998). Finally, these factors have been identified as causal factors in a variety of incident investigations. For example in relation to the 'Storybuilder database' of accidents (Bellamy et al., 2007) and in a comparison between TRIPOD Delta and TRIPOD Beta (Groeneweg, 2002).

1.3. Challenges for further development

From our review of currently available safety questionnaires, challenges for further development were identified. Few, if any, questionnaires combine both motivational and behavioural aspects with workplace conditions and systems. More importantly, many studies show that operational processes play an important role in a organisations overall safety (e.g., Groeneweg, 2002; Hollnagel, 1998; Reason, 1990, 1997; Sklet et al., 2010). Yet, so far safety surveys mainly focus on safety measures or operational safety

processes. For example, rather than looking at communication in general, safety surveys address communication of safety relevant information only (Sklet et al., 2010). This, however, misses out on a significant and recognized proportion of operational processes that can contribute to incidents.

In this paper, an instrument is introduced which promotes integral system management. The constructs included in the instrument aims not only at exposing direct safety weaknesses, but also shortcomings in the 'core business'. This based on the premise that if operational processes play a role in incidents, managing these operational process effectively and efficiently should result in fewer incidents. The goal of the instrument therefore is to measure and map the operational processes to give the organisation the necessary insights in which tools are most effective and in which parts of the organisation they should be employed.

2. Research goal

Given these challenges we set out to develop an instrument with which a wide variety of constructs, including safety and operational process themes from different disciplines, can be measured in a consistent and practical way.

2.1. Goals of the instrument developed

The new instrument should make large scale application in industry practical. This requires the design of a flexible instrument which makes it possible for users to select the topics of interest which are relevant for a particular project from a catalogue of separate constructs. Different combinations of constructs should still be easy to answer without forcing a cognitive burden on respondents through jarring changes. Constructs should therefore use a consistent writing style and the same or similar answer categories when possible. This last goal complicated an indiscriminate inclusion of existing instruments.

2.2. Goals of the present validation study

Goal of the present validation study is to briefly describe the constructs used in the instrument and to report on the tested reliability and construct validity for the developed constructs. This latter goal is achieved through reliability analysis, exploratory factor analysis (EFA) and confirmatory factor analysis (CFA). The long-term goal of the project is to expand data-gathering using this instrument and to test criterion validity at the analysis level of an organisation. This study means to validate the first fifteen constructs both addressing motivational as well as workplace condition aspects of safety. Analysis is based on the application of the instrument amongst five organisations in the period 2013–2015.

3. Instrument development

The instrument was developed through the following phases:

- Identifying relevant themes.
- Defining and operationalising constructs.
- Preliminary use in eight projects.
- First analysis of statistical properties followed by first revision.

To start with, relevant themes were identified with a team of seven safety and human factors researchers. The constructs were subsequently operationalised using three to ten concrete items based on existing literature. Iterative scale and item generating sessions were held by one researcher whereas another researcher focused on identifying and refining items that could be used to measure the constructs. Subsequently two versions were reviewed by the other five researchers for conceptual clarity. This resulted in an item pool of approximately 300 items covering 38 constructs. These constructs include both direct safety measure (i.e., Priority for safety), but also various operational processes (i.e., Procedures). [Table 2](#) provides an overview of the construct definitions and relevant references of the 15 constructs included in the analysis for this paper. In the remainder of this paper we will focus only on these 15 constructs. [Table 6](#) also shows all individual questions included in the instrument for the 15 analysed constructs.

The first version of the questionnaire was tested across eight projects within organisations. Data were separately analysed using reliability analysis for each of these projects. A review was conducted based on these projects in which the following important considerations were made:

- Focus on the day-to-day (real-world) experiences of the employees;
- Concrete and clear questions, with minimal abstract language. The questions should be understandable for shop floor employees;
- Elimination of so-called ‘double barreled’ questions;
- Relevant, with a clear explanation of how each aspect is related to safety outcomes.

It was decided to change the response format from an agree-disagree format towards an item-specific format to reduce agreement/acquiescence bias ([Saris et al., 2010](#); [Podsakoff et al., 2003](#)). Response formats were changed to ‘frequency of occurrence’ or on ‘extent of occurrence’. In addition, a do-not-know answer option was added in an attempt to limit ‘averaging tendencies’ which may occur when respondents feel unable to answer a specific question. Questions were grouped thematically in order to facilitate responding through coherent groupings. This is known to enhance scale reliability compared to random groupings, although effects on scale validity are yet to be established ([Lam et al., 2002](#)). These changes required rephrasing a sizable part of the questions.

An example of one construct as used is shown in [Table 3](#). All constructs make use of this five-point answering format. Most constructs use the same answer categories, while for some constructs the answer categories vary due to the formulation of the questions (e.g., Not at all; To a limited extent; To some extent; To a great extent To a very great extent). The answering format was kept as similar as possible for all questions to allow comparison between constructs.

4. Validation

The measurement tool was further validated across multiple projects with organisations within different sectors (e.g. energy network organisations; drilling rigs; offshore installation; high tech food industry; chemical industry). The projects were conducted in the Dutch language in the Netherlands (four projects) and in the German language in Germany (one project). The instrument was used in one large project and replicated in four separate projects. The participating organisations were organisations who had approached TNO for gaining insight in the state of their safety. As such, we made use of a convenience sample that was self-selected. Nevertheless, the sample also represents the type of target organisation for which the current measurement tool is being developed.

As a result of differences in the exact assignment of each organisation (i.e., what aspects of safety climate was relevant for their particular case), there is variation in the constructs included for each individual project. This is due to the flexible nature of the instrument which allows some customization based on specific and individual cases. This analysis focuses on the main overlapping constructs. An overview of the projects and organisations is given in [Table 4](#).

All projects were part of safety assessments conducted within the participating organisations. The projects were intended to gain insight into and propose improvements to factors that shape safety performance. All the organisations were engaged in relatively high risk activities such as chemical processing and the management of energy transport networks. Project 1 and 3 were business units of the same parent organisation. Four of the projects were conducted in organisations with operations partly subject to the European SEVESO-directive. Projects were part of organisation initiatives in which all, or a very large fraction, of the employees was approached.

4.1. Data analysis and preparation

Data analysis was conducted using IBM SPSS version 22 and R version 3.0.2 with the CFA package Lavaan ([Rosseel, 2012](#)).

Table 2
Overview of safety relevant constructs included.

| Theoretical constructs | Description | Examples of earlier uses |
|-------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|
| Priority for safety | The extent to which (senior) management is committed to and prioritizes safety | Rundmo and Hale (2003), O'Dea and Flin (2003), Watson et al. (2005), Hansez and Chmiel (2010), Lekka and Healey (2012), Clarke (2013) |
| Leader consistency | The extent to which leader priority and commitment is perceived as consistent | – |
| Leading by example | Management encourages safe working by setting a good example | Fleming (2001), Wu et al. (2016) |
| Just culture | Balancing learning from failure with appropriate accountability; i.e. not blaming individuals for 'honest errors', but hold them accountable for wilful violations and gross negligence | Hudson (2007), Reason (1997), Dekker (2007, 2008), Dekker and Breakey (2016), Cromie and Bott (2016) |
| Staffing resources | The quality of the support and resources provided by the organisation for the task or work being performed | Hollnagel (1998), Zwetsloot et al. (2007), Reniers (2010) |
| Tasks roles and responsibilities | Clarifying roles and responsibilities so that all levels of management and employees are clear about which performance is expected | Hidden (1989), Hollnagel (1998), Health and Safety Executive (2002, 2003), Baker et al. (2007), Lekka and Healey (2012) |
| Procedures | The existence of adequate procedures with proper usability to deal with (safety) critical situations and operations to prevent violation and/or poor enforcement | Hollnagel (1998), Bell and Healey (2006), Deepwater Horizon investigation report (2010), Lindhout et al. (2010) |
| Management of organisational change | The extent to which changes (i.e. to working methods, organizational structure or staffing resources) are carried out by taking into consideration any potential consequences | Gupta (2002), Atherton and Gil (2008), Chief Counsel (2011), Guidelines for Managing Process Safety Risks During Organisational Change (2013) |
| Effective communication | Efficiency of communication between various sites, departments or employees both in terms of timeliness and adequacy | Hollnagel (1998), Groeneweg (2002), Newman et al. (2016) |
| Craftsmanship | The skillfulness and expertise of employees | Mascini and Bacharias (2012), Mascini et al. (2007) |
| Work planning | The quality of planning and coordination for various sites, departments or employees | Varonen and Mattila (2000), Rodrigues et al. (2015) |
| Training | The level and quality of training, together with operational experience | Meshkati (1991), Bell and Healey (2006) |
| Personal anticipation | The extent to which individual workers anticipate potentially risky conditions/events that may occur at work | Waugh et al. (2008), Probst et al. (2013) |
| Technical state | The extent to which the equipment and facilities of the organisation are of high quality | Hollnagel (1998), Groeneweg (2002) |
| Safety participation | Behaviours such as participating in voluntary safety activities or attending safety meetings | Griffin and Neal (2000), Neal and Griffin (2004), Curcuruto et al. (2015, 2016) |

Table 3
Example construct items and answering format.

| In my department | Never | Sometimes | Regularly | Often | Always | Do not know |
|-----------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| there are sufficient colleagues to carry out the work | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| it is possible to arrange a replacement if someone is ill | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| it is necessary to put in a lot of overtime | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| the right people are available | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Table 4
Organisations and projects.

| | Year | Organisation business activity | Approximate organisation size | Dataset size before and after cleaning up | Response rate as percentage of administered | Method and language |
|-----------|------|--------------------------------|-------------------------------|-------------------------------------------|---------------------------------------------|---------------------|
| Project 1 | 2014 | Energy transport | 2250–2500 | N = 1553/1269 | 65% | Digital, Dutch |
| Project 2 | 2014 | Chemical processing | 250–500 | N = 187/166 | 73% | Digital, Dutch |
| Project 3 | 2014 | Energy transport | 250–500 | N = 258/235 | 84% | Digital, German |
| Project 4 | 2015 | Specialty chemicals | 1000–1250 | N = 833/706 | 73% | Digital, Dutch |
| Project 5 | 2015 | Equipment maintenance | 150–200 | N = 119/92 | 69% | Digital, Dutch |

Respondents in all studies were free to interrupt and continue the questionnaire at will and could also skip questions or choose the 'do not know' response option. Missing data were expected and individual cases were deleted when the respondents had skipped a proportion of the questions when this was considered to be too large (20–30%). After these deletions, the remaining incidental blanks were substituted with the item mean.

The resulting dataset for Project 1 was randomly split in half. Cases were assigned to one of two groups of approximately equal size: Group 1 (n = 657) and Group 2 (n = 612). The datasets from Project 1 were used for the exploratory factor analysis step. The resulting datasets for the Projects 2 through 5 were used in confirmatory factor analyses. The data from Project 5 (n = 92) and Project 3 (n = 235) were combined to achieve a sufficiently large dataset (n = 327).

4.2. Reliability analysis

The Cronbach's alpha reliability statistics for the included constructs were computed; coefficients alpha above 0.70 are rated as (sufficiently) good and below 0.60 as inadequate (Joint American Educational Research Association, 1999). As reliability analysis is limited to correlation within a particular group of items more elaborate factor analyses were needed also.

4.3. Factor analysis

There is considerable discussion about the benefits of factor analysis and choosing between exploratory (EFA) techniques and confirmatory (CFA/SEM) techniques (e.g. Fabrigar et al., 1999; Russell, 2002; Matsunaga, 2015; Schmitt, 2011). The items in our

instrument were grouped into hypothesized constructs based on their content during instrument development. However, the items were newly operationalized and had not yet been validated in this exact form. Therefore, we decided to use both EFA and CFA. The EFA we used to explore an underlying dimensional structure of respondents' answers. Replication with CFA was then used to confirm whether this structure was also apparent in data gathered during subsequent measurements. For the EFA the dataset derived from Project 1 was used with replications using CFA. In the CFA a second-order model in which individual constructs were grouped under overarching latent variables was tested additionally.

4.3.1. Exploratory factor analysis for Project 1

Extraction techniques used in EFA fit solutions to best describe a specific dataset. As a result poor replication of the underlying structure to a new dataset can occur and which has been noted (Guldenmund, 2007). In addition to replication using CFA we partly remedied this phenomenon by dividing our EFA data into two random halves (Project 1, first half, $n = 657$; Project 1, second half, $n = 612$).

The available literature additionally stresses the difficulty of choosing the right number of factors to extract (e.g. Fabrigar et al., 1999). An EFA can give different conceptual results depending on the number of factors extracted. There is a tendency to 'over-extract' factors when using common criteria such as the 'Kaiser criterion' (eigenvalues larger than one) and the so called 'bend in the scree plot' criterion (e.g. Hayton et al., 2004; Fabrigar et al., 1999). The recommended approach of a 'parallel analysis' was used to determine the number of factors to extract. In this approach, factor eigenvalues are compared to eigenvalues of a similar extraction from a completely random dataset (of the same size).

Finally, a decision had to be made on extraction and rotation techniques. Overall principal axis factoring (PAF) with oblique rotation is most appropriate for our instrument as intercorrelation between constructs is expected (Russell, 2002). A factor analysis with an oblique rotation can be used to identify factors even if they are not orthogonal. In the analysis PAF extraction and the oblique promax rotation were chosen.

EFA communalities were evaluated for both halves of the data from Project 1. For most items both halves gave a similar score for item communality. To decide on retaining items for the CFA step two cut-off values for the individual items were used at 0.6 and 0.5. All items with a loading value below 0.5 in both halves of the data were viewed as poorly contributing and were not included in the CFA analysis. If an item loaded poorly in one half of the data but more strongly (>0.6) in the other half of the data it was included into the CFA.

4.3.2. Confirmatory factor analysis for all data

Confirmatory factor analysis was conducted on the available datasets. Model fit was assessed using three fit indices: CFI, RMSEA and SRMR. Threshold values defined by Hair et al. (2006) were used which recognize that fit index thresholds are dependent on sample size and number of items. The CFA analyses in this project concern a relatively large number of items which requires a large sample size; as a rule-of-thumb the amount of subjects should exceed five times the amount of variables. To enable this, data from Project 3 and Project 5 have been combined and analysed jointly.

With each replication the 'simple factor structure' as indicated by the EFA analysis was tested first. For each replication this model was compared to a single factor model. In addition, a second-order factor model was tested along theoretically expected groupings. Latent variables were allowed to correlate in all cases, which is comparable to the choice for an oblique rotation in the EFA. Not all constructs were available in each dataset. In these cases, only the available constructs were used within the CFA model.

5. Results

5.1. Reliability analysis

Reliability coefficient alpha scores were computed for all the included constructs and datasets based on the original grouping of items. The coefficients ranged from 0.76 to 0.94, which is sufficient for group level analysis and offers the first step in the assessment.

5.2. Exploratory factor analysis

The first random half of the data consisted of $n = 657$ cases and 81 questionnaire items. The Kaiser-Meyer-Olkin Measure of Sampling Adequacy (0.94) indicated a highly sufficient number of cases.¹ Bartlett's test of sphericity was highly significant, $\chi^2(3240, N = 657) = 33,275, p < 0.001$, indicating that items were correlated with other items. The second random half of the data which consisted of $n = 612$ cases was similarly suitable for the application of EFA.

The rotated component matrix was assessed in order to identify which items to keep and which to drop. Items were assessed on size of loading using the method described above using cut-off values of both 0.6 and 0.5. From the original 81 items, 13 items were dropped due to cross-loading or the lack of a distinct factor loading, leaving 68 items. In Table 6 the items that are dropped have been marked. Factor communalities for both halves of the data are shown below in conjunction with the CFA parameters in Table 5.

Fifteen constructs were hypothesized. The exploratory analysis suggested a twelve factor solution with three leadership aspects merged into one construct. In addition, two aspects of planning (work planning and personnel availability) emerged as a single construct in one of the two EFA halves.

6. Confirmatory factor analysis

Confirmatory factor analysis was conducted subsequently on the available datasets. Each dataset was analysed three times:

- **Model A:** a reference 'single factor model' in which all items were assumed to be related to only a single 'common factor'.
- **Model B:** a model as suggested by the EFA analysis using Horn's parallel criterion and using up to 12 constructs.
- **Model C:** a combined model in which 'leadership' and 'planning' were modelled as second order aspects.

If model A would exhibit the best fit to the data, this would be indicative of a single underlying factor for all items such as: 'a positive or negative assessment of safety'. Fit of model B would be indicative of the 12 factors from the EFA providing the best fit. Through model C it is hypothesized that the involved latent factors are themselves again grouped at a second order level. In Table 5 fit indices and tests are shown for the different models as applied to the data for the projects which were included.

For all models (A, B and C) a significant χ^2 is expected, given the size of the datasets, and this is also found. Model B provides a better fit than the simple single factor model in all cases. The second-order model (model C) outperforms the simpler 'model B' and leads to a modest increase in fit indices. Final models show a CFI value greater than 0.90 and a RMSEA value below 0.07.

Finally, the parameter estimates for each item in the questionnaire were assessed. When assessing the parameter estimates we

¹ Values should be higher than 0.50 in order to continue with the factor analysis.

Table 5
Fit indices for different factor models.

| | Project 1 | Projects 3 & 5 | Project 2 | Project 4 |
|----------------------------------------------------|------------------------|------------------------|------------------------|------------------------|
| N | 1269 | 327 | 166 | 706 |
| <i>Model A: Single factor</i> | | | | |
| CFI | 0.40 | 0.49 | 0.59 | 0.48 |
| χ^2 | 34,992 | 9288 | 1427 | 8868 |
| DF | 2210 | 1890 | 350 | 300 |
| <i>Model B: Up to twelve factors</i> | | | | |
| CFI | 0.87 | 0.86 | 0.93 | 0.95 |
| χ^2 | 9245 | 3790 | 520 | 679 |
| DF | 2144 | 1824 | 335 | 265 |
| <i>Final model: Including second-order factors</i> | | | | |
| CFI | 0.92 | 0.90 | 0.95 | ^a |
| χ^2 | 6400 | 3244 | 459 | ^a |
| DF | 2210 | 1819 | 333 | ^a |
| p-value (χ^2) | 0 | 0 | 0 | 0 |
| RMSEA and 90% C.I. | 0.040 (0.039–0.041) | 0.049 (0.046–0.052) | 0.048 (0.037–0.058) | 0.047 (0.043–0.051) |
| RMSEA p-value (probability RMSEA < 0.05) | 1 | 0.74 | 0.63 | 0.863 |
| SRMR | 0.052 | 0.056 | 0.051 | 0.034 |
| <i>Difference tests</i> | | | | |
| – Test of difference (A vs B) | p < 0.001 | p < 0.001 | p < 0.001 | p < 0.001 |
| – Test of difference (B vs C) | p < 0.001 | p < 0.001 | p < 0.001 | – |

^a A second order factor model could not be tested with the data available from project 4.

observed the rule of thumb suggested by Hair et al. (2006) that a parameter estimate, i.e. the loading of an item onto a factor, greater than 0.5 was needed although it should preferably be above 0.7. In our final decision we weighed the items' performance in the available data. The combined table reproduced shows all items and their parameter estimates (Table 6). Based on the replications it was decided to drop three additional items for a total of 16 items dropped. One item was related to the construct 'just culture'. As a result, the construct is now only defined by two indicator items. It will be revised/expanded in later versions of the instrument.

7. Conclusion

This study reports on the development of a catalogue of constructs which were derived from scientific literature and practice and which are thought to be relevant for safety within organisations. The catalogue includes relevant constructs which are related to different scientific approaches – i.e. the safety climate approach and the workplace conditions and systems approach. Each of the constructs in the catalogue has been developed with a view towards measurability in an employee survey. A common problem in the development of safety surveys is that answering formats and themes are widely divergent. The constructs were developed to be similar in their wording and to use a consistent rating method. The harmonisation of question types and integration into a single format has the additional benefit that differences in the factor loadings of items are less likely to be the result of the method or form in which questions were posed.

Fifteen out of 38 constructs in the catalogue – which were considered to be the best developed and most widely used – were evaluated. The analysis was conducted on data derived from four projects within different organisations which are all active in high risk industries. The projects included a total of 2468 respondents. Internal consistency and discriminant validity was assessed using a combination of Exploratory Factor Analysis (EFA) and Confirmatory Factor Analysis (CFA). Both approaches were combined and multiple datasets were used to limit the risk of overfitting within a particular dataset. EFA was conducted on two randomly split halves of the data from the largest project (P1) and presented an exploratory factor solution which substantially matched the design expectation and was similar across both random halves. Confirma-

tory factor analysis presented acceptable fit measures across the datasets from the different projects. Finally, a model in which three elements of safety leadership and two aspects of planning were organised using a second-order factor structure showed the optimal fit to the data.

Components focused on workplace conditions and systems were clearly distinguishable in the factor analyses from components focused on personal motivation. This shows that respondents – with the use of this survey – are able to provide a multi-component insight into elements of safety. The aggregated results can provide diagnostic information which can help organisations to find effective and efficient ways to improve their safety performance.

In conclusion, this instrument allows the mapping and quantification of various aspects of the operational process that are, based on existing knowledge (e.g., Groeneweg, 2002; Hollnagel, 1998; Reason, 1990, 1997; Sklet et al., 2010), related to the occurrence of incidents. This allows organisations to identify weak points in their operational process which if remedied contribute to a more effective, more efficient and therefore safer 'core business'.

8. Discussion

This study forms the first step in the goal to investigate and validate the developed constructs across datasets. Further expansion will allow for evaluation of the factor structure of new constructs where the same overall approach can be used. It will be critically important to continue to evaluate the uniqueness of each new construct with respect to existing measures. For example: considerable interest has been put towards the idea of a 'zero accident vision'. A new measure for the presence/absence of this type of vision in an organisation could be compared to existing constructs.

Several limitations should be noted with regard to the current study. Based upon current literature there is a presumed relation between the factors included in the measurement and safety outcomes. However, this relationship has not been tested in the present study. Safety outcomes in this case should be evaluated at the level of existing groups, for example, by correlating survey scores with organisation or business unit performance. To conduct an analysis with sufficient statistical power therefore requires a substantial number of participating organisations to acquire sufficient data.

Table 6
All items and their parameter estimates.

| Variable | | EFA communalities | | CFA parameter estimates | | | | Decision |
|-------------------------|---------------------------------------------------------------------------------|-------------------|--------|-------------------------|-------------|-------------|-------------|----------|
| | | P1(h1) | P1(h2) | P1 (h1&h2) | P3 & P5 | P2 | P4 | |
| | Procedures, guidelines and regulations in our company | | | | | | | |
| procedures_01 | are clearly written and expressed | 0.64 | 0.62 | 0.63 | 0.73 | 0.64 | 0.77 | Retained |
| procedures_02 | are conflicting | <0.5 | <0.5 | | | | | Removed |
| procedures_03 | are drafted by colleagues who are competent | 0.54 | <0.5 | | | | | Removed |
| procedures_04 | are easily accessible | 0.78 | 0.72 | 0.69 | 0.71 | 0.62 | 0.67 | Retained |
| procedures_05 | are updated regularly and correctly | 0.70 | 0.66 | 0.65 | 0.71 | 0.58 | 0.70 | Retained |
| procedures_06 | are known to the employees in the workplace | 0.75 | 0.79 | 0.75 | 0.72 | 0.73 | 0.77 | Retained |
| procedures_07 | are easy to understand | 0.85 | 0.74 | 0.73 | 0.72 | 0.78 | 0.78 | Retained |
| procedures_08 | really help in daily work | 0.58 | 0.64 | 0.57 | 0.67 | 0.72 | 0.74 | Retained |
| procedures_09 | are changed without good reasons | <0.5 | <0.5 | | | | | Removed |
| procedures_10 | are changed without communicating | <0.5 | <0.5 | | | | | Removed |
| | Our company ensures | P1(h1) | P1(h2) | P1 (h1&h2) | P3 & P5 | P2 | P4 | |
| training_02 | that employees can practice their skills | .73 | .85 | 0.70 | 0.70 | 0.80 | | Retained |
| training_03 | that everyone is trained in major changes (such as new equipment or procedures) | .82 | .88 | 0.83 | 0.79 | 0.78 | | Retained |
| training_05 | that good training is available | 0.88 | 0.87 | 0.84 | 0.76 | 0.85 | | Retained |
| training_06 | that new employees will receive introductory training | 0.58 | 0.58 | 0.57 | 0.72 | 0.67 | | Retained |
| | In our company | P1(h1) | P1(h2) | P1 (h1&h2) | P3 & P5 | P2 | P4 | |
| tvb_01 | It is clear who does what and when | <0.5 | <0.5 | | | | | Removed |
| tvb_02 | it is clear who has important knowledge and skills | <0.5 | 0.64 | 0.66 | 0.58 | 0.77 | | Retained |
| tvb_03 | colleagues with important knowledge and skills are available when needed | <0.5 | 0.79 | 0.82 | 0.90 | 0.86 | | Retained |
| tvb_04 | colleagues who are formally responsible are available when needed | <0.5 | 0.75 | 0.84 | 0.85 | 0.85 | | Retained |
| tvb_05 | colleagues have sufficient authority for the execution of their tasks | <0.5 | 0.65 | 0.70 | 0.69 | 0.63 | | Retained |
| | Changes in the way of working or organisation | P1(h1) | P1(h2) | P1 (h1&h2) | P3 & P5 | P2 | P4 | |
| orgChange_01 | are well prepared | 0.67 | <0.5 | 0.78 | 0.86 | | | Retained |
| orgChange_02 | are well thought out and planned | 0.69 | <0.5 | 0.80 | 0.92 | | | Retained |
| orgChange_03 | are implemented with care for safety | <0.5 | <0.5 | | | | | Removed |
| orgChange_04 | follow one another too quickly | <0.5 | <0.5 | | | | | Removed |
| orgChange_05 | are well directed/controlled | 0.72 | <0.5 | 0.92 | 0.84 | | | Retained |
| orgChange_06 | are guided well | 0.66 | <0.5 | 0.93 | | | | Retained |
| | In my department | P1(h1) | P1(h2) | P1 (h1&h2) | P3 & P5 | P2 | P4 | |
| persAvailable_01 | there are sufficient colleagues to perform the work | 0.75 | 0.68 | 0.72 | 0.66 | 0.67 | | Retained |
| persAvailable_02 | it is possible to arrange a replacement if someone is ill | 0.73 | 0.62 | 0.61 | 0.63 | 0.56 | | Retained |
| persAvailable_03 | it is necessary to put in a lot of overtime | 0.50 | 0.57 | 0.27 | | | | Removed |
| persAvailable_04 | the right people are available | 0.71 | 0.58 | 0.87 | 0.86 | 0.69 | | Retained |
| persAvailable_05 | colleagues are available at the right time | 0.68 | 0.64 | 0.85 | 0.86 | | | Retained |
| | If employees make a mistake or commit an error | P1(h1) | P1(h2) | P1 (h1&h2) | P3 & P5 | P2 | P4 | |
| just_01 | they are comfortable reporting this | <0.5 | <0.5 | | | | | Removed |
| just_02 | they are treated justly | 0.57 | 0.53 | 0.56 | | | | Removed |
| just_03 | they get unfairly blamed by the manager(s) | 0.87 | 0.76 | 0.81 | 0.76 | | 0.72 | Retained |
| just_04 | unjust sanctions are imposed | 0.81 | 0.80 | 0.76 | 0.57 | | 0.76 | Retained |
| just_05 | colleagues resent them for their error or mistake | 0.63 | 0.64 | 0.40 | 0.35 | | 0.43 | Removed |
| Just_06 | they are comfortable asking others for help | <0.5 | <0.5 | | | | | Removed |
| | In our department | P1(h1) | P1(h2) | P1 (h1&h2) | P3 & P5 | P2 | P4 | |
| plan_01 | good working arrangements are made | <0.5 | <0.5 | | | | | Removed |
| plan_02 | activities are planned thoroughly in advance | 0.72 | 0.75 | 0.86 | 0.84 | 0.82 | | Retained |
| plan_03 | the right resources are available for carrying out the work | 0.74 | 0.83 | 0.90 | | 0.74 | | Retained |
| plan_04 | activities are well coordinated | 0.57 | 0.66 | 0.69 | 0.88 | 0.92 | | Retained |
| plan_05 | the deployment of staff is planned well | 0.57 | 0.76 | 0.82 | 0.85 | | | Retained |
| | My managers | P1(h1) | P1(h2) | P1 (h1&h2) | P3 & P5 | P2 | P4 | |
| priority_01 | are committed to safe and healthy working | 0.85 | 0.70 | 0.74 | 0.71 | | | Retained |
| priority_02 | give safety a high priority | 0.86 | 0.72 | 0.73 | 0.78 | | | Retained |
| priority_03 | take safety seriously | 0.88 | 0.73 | 0.74 | 0.74 | | | Retained |
| priority_04 | overlook violations when it is very busy | <0.5 | <0.5 | | | | | Removed |
| priority_05 | take safety into account when making investment decisions | <0.5 | 0.51 | | | | | Removed |
| consistency_01 | are predictable in their behaviour | <0.5 | 0.57 | | | | | Removed |
| consistency_02 | have a credible safety message | 0.76 | 0.87 | 0.82 | 0.82 | | | Retained |
| consistency_03 | are consistent | 0.67 | 0.83 | 0.79 | 0.78 | | | Retained |
| consistency_04 | Retained their promises | 0.60 | 0.78 | 0.76 | 0.68 | | | Retained |

(continued on next page)

Table 6 (continued)

| Variable | | EFA communalities | | CFA parameter estimates | | | | Decision |
|------------------------|-----------------------------------------------------------------------------------|-------------------|--------|-------------------------|-------------|-------------|-------------|----------|
| | | P1(h1) | P1(h2) | P1 (h1&h2) | P3 & P5 | P2 | P4 | |
| | Procedures, guidelines and regulations in our company | | | | | | | |
| rolemodel_01 | set a good example | 0.79 | 0.87 | 0.83 | 0.88 | | | Retained |
| rolemodel_02 | inspire employees to behave in a safe manner | 0.74 | 0.77 | 0.83 | 0.85 | | | Retained |
| rolemodel_03 | do themselves what they ask of others | 0.80 | 0.84 | 0.84 | 0.87 | | | Retained |
| | The employees in my department | P1(h1) | P1(h2) | P1 (h1&h2) | P3 & P5 | P2 | P4 | |
| participate_01 | voluntarily take on extra tasks to improve safety | 0.73 | 0.70 | 0.64 | 0.67 | | 0.59 | Retained |
| participate_02 | help each other to work safely | 0.85 | 0.76 | 0.82 | 0.86 | | 0.85 | Retained |
| participate_03 | discuss how the work can be done safely | 0.90 | 0.89 | 0.85 | 0.87 | | 0.87 | Retained |
| participate_04 | check whether a task can be done safely | 0.93 | 0.89 | 0.88 | | | 0.82 | Retained |
| participate_05 | do everything to improve unsafe situations | 0.77 | 0.83 | 0.82 | 0.86 | | 0.78 | Retained |
| participate_06 | inform the manager(s) about unsafe situations | 0.69 | 0.71 | 0.73 | 0.73 | | 0.72 | Retained |
| | The employees in my department | P1(h1) | P1(h2) | P1 (h1&h2) | P3 & P5 | P2 | P4 | |
| open_01 | know how to give and receive criticism amongst each other | 0.64 | 0.71 | 0.69 | 0.72 | 0.88 | 0.74 | Retained |
| open_02 | know how to conduct difficult conversations | 0.74 | 0.83 | 0.67 | 0.79 | 0.81 | 0.68 | Retained |
| open_03 | address each other about behaviour | 0.75 | 0.82 | 0.71 | 0.76 | 0.78 | 0.75 | Retained |
| open_04 | communicate openly and honestly with each other | 0.85 | 0.82 | 0.87 | 0.83 | 0.91 | 0.86 | Retained |
| open_05 | communicate easily with each other | 0.79 | 0.77 | 0.82 | 0.77 | 0.91 | 0.81 | Retained |
| open_06 | communicate openly and honestly with their supervisor | 0.70 | 0.74 | 0.81 | 0.74 | | | Retained |
| | The employees in my department | P1(h1) | P1(h2) | P1 (h1&h2) | P3 & P5 | P2 | P4 | |
| skilled_01 | are professionally competent | 0.87 | 0.83 | 0.85 | 0.83 | | | Retained |
| skilled_02 | know what is important when working | 0.86 | 0.81 | 0.84 | 0.88 | | | Retained |
| skilled_03 | have experience doing the work | 0.90 | 0.87 | 0.86 | 0.81 | | | Retained |
| skilled_04 | are knowledgeable about the work | 0.92 | 0.90 | 0.88 | 0.89 | | | Retained |
| skilled_05 | do a good job | 0.82 | 0.82 | 0.82 | 0.82 | | | Retained |
| | – | P1(h1) | P1(h2) | P1 (h1&h2) | P3 & P5 | P2 | P4 | |
| anticipate_01 | I anticipate potentially risky conditions/events which could occur during my work | 0.74 | 0.87 | 0.78 | 0.85 | | 0.81 | Retained |
| anticipate_02 | Whilst working I keep a close eye out for threats or dangers | 0.80 | 0.88 | 0.87 | 0.87 | | 0.83 | Retained |
| anticipate_03 | During work, I am attentive to signals which indicate a (possible) risk | 0.81 | 0.88 | 0.87 | 0.89 | | 0.79 | Retained |
| anticipate_04 | I have prepared for errors which may occur during work | 0.83 | 0.74 | 0.65 | 0.72 | | 0.62 | Retained |
| anticipate_05 | I investigate errors or deviations at work | 0.75 | 0.74 | 0.61 | 0.67 | | 0.55 | Retained |
| | The equipment and facilities in our company | P1(h1) | P1(h2) | P1 (h1&h2) | P3 & P5 | P2 | P4 | |
| techstate.pl_01 | are of good quality | 0.88 | 0.83 | 0.85 | 0.81 | 0.73 | | Retained |
| techstate.pl_02 | are in a good technical condition | 0.85 | 0.85 | 0.88 | 0.89 | 0.85 | | Retained |
| techstate.pl_03 | are reliable and available | 0.86 | 0.82 | 0.84 | 0.90 | 0.72 | | Retained |
| techstate.pl_04 | are expertly maintained | 0.71 | 0.76 | 0.65 | 0.82 | | | Retained |
| techstate.pl_05 | are maintained according to schedule | 0.57 | 0.64 | 0.51 | 0.74 | | | Retained |
| techstate.pl_06 | are easy to operate | 0.54 | 0.54 | 0.49 | 0.50 | | | Removed |

Items were developed with a focus on plain and straightforward language and reviewed extensively by representatives from participating organisations. There was no indication that questions were too difficult for the respondent in these organisations; however the method still requires that participants have sufficient language and intellectual abilities. The questions have not been tested and may not be suitable for employees with underdeveloped language abilities.

The study has been conducted in a relatively homogenous group of organisations in terms of activity and safety performance. This limits generalisability. All participating organisations put substantial effort into safety and had an active safety program. The approach should be expanded towards other types of organisations and safety domains, e.g., construction companies, hospitals.

In future research the safety survey results should be correlated to concurrent measures such as the outcomes of an audit of the safety management system or other safety and operational outcomes.

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References

- Ale, B., Bellamy, L.J., Cooke, R., Duyvis, M., Kurowicka, D., Lin, P.H., Morales, O., Roelen, A., Spouge, J., 2008. Causal Model for Air Transport: Final Report. Ministerie van Verkeer en Waterstaat, Directoraat-Generaal Luchtvaart en Maritieme zaken.
- Atherton, J., Gil, F., 2008. Incidents That Define Process Safety. Centre for Chemical Process Safety and Wiley, New York.
- Baker, J.A., Bowman, F.L., Erwin, G., Gorton, S., Hendershot, D., Leveson, N., Priest, S., Rosenthal, I., Tebo, P.V., Wiegmann, D.A., Wilson, L.D., 2007. The Report of the BP U.S. Refineries Independent Safety Review Panel Retrieved from: <<http://www.propublica.org/documents/item/the-bp-us-refineries-independent-safety-review-panel-report>>.
- Bell, J., Healey, N., 2006. The Causes of Major Hazard Incidents and How to Improve Risk Control and Health and Safety Management: A Review of the Existing Literature (HSL/2006/117) Retrieved from: <http://secure-qnb.co.uk/research/hsl_pdf/2006/hsl06117.pdf>.
- Bellamy, L.J., Ale, B.J.M., Geyer, T.A.W., Goossens, L.H.J., Hale, A.R., Oh, J., Mud, M., Bloemhof, A., Papazoglou, I.A., Whiston, J.Y., 2007. Storybuilder: a tool for the analysis of accident reports. Reliab. Eng. Syst. Saf. 92, 735–744.
- Cambon, J., Guarnieri, F., Groeneweg, J., 2006. Towards a new tool for measuring safety management systems performance. In: Hollnagel, E., Rigaud, E. (Eds.), Proceedings of the Second Resilience Engineering Symposium. Mines Paris, Less Presses, Antibes – Juan-les-Pins, France, pp. 53–62.
- Chief Counsel, 2011. Macondo the Gulf Oil Disaster Retrieved from: <<http://www.eoearth.org/view/article/164618>>.
- Christian, M.S., Bradley, J.C., Wallace, J.C., Burke, M.J., 2009. Workplace safety: a meta-analysis of the roles of person and situation factors. J. Appl. Psychol. 94 (5), 1103–1127.
- Clarke, S., 2006. The relationship between safety climate and safety performance: a meta-analytic review. J. Occup. Health Psychol. 11 (4), 315–327.

- Clarke, S., 2013. Safety leadership: a meta-analytic review of transformational and transactional leadership styles as antecedents of safety behaviours. *J. Occup. Psychol.* 86 (1), 22–49.
- Cromie, S., Bott, F., 2016. Just culture's "line in the sand" is a shifting one; an empirical investigation of culpability determination. *Saf. Sci.* 86, 258–272.
- Cullen, W., 1990. *The Public Inquiry into the Piper Alpha Disaster*. Department of Energy, Her Majesty's Stationary Office, London.
- Curcuruto, M., Conchie, S.M., Mariani, M.G., Violante, F.S., 2015. The role of prosocial and proactive safety behaviors in predicting safety performance. *Saf. Sci.* 80, 317–323.
- Curcuruto, M., Mearns, K.J., Mariani, M.G., 2016. Proactive role-orientation toward workplace safety: psychological dimensions, nomological network and external validity. *Saf. Sci.* 87, 144–155.
- Deepwater Horizon Accident Investigation Report, 2010. BP Executive Summary Retrieved from: <http://www.bp.com/content/dam/bp/pdf/sustainability/issue-reports/Deepwater_Horizon_Accident_Investigation_Report_Executive_summary.pdf>.
- Dekker, S.W.A., 2007. *Just Culture: Balancing Safety and Accountability*. Ashgate Publishing Limited, Hampshire.
- Dekker, S.W.A., 2008. Just culture: who gets to draw the line? *Cogn. Technol. Work* 11 (3), 177–185.
- Dekker, S., 2014. *The Field Guide to Understanding 'Human Error'*. CRC Press.
- Dekker, S., 2015. *Safety Differently: Human Factors for a New Era*. CRC Press.
- Dekker, S.W.A., Breakey, H., 2016. 'Just culture': improving safety by achieving substantive, procedural and restorative justice. *Saf. Sci.* 85, 187–193.
- Duijm, N.J., Goossens, L., 2006. Quantifying the influence of safety management on the reliability of safety barriers. *J. Hazard. Mater.* 130 (3), 284–292.
- Fabrigar, L.R., Wegener, D.T., MacCallum, R.C., Strahan, E.J., 1999. Evaluating the use of exploratory factor analysis in psychological research. *Psychol. Methods* 4 (3), 272.
- Fleming, M., 2001. Effective Supervisory Safety Leadership Behaviours in the Offshore Oil and Gas Industry. Offshore Technology Report (1999/065) Retrieved from: <<http://www.hse.gov.uk/research/otopdf/1999/oto99065.pdf>>.
- GPO, 2011. *Deep Water: The Gulf Oil Disaster and the Future of Offshore Drilling: Report to the President*. National Commission on the BP Deepwater Horizon Oil Spill and Offshore Drilling. Retrieved from: <<https://www.gpo.gov/fdsys/pkg/GPO-OILCOMMISSION/pdf/GPO-OILCOMMISSION.pdf>>.
- Griffin, M.A., Curcuruto, M., 2016. Safety climate in organizations. *Annu. Rev. Org. Psychol. Org. Behav.* 3, 191–212.
- Griffin, M.A., Neal, A., 2000. Perceptions of safety at work: a framework for linking safety climate to safety performance, knowledge, and motivation. *J. Occup. Health Psychol.* 5 (3), 347–358.
- Groeneweg, J., 2002. Controlling the Controllable, Preventing Business Upsets. Global Safety Group, Leiden.
- Guidelines for Managing Process Safety Risks During Organizational Change (2013). Center for Chemical Process Safety (CCPS). ISBN: 978-1-1183-7909-7.
- Guldenmund, F.W., 2000. The nature of safety culture: a review of theory and research. *Saf. Sci.* 34 (1), 215–257.
- Guldenmund, F.W., 2007. The use of questionnaires in safety culture research – an evaluation. *Saf. Sci.* 45 (6), 723–743.
- Guldenmund, F., Hale, A., Goossens, L., Betten, J., Duijm, N.J., 2006. The development of an audit technique to assess the quality of safety barrier management. *J. Hazard. Mater.* 130 (3), 234–241.
- Gupta, J.P., 2002. The Bhopal gas tragedy: could it have happened in a developed country? *J. Loss Prev. Process Ind.* 15 (1), 1–4.
- Hair, J.F., Black, W.C., Babin, B.J., Anderson, R.E., Tatham, R.L., 2006. *Multivariate Data Analysis*, vol. 6. Pearson Prentice Hall, Upper Saddle River, NJ.
- Hansez, I., Chmiel, N., 2010. Safety behaviour: job demands, job resources and perceived management commitment to safety. *J. Occup. Health Psychol.* 15 (3), 267–278.
- Hayton, J.C., Allen, D.G., Scarpello, V., 2004. Factor retention decisions in exploratory factor analysis: a tutorial on parallel analysis. *Org. Res. Methods* 7 (2), 191–205.
- Health and Safety Executive, 2002. *Train Derailment at Potters Bar*. HSE Interim Report Retrieved from: <<http://www.rail-reg.gov.uk/upload/pdf/incident-pottersbar-interim.pdf>>.
- Health and Safety Executive, 2003. *Train Derailment at Potters Bar. A Progress Report by the HSE Investigation* Retrieved from: <http://www.railwaysarchive.co.uk/documents/HSE_PottersRep052003.pdf>.
- Hidden, A., 1989. *Investigation into the Clapham Junction Railway Accident*. HMSO, London.
- Hollnagel, E., 1998. *Cognitive Reliability and Error Analysis Method: Cream*. Elsevier Science, Oxford.
- Hudson, P.T.W., 2007. Implementing a safety culture in a major multi-national. *Saf. Sci.* 45 (6), 697–722.
- Hudson, P.T.W., Wagenaar, W.A., Reason, J.T., Groeneweg, J., Van der Meer, R.J.W., Visser, J.P.M., 1991. Enhancing safety in drilling: implementing TRIPOD in a desert drilling operation. In: *SPE Health Safety and Environment in Oil and Gas Exploration and Production Conference*, The Hague, The Netherlands.
- Hudson, P.T.W., Riley, E.D., Gidley, J.K., 1998. A new model for integrity of management systems. In: *SPE International Conference on Health, Safety, and Environment in Oil and Gas Exploration and Production*, Caracas, Venezuela.
- International Association of Oil & Gas Producers, 2015. *Safety Performance Indicators – 2014 Data* Retrieved from: <<http://www.iogp.org/pubs/2014s.pdf>>.
- Joint American Educational Research Association, 1999. *The Standards for Educational and Psychological Testing*. American Educational Research Association, Washington, DC.
- Kines, P., Lappalainen, J., Mikkelsen, K.L., Olsen, E., Pousette, A., Tharaldsen, J., Tómasson, K., Törner, M., 2011. Nordic Safety Climate Questionnaire (NOSACQ-50): a new tool for diagnosing occupational safety climate. *Int. J. Ind. Ergon.* 41 (6), 634–646.
- Lam, T.C.M., Green, K.E., Bordignon, C., 2002. Effect of item grouping and position of the don't know option on questionnaire response. *Field Methods* 14, 418–432.
- Lekka, C., Healey, N., 2012. *A Review of the Literature on Effective Leadership Behaviours for Safety (Research Report RR952)*. Health and Safety Laboratory. Retrieved from: <<http://www.hse.gov.uk/research/rrpdf/rr952.pdf>>.
- Lindhout, P., Kingston-Howlett, J.C., Ale, B.J.M., 2010. Controlled readability of Seveso II company safety documents, the design of a new KPI. *Saf. Sci.* 48, 734–746.
- Mascini, P., Bacharias, Y., 2012. Integrating a top-down and a bottom-up approach: formal and informal risk-handling strategies in a utility company. *Risk Anal.* 32 (9), 1547–1560.
- Mascini, P., Bacharias, Y., Aabaaziz, I., 2007. Formal and informal safety management: the importance of ethnographic research for safety surveys. In: *'Risk and Rationalities' Conference SCARR*, Cambridge, UK.
- Matsunaga, M., 2015. How to factor-analyze your data right: do's, don'ts, and how-to's. *Int. J. Psychol. Res.* 3 (1), 97–110.
- Meshkati, N., 1991. Human factors in large-scale technological systems' accidents: three mile Island, Bhopal, Chernobyl. *Org. Environ.* 5, 133–154.
- Nahrgang, J.D., Morgeson, F.P., Hofmann, D.A., 2007. Predicting safety performance: a meta-analysis of safety and organizational constructs. In: *22nd Annual Conference of the Society for Industrial and Organizational Psychology*, New York.
- Neal, A., Griffin, M.A., 2004. Safety climate and safety at work. In: *Barling, J., Frone, M.R. (Eds.), The Psychology of Workplace Safety*. American Psychological Association, Washington, DC, pp. 15–34.
- Newman, S., Goode, N., Griffin, M., Foran, C., 2016. *Defining Safety Communication in the Workplace: An Observational Study*. Research Report #: 068–0216-R01.
- O'Dea, A., Fliin, R., 2003. The Role of Managerial Leadership in Determining Workplace Safety Outcomes. HSE Books. Retrieved from: <<http://www.safetynetmoodle.com/video/BSB51315/BSBWH506/downloads/7.pdf>>.
- Onderzoeksraad voor Veiligheid, 2013. *Veiligheid Odfjell Terminals: periode 2000–2012 (20120731)*. The Netherlands, The Hague. Retrieved from: <<http://www.onderzoeksraad.nl/uploads/phase-docs/326/bb9e4abaeb2brapport-odfjell-web.pdf>>.
- Parker, D., Lawrie, M., Hudson, P., 2006. A framework for understanding the development of organisational safety culture. *Saf. Sci.* 44 (6), 551–562.
- Podsakoff, P.M., MacKenzie, S.B., Lee, J.Y., Podsakoff, N.P., 2003. Common method biases in behavioral research: a critical review of the literature and recommended remedies. *J. Appl. Psychol.* 88 (5), 879–903.
- Powell, T., 2006a. *The Buncefield Investigation: Progress Report* Retrieved from: <<http://www.buncefieldinvestigation.gov.uk/report.pdf>>.
- Powell, T., 2006b. *The Buncefield Investigation: Second Progress Report* Retrieved from: <<http://www.buncefieldinvestigation.gov.uk/reports/report2.pdf>>.
- Powell, T., 2006c. *The Buncefield Investigation: Third Progress Report* Retrieved from: <<http://www.buncefieldinvestigation.gov.uk/reports/report3.pdf>>.
- Probst, T.M., Graso, M., Estrada, A.X., Greer, S., 2013. Consideration of future safety consequences: a new predictor of employee safety. *Accid. Anal. Prev.* 55, 124–134.
- Rasmussen, J., 1980. Notes on human error analysis and prediction. In: *Apostolakis, G., Garribba, S., Volta, G. (Eds.), Synthesis and Analysis Methods for Safety and Reliability Studies*. Plenum Press, New York, pp. 357–389.
- Reason, J.T., 1990. *Human Error*. Cambridge University Press, New York.
- Reason, J.T., 1997. *Managing the Risks of Organizational Accidents*. Ashgate, Manchester, UK.
- Reniers, G.L.L., 2010. A management of change approach for assessing and Evaluating operational Staffing Levels (MocESL) in chemical plants. *Saf. Sci.* 48, 885–893.
- Rodrigues, F., Coutinho, A., Cardoso, C., 2015. Correlation of causal factors that influence construction safety performance: a model. *Work* 51 (4), 721–730.
- Rosseel, Y., 2012. Lavaan: an R package for structural equation modeling. *J. Stat. Softw.* 48 (2), 1–36.
- Rundmo, T., Hale, A.R., 2003. Manager's attitudes towards safety and accident prevention. *Saf. Sci.* 41 (7), 557–574.
- Russell, D.W., 2002. In search of underlying dimensions: the use (and abuse) of factor analysis in Personality and Social Psychology Bulletin. *Pers. Soc. Psychol. Bull.* 28 (12), 1629–1646.
- Saris, W.E., Revilla, M., Krosnick, J.A., Shaeffer, E.M., 2010. Comparing questions with agree/disagree response options to questions with item-specific response options. *Surv. Res. Methods* 4 (1), 61–79.
- Schmitt, T.A., 2011. Current methodological considerations in exploratory and confirmatory factor analysis. *J. Psychoeduc. Assess.* 29 (4), 304–321.
- Schwatka, N.V., Hecker, S., Goldenhar, L., 2016. Defining and measuring safety climate: a review of the construction industry literature. *Ann. Occup. Hyg.* 60 (5), 537–550.
- Sklet, S., Ringstad, A.J., Steen, S.A., Tronstad, L., Haugen, S., Seljelid, J., Wæra, I., 2010. Monitoring of human and organizational factors influencing the risk of major accidents. In: *SPE International Conference on Health Safety and Environment in Oil and Gas Exploration and Production*, Rio de Janeiro, Brazil.
- Takala, J., Hämäläinen, P., Saarela, K.L., Yun, L.Y., Manickam, K., Jin, T.W., Heng, P., Tjong, C., Kheng, L.G., Lim, S., Lin, G.S., 2014. Global estimates of the burden of injury and illness at work in 2012. *J. Occup. Environ. Hyg.* 11 (5), 326–337.
- van Kampen, J., van der Beek, A., Groeneweg, J., 2014. The value of safety indicators. *SPE Econ. Manage.* 5 (5), 131–140.

- van Schoten, S.M., Baines, R.J., Spreeuwenberg, P., de Bruijne, M.C., Groenewegen, P. P., Groeneweg, J., Wagner, C., 2014. The ecometric properties of a measurement instrument for prospective risk analysis in hospital departments. *BMC Health Serv. Res.* 14.
- Varonen, U., Mattila, M., 2000. The safety climate and its relationship to safety practices, safety of the work environment and occupational accidents in eight wood-processing companies. *Accid. Anal. Prev.* 32 (6), 761–769.
- Vinnem, J.E., Bye, R., Gran, B.A., Kongsvik, T., Nyheim, O.M., Okstad, E.H., Sljelid, J., Vatn, J., 2012. Risk modelling of maintenance work on major process equipment on offshore petroleum installations. *J. Loss Prev. Process Ind.* 25 (2), 274–292.
- Wagenaar, W.A., Groeneweg, J., 1987. Accidents at sea: multiple causes and impossible consequences. *Int. J. Man Mach. Stud.* 27 (5–6), 587–598.
- Wagenaar, W.A., Groeneweg, J., Hudson, P.T.W., Reason, J.T., 1994. Promoting safety in the oil industry. *Ergonomics* 37 (12), 1999–2013.
- Watson, G.W., Scott, D., Bishop, J., Turnbeaugh, T., 2005. Dimensions of interpersonal relationships and safety in the steel industry. *J. Bus. Psychol.* 19 (3), 303–318.
- Waugh, C.E., Wagner, T.D., Frederickson, B.L., Noll, D.C., Taylor, S.F., 2008. The neural correlates of trait resilience when anticipating and recovering from threat. *Soc. Cogn. Affect. Neurosci.* 3 (4), 322–332.
- Winsemius, W., 1965. Some ergonomic aspects of safety. *Ergonomics* 8 (2), 151–162.
- Wu, C., Wang, F., Zou, P.X.W., Fang, D., 2016. How safety leadership works among owners, contractors and subcontractors in construction projects. *Int. J. Project Manage.* 34, 789–805.
- Zacharatos, A., Barling, J., Iverson, R.D., 2005. High-performance work systems and occupational safety. *J. Appl. Psychol.* 90, 77–93.
- Zohar, D., 2010. Thirty years of safety climate research: reflections and future directions. *Accid. Anal. Prev.* 42 (5), 1517–1522.
- Zwetsloot, G.I.J.M., Gort, J., Steijger, N., Moonen, C., 2007. Management of change: lessons learned from staff reductions in the chemical process industry. *Saf. Sci.* 45, 769–789.
- Zwetsloot, G.I.J.M., Kines, P., Wybo, J.-L., Ruotsala, R., Drupsteen, L., Bezemer, R.A., 2017. Zero accident vision based strategies in organisations: innovative perspectives. *Saf. Sci.* 91, 260–268.