

Chapter 1: Introduction

The poor level of road safety in South Africa is a cause for concern. In the period between 2010 and 2011, 10 845 fatal crashes were reported, with 13 802 fatalities (Road Traffic Management Corporation, 2011). Of these accidents, busses had the highest accident rates per 10 000 vehicles registered (Road Traffic Management Corporation, 2011). The reasons why these incidents are occurring needs to be explored in more depth.

Bus accidents occur for many reasons. Mechanical failure is one of the causes, as well as driver-related errors that result in accidents, for example, intoxication, sleep deprivation, substance abuse, and distractions (Blower, Green, & Matteson, 2008). The focus of this research is an account of why these safety incidents may be occurring. The research focuses on the drivers' perceptions of events within their organisations.

Justice or fairness refers to the idea that an action or decision is morally right, and this may be defined by any number of criteria such as ethics, religion, or law (Quratulain, Khan, & Peretti, 2012). Individuals react to actions and decisions made by organisations every day. An individual's perceptions of these decisions as fair or unfair can influence the individual's subsequent attitudes and behaviours (Tabibnia, Satpute, & Lieberman, 2008). Fairness is often of central interest to organisations because the implications of perceptions of injustice can impact job attitudes and behaviours at work. Justice in organisations includes issues related to perceptions of fair pay, equal opportunities for promotion, and personnel selection procedures amongst others (Tabibnia, Satpute, & Lieberman, 2008).

The Traffic Incident Management Handbook (Owens, et al., 2010, p. 7) defines an incident as "any non-recurring event that causes a reduction of roadway capacity or an abnormal increase in demand."

Under this definition, events such as traffic crashes, disabled vehicles, spilled cargo, highway maintenance and reconstruction projects, and special non-emergency events are classified as incidents. The Traffic Management Data Dictionary (TMDD), as published by ITE and AASHTO, defines an incident as 'an unplanned randomly occurring traffic event that

adversely affects normal traffic operations' (US Department of Transport Federal Highway Administration, 2014). For this research an accident is considered an incident due to the definition of incidents.

There are a large number of officially reported incidents and accidents. However, the number of unreported incidents and accidents must also be reported. These are often minor 'bumper bashings' which are considered unnecessary to report or are too expensive to report to insurance agencies, as insurance rates would increase were the accident reported and claimed for (Road Traffic Management Corporation, 2011). As professional bus drivers are on the road for a large proportion of their job. There may be an increased possibility of their being exposed to potential incidents and accidents for various reasons. In order to better understand why so many accidents and safety incidences are occurring on South African roads this research focuses on the narrative of bus drivers from a particular transport company in South African and their perception of safety. Furthermore, the research explores whether the bus drivers' perceptions of their organisation and in particular their perceptions of organisational justice are related to safety incidents and accidents.

On the 31st of March 2011 the Department of Transport of the Republic of South Africa released the official Road Traffic Report (Road Traffic Management Corporation, 2011). This report includes a summary of the state of South African traffic related data, as well as stating the desired target of reducing fatalities by 50% by 2015. The report endeavours to make it known that the South African government is attempting to rectify the state and danger of South African roads, and states that the government believes it is on its way to realising its goal by achieving decreases in what they consider to be negative driving behaviours. These include a slight decrease in the number of urban speeding offences, and a decrease in the day time barrier line offence index (crossing solid lines) from 16.1% to 10.3% (Road Traffic Management Corporation, 2011). However, further reading into the report is cause for concern.

There is a conservative reported figure of 9 216 918 vehicles (including unregistered vehicles) on South Africa's roads as of the last official road traffic report in 2011. There is a steady growth of 2.75% in the number of vehicles being registered every year (Road Traffic

Management Corporation, 2011). This means that realistically by March 2014 there would have been close to 10 000 000 vehicles on South Africa's roads. This is important to consider because increased volume of vehicles could lead to an increase in road accidents.

The number of road accident fatalities recorded for the full year of 2010, stood at 13 968, whilst the combined total of fatalities for the first 3 months of 2011 was 3218 (Road Traffic Management Corporation, 2011). When comparing road fatality rates per 100 000 individuals of South Africa to the rest of the world, some worrying statistics emerge. South Africa is eighth on the list of internationally recorded fatality rates, with 31.9 fatalities for every 100 000 inhabitants. This is higher than both the Republic of Tanzania and Democratic Republic of the Congo which have fatality rates of 22.7 and 20.9 respectively; both African countries have a similar population size to South Africa (World Health Organisation, 2013). The United Kingdom has a fatality rate of 2.75 per 100 000 and 1 754 total fatalities (Department for Transport, 2013) compared to South Africa's 13 802 (Road Traffic Management Corporation, 2011).

As this research focuses on bus drivers, the number of fatalities that are directly linked to busses is looked at. In the reported time period of 2009-2010, there were 392 busses involved in fatal accidents and from 2010-2011 there were 292 busses involved in fatal accidents. The total number of fatalities resulting from these accidents (taking into account drivers, passengers and pedestrians) numbered 344 for 2009-2010 and 286 for 2010-2011.

The Department for Transport in South Africa (2011) includes a list of road traffic offences which include un-roadworthy and unlicensed vehicles, as well as unlicensed drivers operating vehicles. The report also lists a number of human errors that have led to fatal accidents. These include, speeding; unlawful overtaking; disregard for road traffic signs such as traffic lights, stop and yield signs; following other vehicles too closely; intoxicated drivers and fatigue or falling asleep at the wheel (Road Traffic Management Corporation, 2011). Finally the report states that 51.73% of fatal accidents happen between the hours of 18:00 and 6:00 (Road Traffic Management Corporation, 2011). This may be because drivers are experiencing greater levels of fatigue after long driving shifts, as well as a poor level of visibility on the roads at this time.

There are a number of reasons for accidents and incidents occurring. These may include factors relating to the operation of the vehicles such as mechanical failures, faulty brakes, engine malfunction, physical breakages such as snapped axles, blown tires and poor bus maintenance (Blower, Green, & Matteson, 2008). There may also be factors relating to the drivers themselves. There are considerable psychophysiological costs involved in driving a bus (Meijman & Kompier, 1998). These include relatively high blood pressure, elevated levels of neuroendocrine hormones (such as adrenaline), as well as strong feelings of fatigue and tension and complaints of mental overload. Some explanations for these are ergonomic deficiencies in the design and construction of the bus, irregular work schedules and shift patterns, and psychosocial constraints in the work situation such as interaction with the passengers as well as supervisors (Meijman & Kompier, 1998). The bus driver's job is often dictated by high and conflicting demands, for example, the company and the public want the driver to be service-oriented, maintaining a good relationship with the passengers, and this demand for service often conflicts with the need to keep to a tight schedule in busy traffic while operating the bus safely (Road Traffic Management Corporation, 2011).

High demands, low job control, and poor social support present a significant psychosocial health risk at work (Kivimaki et al., 2004). Both men and women with low control and high job demands reported a lower level of health in studies. The types of jobs studied were government workers which included clerical staff, administrative staff, and support staff in a civil department (Kivimaki et al., 2004; Elovainio, et al., 2010). A meta-analysis by Tse, Flin and Mearns (2006) found that the most common health outcomes of bus drivers who perceived a high demand and low control in their jobs were: cardiovascular disease, gastrointestinal issues, musculoskeletal injury, fatigue, anxiety, depression, post-traumatic stress disorder. There was also a high level of reported substance abuse, including use of alcohol and drugs, although it was not reported if these were used during driving shifts. Given the high demand that bus drivers face in their everyday tasks, coupled with the low control they have over how to perform these tasks, it is assumed that bus drivers experience a high level of demand which may impact on their health as well as their job performance. Although the current study did not focus specifically on the psychosocial health risks of bus drivers, a systemic approach was adopted that allowed for bus drivers to raise these issues if they chose.

The subject of employment relations in South Africa has a rich and varied background. Often relations between employees and employers are mediated by trade unions (Bendix, 2010). Unions are in place to protect the employee's interests in the organisation as well as protect them from unjust work practices (Bendix, 2010). There has been a history of mistrust between employees and employers in the South Africa. Examples of this are the strikes that took place in Marikana by the mine workers in 2012, and the metal working industry in 2014. These strikes often arise due to perceived inequity between the employees and the employers (Bendix, 2010). The perceived inequity arises from pay structures where employees often only get a small portion of the money that the company generates, whilst the employees feel that they are integral to the production of this income and are therefore justified in asking for a larger percentage (Bendix, 2010). This research study explores the concept of organisational justice and its potential link with safety incidents. This research explores drivers' perceptions of organisational justice and their possible link with safety incidents.

Chapter 2: Conceptual and theoretical background

2.1. South African road safety

South Africa has a high incidence of bus accidents. There were 684 bus accidents that involved fatalities from the observed period of March 2009 to March 2011, an average of 28.5 fatal crashes a month (Road Traffic Management Corporation, 2011). However, this high fatality rate is not only restricted to bus operators on South African roads. During the same period there was a total of 28 458 fatal accidents on South African roads, a figure that includes motorcars, minibusses, motorcycles, and trucks (Road Traffic Management Corporation, 2011). Busses only make up a small percentage of the total number of fatal accidents. Two things are to be considered. Firstly, there is a significantly lower number of busses on the road with 47 799 busses registered as of March 2011, making up 0.54 percent of the total number of vehicles on South African roads (Road Traffic Management Corporation, 2011). This is compared to the 326 721 registered trucks and 5 675 488 registered motorcars (Road Traffic Management Corporation, 2011). Secondly, the high fatality rate that bus accidents have due to the number of passengers that they carry. A motorcar accident may involve five fatalities if it carrying at capacity, a bus may have as many as 40-80 fatalities, depending on the type of bus.

Certain examples of high fatality bus accidents include the Westdene Dam disaster of 1985, the Bethlehem crash of 2003, and the De Doorns crash of 2013. The Westdene Dam disaster is well known to many Johannesburg residents. On March 27 1985, a double decker bus carrying school children from a local school lost control and crashed into the Westdene Dam reservoir. It was reported that 40 school children drowned at the scene of the accident, and two more passed away from injuries in hospital later that day, bringing the death toll to 42 children. A similar incident occurred on May 1st 2003 when a bus driver became disoriented in the dark and took a wrong road, eventually leading to him driving straight into a dam. Sixty three people were confirmed dead at the scene with 17 missing and presumed dead (theguardian.com, 2003). The bus was rated to carry 65 passengers. However, it was severely overloaded, with an estimated load of between 80 to 90 people on board (Ndaba,

2003). Estimates put the final death toll at 80 individuals, making it one of South Africa's worst road disasters to date. Unfortunately, the prevalence of overloading in South Africa is all too common and often the high death rate in road accidents are due to the fact that there are too many people on board to safely operate the vehicle. The De Doorns incident occurred on the 15th of March 2013 near De Doorns. Twenty-four people were killed whilst eight were critically injured, 14 seriously injured and 44 moderately injured, according to a provincial health department (Mama & Solomons, 2013). Survivors of the accident believe that there was a failure of the bus's braking system which led to the driver losing control down the steep valley road and finally crashing the bus against the mountain side (SAPA, 2013). It is important to consider these examples, as it is possible that they could have been averted had operators been committed to a safety culture. The Bethlehem crash, for example, may have had fewer fatalities had there been the regulated number of passengers. An organisation that operated within a framework of safety culture would not have allowed the bus to have been overloaded.

It was found that school bus accidents occurred most frequently on weekday mornings and afternoons, which accounts for the majority of driving exposure as busses travel to and from school as well as work. Furthermore, drivers of other vehicles were more likely to have caused the accident than the bus driver (Yang, et al., 2009). Af Wahlberg (2004) investigated a bus company in Sweden and conducted a series of city bus studies. It was found that many accidents occurred at intersections and bus stops. A study by Tseng (2012) on Taiwanese bus drivers found that carelessness while turning or impacting other vehicles was the highest cause of accidents (71.0%). 'Didn't concentrate while driving straight' (9.7%) and 'didn't keep a safety distance' (4.8%) were the second and third highest causes of accidents. Another interesting finding of the study is the relationship between the number of kilometres driven per year and accident rates. 4.3 percent of drivers who drove more than 60 000 kilometres per year were involved in an 'at fault' accident, an accident that was directly caused by them. This was followed by 2.4 percent of all drivers who drove less than 30 000 kilometres being involved in at fault accidents. Drivers who drove between 30 000 – 60 000 kilometres per year had the lowest reported level of at fault accidents with only 1.7 percent being involved (Tseng, 2012). This seems to indicate that there is an optimal amount of time for bus drivers to work: too many kilometres per year and they may suffer

from burnout and fatigue; and they may suffer from complacency. This U-shaped phenomenon also occurred when considering drivers' experience. It was found that drivers with 6 to 14 years' bus driving experience possessed a relatively low accident risk, whilst there was a significantly higher number of accidents for drivers with less than three years' experience and those with more than 15 years' of experience.

2.2. Safety Culture

2.2.1. Origins of safety culture.

Pidgeon and O'Leary (1994) define safety culture as 'the set of beliefs, norms, attitudes, roles and social and technical practices within an organisation which are concerned with minimising the exposure of individuals both within and outside an organisation to conditions which are considered to be dangerous' (pg.32). Zhang et al. (2002) describes safety culture as;

'The enduring value and priority placed on worker and public safety by everyone in every group at every level of an organization. It refers to the extent to which individuals and groups will commit to personal responsibility for safety; act to preserve, enhance and communicate safety concerns; strive to actively learn, adapt and modify (both individual and organizational) behaviour based on lessons learned from mistakes; and be rewarded in a manner consistent with these values.' (Zhang et al., 2002, p. 1406).

The term 'safety culture' can be traced back to the nuclear accident at Chernobyl in 1986 (Mearns & Flin, 1999). In April 1986, two explosions blew off the concrete cap sealing the Chernobyl-4 reactor, allowing molten core fragments to be released into the vicinity and nuclear products into the atmosphere (Zhang et al., 2002). A "poor safety culture" was identified as a factor contributing to the Chernobyl disaster by the International Atomic Energy Agency. Since then safety culture has been discussed in other major accident enquiries and analyses of safety failures, such as the King's Cross underground fire in London and the Piper Alpha oil platform explosion in the North Sea (Zhang et al., 2002).

The concept of safety culture developed and has been researched in two major fields; aviation safety and in the medical field. Today, almost every accident is followed by

questions centering on 'Whose fault?' and 'What damages, compensation?' (Dekker S. W., 2009). Accidents are increasingly being seen as the result of people not doing their jobs properly, and the possibility of punishing them for their actions is no longer remote (Dekker S. W., 2009). In 2006 a nurse from Wisconsin was charged with criminal 'neglect of a patient causing great bodily harm' in the medication death of a 16- year-old girl during labour. Instead of giving the intended penicillin intravenously, the nurse accidentally administered a bag of epidural analgesia. She lost her job, faced action on her nursing license and the threat of six years in jail as well as a 25,000 Dollar fine (Dekker S. W., 2009). Her situation is similar to that of three nurses in Denver in 1998, who administered benzathine penicillin intravenously, causing the death of a neonate. The nurses were charged with criminally negligent homicide and faced 5 years in jail (Cook, Render, & Woods, 2000).

2.2.2. Safety culture in other transport sectors.

Due to their nature, aircraft accidents will almost always be disastrous. These accidents led to a political, social and commercial awareness that safety in aviation has to be taken seriously (Nævestad & Bjørnskau, 2012). The aviation industry is considered to have a very high organisational safety culture level because of its well-functioning incident reporting systems, positive attitudes to safety among personnel, clear standards, rigorous requirements, and systematic safety management systems (Reason, Managing the Risks of Organisational Accidents, 1997).

In a 1996 ValuJet accident, mechanics loaded oxygen generators into the cargo hold of a DC-9 airliner which caught fire during the flight. The editor of Aviation Week and Space Technology strongly believed the failure of SabreTech employees to put caps on oxygen generators constituted wilful negligence that led to the killing of 110 passengers and crew (Dekker S. W., 2009).

The notion of safety culture has also been used in the railway industry, and has led to railway accident/incident investigations becoming the norm (Blewetta et al., 2012). The concept of safety culture has only recently been applied in studies of professional drivers in road transport (Commercial Truck and Bus Safety Synthesis Program (CTBSSP) Transportation Research Board, 2005). Research indicates that professional drivers take more risks in road traffic than non-professional drivers (Nævestad & Bjørnskau, 2012).

This is due to their own belief in their driving skills as well as an increased level of speeding and using cell phones whilst driving (Nævestad & Bjornskau, 2012). Bjornskau and Longva (2009) compared safety culture and safety levels in different transport sectors. They found that aviation pilots achieved the highest score on the Safety Culture index they used in their study, followed by rail drivers. Bus drivers showed the poorest safety culture in their study, and the authors suggested that these results reflected the different external conditions of the different transport modes (Bjornskau & Longva, 2009, as cited by Nævestad & Bjornskau, 2012).

Many industries, such as the construction, transport, and mining, are showing an increasing interest in the concept of 'safety culture' as a way of reducing the potential for large-scale disasters and accidents associated with routine tasks (Cooper, 2000). Organisational culture refers to the beliefs and values of an organisation. These define how individuals should work within the organisation (Quratulain, Khan, & Peretti, 2012). Safety culture may be seen as part of an organisational culture, where the organisation's beliefs and values are specifically orientated towards health and safety (Clarke, 1999).

This research focuses on selected components of safety culture. These include behaviours, attitudes, beliefs, values, and norms. Behaviour is an important component as it is the simplest way to see if a safety culture is being adhered to (Cooper, 2000). If employees are behaving in unsafe ways, the organisation cannot consider itself as a following safety culture. In the context of bus drivers, this behaviour is very important to consider. This is because the organisation may be asking the drivers to behave in a certain way, such as following defensive driving procedures, and consider this as a safety procedure. However, if the drivers do not behave in a defensive way, safety standards will not have been met. Attitudes and beliefs are just as important as behaviours (Cooper, 2000). If employees of an organisation at any level do not believe in the importance of safety culture and therefore do not perceive it necessary to act towards the implementation and following of procedures, it will be impossible to create an organisational safety culture (Neal & Griffin, 2004). An example may be an organisation that wishes to have a safety culture, yet needs to cut costs. Managers may believe that the most important factor is to save money and therefore may not follow safety procedures as strictly as possible. Finally, norms should be considered as

they are the best way to implement behaviour, belief, and attitudes (Pidgeon N. , 1998). A norm is a group-held belief about how members should behave in a given context (Pidgeon N. , 1998). Therefore, even if an individual does not perceive safety culture as important in the organisation, they may still practice it within the organisation. Organisations should strive for safety culture to become the norm. The organisation will not have to actively try and implement safety culture, but rather rely on employees to practice safety culture themselves.

It is recognised that safety culture is important in various organisational settings, including hazardous industries. The concept of safety culture is being applied to an increasing range of sectors and industries (Dekker S. W., 2009). In the last few years, research into traffic safety has started to study the role that traffic safety culture may play in explaining and reducing risks in road transport (Nævestad & Bjornskau, 2012).

2.2.3. Swiss Cheese Model of accidents.

The 'Swiss Cheese Model' is a framework for communicating the interactions that occur when a complex system suffers a breakdown (Reason, Hollnagel, & Paries, 2006). In particular, it conveys the fact that no single failure, human or technical, is sufficient to cause an accident (Reason et al., 2006). Rather, it involves the unlikely and often unforeseeable combination of several contributing factors arising from different levels of the system (Reason et al., 2006). The defences, portrayed as cheese slices, are shown as intervening between the local hazards and potential losses, each slice of cheese represents one layer of defence (Reason, 1998). Ideally, all of these layers would be intact. However, each layer has holes or gaps (Reason, 1998). These gaps are created by active failures. The errors and violations of those at the human-system interface and by latent conditions arising from the failure of designers, builders, managers and maintainers to anticipate all possible scenarios (Reason et al., 2006). The holes due to active failures are likely to be relatively short-lived, while those arising from latent conditions may lie dormant for many years until they are revealed by regulators, internal audits or by incidents and accidents (Reason, 1998). It is also important to realise that, unlike the holes in Swiss cheese slices, these defensive gaps are not static. They are in continuous flux, moving around and opening and shutting according to circumstances (Reason, 1998). This metaphor makes it clear why organisational accidents

are rare events. For such a failure to occur, it requires a lining up of the holes to permit a brief trajectory of accident opportunity (Reason, 1998). Figure 1.2 illustrates the concept of the Swiss Cheese Model.

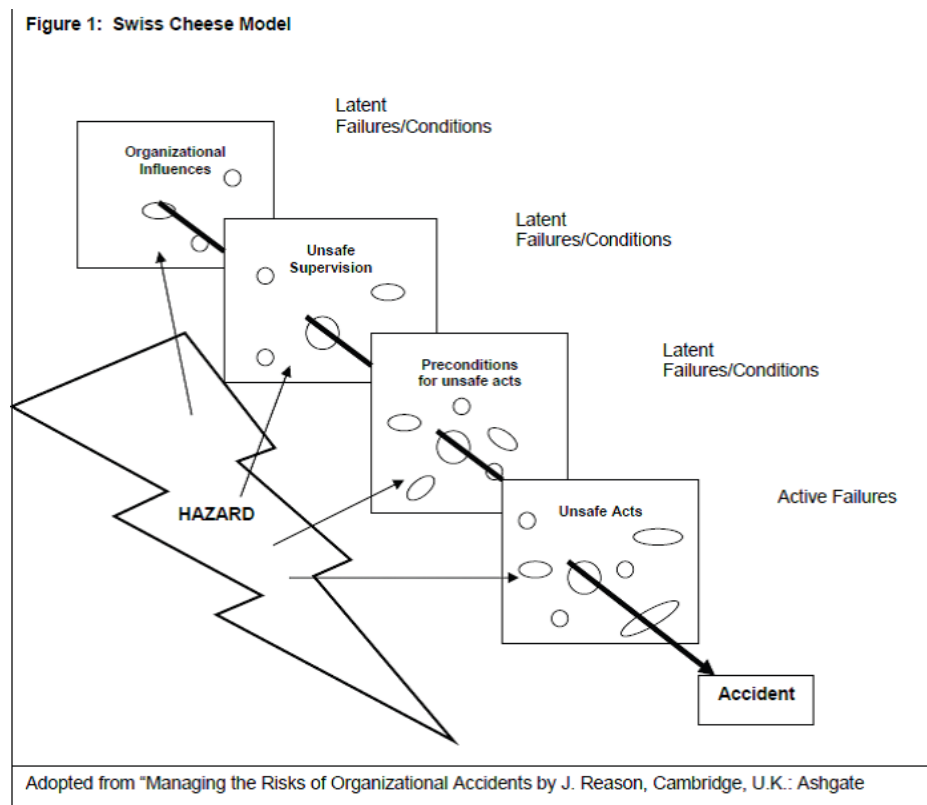


Figure 1.2: Swiss Cheese Model (SeaBright Insurance Company, 2012)

This model is used to understand a traditional 'close encounter' industry, such as mining or construction, where dangers are evident in normal working conditions. Even where a poor safety culture has led to the provision of inadequate tools, equipment and protective measures, most workers are wary of the all too apparent local hazards (Reason, 1998). This self-protecting vigilance lapses once in a while and accidents happen, but the dangers are unlikely to be disregarded for very long (Reason, 1997).

There are at least three ways in which a poor safety culture can undermine a system's protection, and all of these influences stem from a failure to understand the full range of operational hazards (Reason, 1998). First, a poor safety culture is likely to increase the number of defensive weaknesses due to active failures (Reason, 1998). Front-line errors are

more likely in organisations that are insufficiently concerned about the working conditions known to promote the slips, lapses and mistakes of both teams and individuals. These include factors such as inadequate training, poor communication, bad procedures and problems with the design of the man-machine interface (Reason, 1998). But, a poor safety culture will encourage an atmosphere of non-compliance to safe operating practices (Reason, 1997). Violations are likely to be most common in organisations where the unspoken attitudes and beliefs mean that production and commercial goals are seen to outweigh those relating to safety (Reason, 1998).

Second, an inability to appreciate the full extent of the operational dangers can lead to the creation of more longer-lasting holes in the defences (Reason, 1998). These may arise as latent conditions during maintenance, testing and calibration, or through the provision of inadequate equipment, or by downgrading the importance of training in handling emergencies (Reason et al., 2006). Finally the most problematic and far-reaching effects of a poor safety culture will be evident in an unwillingness to deal proactively with known deficiencies in the defences (Reason, 1998). This means that defensive gaps will be worked around and allowed to continue as they are.

2.2.4. Systems Theory Model of Accidents.

The Systems Theory Model of Accidents argues that accidents arise from interactions amongst different elements in the system. In this case the system consists of elements such as bus drivers, the busses, and the traffic conditions in the environment, organisational safety measures, other drivers and pedestrians (Leveson, 2004). Accidents do not occur only due to chains of events or linear causality, but due to more complex causal connections (Leveson, 2004). This is similar to Reason's Swiss Cheese Model as accidents cannot be explained by simple linear processes but rather occur due the combination of many smaller circumstances. Complex systems are systems that consist of various parts that are interdependent on one another (Salmon, McClure, & Stanton, 2012). Within a complex system, unexpected interactions exist between certain components of the system (Salmon et al., 2012). These interactions were not anticipated and therefore there is no guiding principle for how the interactions will develop (Salmon, McClure, & Stanton, 2012).

Systems theory studies error within the system's operation or organisation in order to see what caused an accident to occur (Leveson, 2004). According to systems theory, the chances of an accident occurring is low under normal circumstances (Leveson, 2004). Therefore, rather than seeing the surrounding environment as being filled with risk and human beings as being bound to make errors, this theory argues that system safety presumes harmony, that is, a stable situation exists between individuals and their work environment (Shamu, 2014).

Systems theory argues that safety can be seen as an 'emergent property' that occurs when components of a particular system interact with each other within a large environment (Larsson, Dekker, & Tingvall, 2010). According to Larsson et al. (2010) safety as an emergent property is an important aspect within the systems theory as it takes place when the interaction of independent parts stops and parts start to influence each other. The relationship that exists between the components of a system determines the properties as well as behaviours of the system rather than the nature of the components (Larsson, Dekker, & Tingvall, 2010). Systems theory studies an interaction between three elements namely driver, vehicle, and road infrastructure (Larsson, Dekker, & Tingvall, 2010). It argues that road accidents result from a failure of the whole traffic system rather than just a failure of the driver.

Salmon, McClure, and Stanton (2012) view the 'systems approach' to safety in more complex socio-technical systems due to the fact that safety is a developing property that occurs as a result of non-related interactions between multiple components across complex socio-technical systems. Leveson (2004) states that the systems model takes into account the complete socio-technical system, arguing that the full system should be taken as a whole by considering all the features that relate to both the social and technical aspects. Parts of a system must not be observed in isolation from one another, but instead as parts that are related to one another in a broader context in which they influence each other (Shamu, 2014). Safety can be seen as an emergent property of systems that arises from the interaction of system components and safety can be determined by the relationship

between the components and the context as a whole (Leveson, 2004). Therefore, it is not possible to assess the safety of a single system component in isolation, as a component that is safe in one system may not be used in another (Leveson, 2004). Treating safety as an emergent property that occurs when the systems components interact within a certain environment has led to the development of an accident model that views accidents as a control problem (Leveson, 2004). This model argues that accidents occur when component failures, external disturbances and/or dysfunctional interactions among system components are not satisfactorily handled by the control system. It is argued that certain safety constraints are introduced in order to control emergent properties, and these constraints are related to the behaviour of the system components (Leveson, 2004). Accidents then result from interactions among components that violate these safety constraints; therefore, a lack of appropriate control actions to enforce safety constraints on the interactions results in an accident (Leveson, 2004).

Safety culture is an important concept in this research. It has been shown that road safety in South Africa is a major cause for concern. This arises partly from unsafe road habits being tolerated in the past (Road Traffic Management Corporation, 2011). To improve safety on South African roads, one solution may be to focus on the safety culture of transport organisations, and in this research specifically on bus transport. Safety culture influences the ways in which safety is managed in the workplace, and often reflects the attitudes, beliefs, perceptions and values that employees share in relation to safety (Cox & Cox, 1991). Therefore, an organisation that is committed to operating within the framework of a safety culture will encourage employees to perform their duties in a safe manner, within the established operating procedure. It is important that the entire organisation embraces the concept of safety culture. It is therefore vital that the way in which senior managers instruct, reward, allocate their attention and behave when under pressure is taken into consideration (Clarke, 1999). Perceptions of senior managers' attitudes and behaviours in relation to the safety and well-being of the workforce, therefore, will form the basis for the safety behaviour of workers (Clarke, 1999). Furthermore, as accidents cannot always be avoided, these organisations would also embrace the concept of a just culture. This concept is explored later.

The related concept of safety climate represents employees' shared beliefs about how safety behaviours are rewarded and supported (Clarke, 1999). Neal and Griffin (2004) have proposed a model linking safety climate to safety outcomes. They suggest that safety climate, as well as other organisational variables, combine with an individual employee's characteristics, and affect the employee's safety knowledge and safety motivation (Neal & Griffin, 2004). The employee's knowledge and motivation then leads to safety performance, which is how safely a work task is performed, as well as following safety procedures correctly. A poor prevalence of safety performance relates to high levels of accidents and injuries (Neal & Griffin, 2004).

Basic assumptions also play a role in how safety culture is perceived (Guldenmund, 2000). Basic assumptions are the implicit assumptions that guide behaviour and guide an individual's perceptions and feelings about situations. This means that the assumptions of one individual in a culture will be very similar to someone else within the culture. Therefore if bus drivers are of the same culture, it can be assumed that they will perceive safety culture in the same fashion. If an employee considers written rules and procedures as futile, safety rules will also be perceived as futile (Guldenmund, 2000), because the employee has a negative attitude towards the rules and procedures that the organisation has in place and will tend to have a negative attitude towards what the organisation has implemented regarding safety. This is an important consideration because even if an organisation is attempting to create a culture of safety, they may not be able to achieve this due to preconceived notions and attitudes that the employees hold towards their particular organisation.

Harvey, Erdos, Bolam, Cox, and Gregory (2002) (p.19) state that "safety culture is viewed as involving perceptions and attitudes, as well as the behaviour of individuals, within an organisation". Therefore, it can be concluded that individuals are responsible for their own safety, as well as maintaining an important role in the safety of others through their influence on other members of an organisation (Short, Boyle, Shackelford, Inderbitzen, & Bergoffen, 2007).

The image of the truck driver is linked to images of the 'open road' and 'independence' (Short et al., 2007). Truck drivers do have a high level of responsibility. They are;

“responsible for safety, on-time delivery, customer relations, equipment breakdowns, and insurance rates, all of which have bottom-line consequences for motor carriers” (Short et al., 2002, p.11).

Safety is listed first in the previous quote, but many factors lead to the actual prioritisation of safety among a driver’s responsibilities. The same can be said for bus drivers. Whilst safety may be stated as the first priority, there are many other pressures that drivers are exposed to and need to make decisions about, such as timing, efficiency, economic effectiveness and passenger demands. When confronted with the decision of whether to go through an orange traffic light and complete the route on time or stop at the light and get caught in traffic, the driver may face a dilemma. Either s/he can take the safe option, considering values instilled by a safety culture, and stop at the orange light, avoiding a potential incident, or s/he decides to go through the orange light due to pressures such as time demands placed by external forces and create the possibility of an incident occurring.

2.3. Just culture

Just culture is considered to be one of the five elements of safety culture by Reason (1998). The other elements include: an informed culture; a reporting culture; a learning culture; and a flexible culture. In a just culture errors and unsafe acts should not be punished if the error was inadvertent. However, those who act recklessly or take deliberate and unjustifiable risks would still be held accountable and face potential disciplinary action (Golda, 2013). A just culture is concerned with the sustainability of learning from failure through the reporting of errors, adverse events, and incidents (Dekker, 2009). If operators perceive that their reports are treated unfairly or lead to negative consequences, their willingness to report will decline (Dekker S. W., 2009). Ruitenberg (2002) reported a 50% drop in incident reports after the prosecution of air traffic controllers involved in a near-miss. Reason (1997) describes a just culture as a climate of trust in which people are encouraged (even rewarded) for providing essential safety-related information, but in which they are also clear about where the line must be drawn between acceptable and unacceptable behaviour. A just culture refers to a way of safety thinking that promotes an attitude of questioning, is resistant to complacency, committed to excellence, and allows for both personal accountability and corporate self-regulation in safety matters (GAIN Working Group E, 2004). Personal attitudes and

corporate culture can create an environment for unsafe acts and conditions that have the potential to become accidents or incidents; therefore it is important not only to identify safety issues, but also to respond appropriately (GAIN Working Group E, 2004).

A just culture uses an incident or accident as an opportunity to learn rather than punish the individuals 'responsible' for the incident or accident (Reason, 1997). The first goal of any organisation should be to improve safety and production. Any event that relates to safety, especially human or organisational errors, must be considered as an opportunity to improve operations through feedback and the lessons learnt (GAIN Working Group E, 2004).

Incidents and accidents are considered by organisations with a strong safety culture as lessons that can be used to avoid more serious accidents or incidents in the future (GAIN Working Group E, 2004). It is important that all incidents and accidents that have the potential to be instructive are reported and investigated to discover the root causes. Timely feedback should then be given and remedial actions, where appropriate, taken. This should happen for the parties involved in the incident, as well as other members of the organisation who could potentially experience the same problem (GAIN Working Group E, 2004).

A just culture cannot happen easily and without effort (Reason 1998). Whilst an organisation can attempt to implement a just culture there, must be acceptance at all levels of the organisation in order for it to be effective. Trust is therefore essential in the effective implementation of this concept (Dekker, 2009). There are certain difficulties in practicing just culture. Safety incidents often include an element of litigation, in the form of insurance claims or attempted criminal prosecutions (Dekker, 2009). This creates a culture of 'blame' in which the incident must be someone's fault - the very concept that just culture is trying to address and move away from. Just culture is included in this research as it is crucial to understand how bus drivers perceive the culture of their organisation, the extent to which they believe it is a just culture and how it relates to safety culture. The issue of just culture is important in this research, because just culture offers a potential approach to operating within a safety culture. A just culture could create an environment where bus drivers feel more comfortable reporting incidents due to the reframing of accountability and the emphasis on learning from the incident rather than blaming the driver.

2.4. Organisational justice

In line with a systems approach, the current research explores bus drivers' perceptions of organisational justice. It is noted that the meaning of the term 'justice' in this context differs from the meaning of 'just' in 'just culture.' In this section, justice cannot simply be understood as the lack of injustice in a situation. It is deeply rooted in human nature and is a complex concept. Understandings of justice differ across cultures as cultures are usually dependent on a shared history (Minkov & Hofstede, 2011). Each culture creates values which influence notions of justice. Whilst there may be some justice principles that are similar between most cultures, there is no universally accepted and recognised notion of justice (Quratulain, Khan, & Peretti, 2012). However, for this research, justice can be understood as the upholding of what is just, especially fair treatment and due reward in accordance with honour, standards, or law (Houghton Mifflin Company, 2009).

Organisational justice is the perception of fairness and reactions to these perceptions in the organisational context (Greenberg, 1987).

The concept of organisational justice was introduced by Greenberg (1987) who stated that organisational justice relates to how an employee judges the behaviour of the organisation and the resulting attitudes and behaviours that arise from this. Individuals react to decisions made by their organisations every day. Whether an individual perceives these decisions as fair or unfair will influence the individual's perceptions towards the organisation. Fairness is of central interest to the organisation as the implications of perceptions of injustice can impact the effectiveness of employees (Tabibnia, Satpute, & Lieberman, 2008). Justice in organisations can include, for example, issues related to perceptions of fair pay, equal opportunities for promotion, and personnel selection procedures. Furthermore, organisational justice research, which focuses on the role of fairness in the workplace, has demonstrated that the perception of fairness is associated with a variety of individual work attitudes, such as satisfaction and commitment, and individual behaviours, such as absenteeism and citizenship behaviour (Kang, 2007). Additionally, it has been found that negative perceptions of fairness (in particular with bus drivers) led to absenteeism, high turnover rates and an increase in accidents (Tse, Flin, & Mearns, 2006).

The concept of organisational justice grew out of equity theory (Adams, 1963), which states that judgements of equity and inequity are derived by comparing one's own and others' inputs and outcomes. Inputs are what a person perceives they have contributed, such as effort or skills, whilst outcomes are what an individual perceives they have received out of the exchange relationship, such as remuneration or recognition (Adams, 1963). An individual's point of comparison may be internal, where they are compared to one's self from an earlier experience, or external, comparing one's self to colleagues or people in other organisations. If the individual perceives the comparison to be inequitable, a discrepancy occurs and the individual perceives the interaction to be unjust. There are three main components of organisational justice: distributive, procedural and interactional justice.

2.4.1. Distributive justice.

Distributive justice is related to the perceived fairness of certain outcomes (Cohen-Charash & Spector, 2001). Distributive justice has been found to affect individuals' perceptions of fairness with regards to satisfaction (Gilliland, 1993), commitment (Elkins, Phillips, & Bozeman, 1999), promotions, and pay raises (Tang & Sarsfield-Baldwin, 1996 as cited in McMillan-Capehart, 2005). Distributive justice deals with the perceived fairness of outcomes such as pay and recognition, where recognition may manifest itself in decision or actions such as employee promotions in the organisation (Shah, 2011). With regards to bus drivers, distributive justice may refer to the allocation of shift hours per month, as well as when these shifts occur (Tse et al., 2006). Furthermore, the idea of pay equity as a facet of distributive justice cannot be ignored in the South African context. Strikes are a common occurrence that often evolve out of dissatisfaction with pay structures and salaries (Bendix, 2010). The idea of recognition for bus drivers would align well with the concept of a just culture, rewarding drivers who embrace the concept and feel comfortable reporting incidents.

2.4.2 Procedural justice.

Nowakowski and Conlon (2005) define procedural justice as the fairness of the process that is used to arrive at decisions. Control or influence over the decision-making process plays an important role in creating high levels of procedural justice (Thibaut and Walker, 1975; Esterhuizen & Martins, 2008). Fischer and Smith (2006) reported that greater perceived

justice of organisational procedures is associated with higher satisfaction, greater commitment to the organisation and more extra-role behaviour. According to Leventhal's (1980) conceptualisation, there are six rules which, when followed, yield procedures that are considered to be fairer than otherwise would have been the case:

- The consistency rule – the allocation procedures should be consistent across persons and over time.

In the case of drivers this is related to standard operating procedure. The drivers should all be equally regarded in terms of how resources are allocated, such as shift times and bus usage. Over time a norm should be created.

- The bias-suppression rule – personal self-interests of decision-makers should be prevented from operating during the allocation process.

In this case, the management should not allow personal agendas and feelings to affect allocations within the organisation and decision making. For example when coming up with shift times and schedules, the decision maker should not give one driver a favourable schedule which allows for more free time than other drivers due to the fact that they may be related.

- The accuracy rule - refers to the goodness of the information used in the allocation process.
- The correctability rule – deals with the existence of procedures to change unfair decisions.

This rule allows for procedures that can change unfair decisions. For example if a complaint is made against a driver, which causes the driver to be issued with a written warning straight away, procedures should be in place that the driver can follow that allows for the challenging of this decision. If it was found that issuing the driver with a written warning straight away was not fair as there should be some form of discussion initially then the decision should be overturned.

- The representativeness rule – the needs, values and outlooks of all the parties affected by the allocation process should be represented in the process.

This rule requires that when a decision is made the interests of all the stakeholders are taken into account. For example if there is a decision to change the start of shift times from 6 AM to 5AM, the needs of the bus drivers ought to be taken into

account. If the drivers are not willing for such a decision to be agreed upon it would not be right for the decision makers to put this decision into action.

- The ethicality rule – the allocation process must be compatible with the moral and ethical values of the employee or person perceiving the procedures.

This requires that process aligns with the drivers' values. For example, if a certain driver is Muslim, it would be unethical to force the driver to work a midday Friday shift if that driver wished to go to Mosque. There should be an allowance for driver's values and a distribution of processes that takes all the drivers values into consideration.

Organisational procedures represent the way the organisation allocates resources (Cohen-Charash & Spector, 2001). When a process leading to a certain outcome is perceived to be unfair, the person's reactions are predicted to be directed at the whole organisation, rather than at their tasks or the specific outcome (Cohen-Charash & Spector, 2001). Bus drivers may consider procedural justice in its most basic form. When decisions are made that affect them, are they part of that decision process? For example, if shift hours were to change, have the bus drivers' views been taken into consideration and have they been part of the decision-making process?

2.4.3. Interactional justice.

Interactional justice refers to the human factors of organisational practices. The way people in charge of controlling rewards and resources behave towards the individuals who are on the receiving end of the justice (Cohen-Charash & Spector, 2001). Interactional justice relates to aspects of the communication process (Cohen-Charash & Spector, 2001). This form of justice focuses more on the behaviour of the decision makers than on the structural aspects of procedures or the specific outcomes (Nowakowski & Conlon, 2005).

Furthermore interactional justice can be broken down into two separate forms of justice; interpersonal and informational justice. Interpersonal justice refers to the sensitivity, politeness and respect people receive from their superiors during procedures (Esterhuizen & Martins, 2008). Informational justice refers to the explanation, justification or information provided by decision makers as to why outcomes or resources were dispersed in a certain way (Bies & Moag, 1986). Interpersonal justice serves to alter reactions to outcomes

because the manner in which people are referred to can make people feel better even if the outcome is unfavourable to them (Colquitt, Conlon, Wesson, Porter, & Ng, 2001).

Informational justice is perceived positively when information is comprehensive, reasonable, truthful, and timely, as this information helps people evaluate the structural aspects of the process (Colquitt et al., 2001). An example of interactional justice that is related to drivers is the way in which the organisation communicates with them. A common complaint concerns not knowing what is 'going on' in the organisation (Tse et al., 2006). This is often due to a lack of communication between higher and lower ranking employees. A simple way to improve perceptions of interactional justice would be to create clear and effective channels of communication throughout the organisation. For example, a driver should be able to have a clear communication path, and understand how to use it, between him/herself and upper management in order to get a message heard. This does not mean that a driver necessarily can go directly to a director in the company and speak to them. There should, however, be a clear and simple process for the drivers to communicate. This may mean that the driver speaks to the shift supervisor, who in turn is able to escalate it.

Three different models have been suggested to explain the structure of organisational justice perceptions, including a two-factor model (Bies & Moag, 1986), a three-factor model (DeConinck, 2010), and a four-factor model (Colquitt, 2001). Many researchers have studied organisational justice in terms of the three-factor model, distributive, procedural, and interactional justice (DeConinck, 2010; Liljegren & Ekberg, 2010). Others such as Sweeny and McFarlin (1993) and Greenberg (1990) have used the two-factor model, in which interpersonal justice fits under the scope of procedural justice. Researchers such as Colquitt (2001) suggest that a four-factor model is appropriate, where interactional justice is broken into interpersonal and informational justice. Bies and Moag (1986) argued that interactional justice is distinct from procedural justice. This is because it represents the social exchange component of the interaction and how the individual is treated rather than just representing the processes that were used arriving at a decision, as procedural justice does. This research makes use of the three-factor model, accepting the distinction between interpersonal and informational justice.

2.4.4. Implications of organisational justice.

Justice perceptions are considered to be influenced firstly by the outcomes one receives from the organisation; secondly by organisational practices (procedures and quality of interactions); and finally by characteristics of the perceiver, such as age, gender, race, and tenure and personality traits such as negative affectivity and self-esteem (Cohen-Charash & Spector, 2001). Perceived procedural and interactional justice violations are evident in the reported lack of trust between management and employees, as well as ineffective conflict management procedures (Esterhuizen & Martins, 2008).

Studies have shown that greater perceived procedural justice was associated with higher satisfaction, greater commitment to the organisation and more extra-role behaviour (Fischer & Smith, 2006). This is important as a study by Hackett et al. (1994) showed that high organisational commitment levels were related to fewer accidents for bus drivers. Medically the experience of lower levels of justice has been found to be associated with an increased risk of psychological distress, sickness absence and coronary heart disease as well as lower physical and psychological wellbeing (Elovainio et al., 2010), higher self-reported morbidity, higher medically certified absence, increased mental health problems, and greater likelihood of maladaptive coping (Kivimaki et al., 2004). When employees perceive things as unfair, they'll tend to show rejection and resistance (Esterhuizen & Martins, 2008). Perceived injustice is followed by moral outrage which may lead to anger and resentment towards the organisation (Esterhuizen & Martins, 2008). This can manifest itself through the behaviour of the drivers such as unsafe practices, showing late for shifts, not completing job tasks satisfactorily or purposely not listening to and completing directives from management. Furthermore, research has shown that perceived violations of organisational justice lower employees' job satisfaction, organisational commitment and trust in authority (Colquitt et al., 2001). A number of negative behaviours such as staff turnover, absenteeism, and insubordination may also occur (Esterhuizen & Martins, 2008). Finally in terms of the organisation, performance has been found to be negatively affected by perceived procedural injustice (Colquitt et al., 2001).

Findings show that the demographic characteristics of the employee generally play a minor role in justice perceptions. Therefore, regardless of age, gender, race, education level, and

tenure, people tend to perceive justice similarly (Cohen-Charash & Spector, 2001). However, considering South Africa's history, it is not clear if this applies in the South African context.

Organisational justice is important to individuals as it provides them with information about their standing within the group, as well as their relationship with authorities (Fischer and Smith, 2006). Results from field studies show that work performance is strongly related to procedural justice, but does not relate to distributive and interactional justice as strongly (Cohen-Charash & Spector, 2001). This contradicts most theories regarding the relationship between distributive justice and performance, which has been considered to be linked (Lind & Tyler, 1988). It is possible that when outcomes are perceived to have been distributed unfairly, people examine the procedure, and only if it is perceived as being unfair, do they withhold performance as a "legitimate" means of restoring equity (Cohen-Charash & Spector, 2001). In view of this, organisational justice perceptions by the drivers may lead to poor work performance (in the opinion of supervisors and passengers) such as running late for certain pickups, not following the correct route set out, or having a poor interactional relationship with passengers.

Cohen-Charash and Spector (2001) report a large difference between laboratory and field studies outcomes when dealing with work performance and organisational justice. Field studies show a strong relationship between procedural justice and performance, where laboratory studies show a weak relationship between the two, and no relationship between distributive justice and performance (Cohen-Charash & Spector, 2001). It could be that the relationship shown in the field study is stronger as performance may be influenced by situational demands present in the field whilst they may not be a factor that has been considered in the laboratory. It is therefore important to consider what the bus drivers may experience everyday situations and ask them about real experiences rather than giving them scenarios and asking them how they would react to these.

All safety-critical work is ultimately channelled through relationships between human beings (e.g., in medicine), or through direct contact of people with risky technology (e.g., bus drivers). There is almost always a discretionary space into which no system improvement can completely reach (Dekker & Laursen, 2007). This is in part a space in the almost literal sense of 'room for manoeuvring' that operators enjoy while executing their

work relatively unsupervised such as the bus drivers experience whilst driving their routes (Dekker S. W., 2009). An organisation must deliberate on how it will motivate people to carry out their duties conscientiously and inside the discretionary space (Dekker S. W., 2009). There is evidence that empowering people to affect their work conditions and to involve them in the outlines and content of that discretionary space most actively promotes their willingness to shoulder their responsibilities inside of it (Dekker & Laursen, 2007).

An example of this is illustrated by an anecdote reported by Morreim (2004) during surgery. An anaesthetist reached into a drawer that contained two vials that were side by side, both with yellow labels and yellow caps. One, however, contained a paralytic agent, the other a reversal agent for when paralysis was no longer needed. At the beginning of the procedure, the anaesthetist administered the paralyzing agent. But toward the end, he took the wrong vial, administering additional paralytic instead of its reversal agent. There was no negative outcome in this case. But when he discussed the event with his colleagues, he found that this had happened to them too, and that they were all quite aware of the potential risks. Yet none had spoken out about it, which could raise questions about the empowerment anaesthetists may have felt to influence their work conditions or discretionary space. Bus drivers could experience a similar situation. For example, whilst breaking the speed limit would be considered an incident and should be reported, there may have been a reason for why the speed limit was broken. The driver operates in this discretionary area in order to perform his job effectively and efficiently. If every technical incident was reported by the drivers they may face losing their discretionary decision making through punitive action by decision makers/prosecutors in the organisation.

2.5. Research aims and questions

The overall aim of the study is to identify bus drivers' perceptions of safety incidents and their relation to organisational justice in their company. Specific research questions are:

1. How does the organisation define safety incidents and accidents?
2. Based on the organisation's policies and procedures, what emphasis is placed on safety and developing a safety culture?

3. What safety incidents have been reported at the relevant depot between 2011 and 2014?
4. How, if at all, has the frequency of safety incidents changed between 2011 and 2014 at the depot concerned?
5. What are bus drivers' perceptions of safety in the company?
6. What are bus drivers' perceptions of organisational justice in the company?
7. Does the perception of organisational justice influence attitudes and behaviours towards safety in the organisation?

The research includes a methods chapter which describes the methodology used in the research, as well as the sample and documents analysed in this study. This is followed by the results section which reports what has been found in the research through the three phases. The discussion section merges the reports from the results section. These results are deliberated and used to answer the research questions. The final chapter is a conclusion to the research which includes limitations to the study as well as future recommendations.

Chapter 3: Methodology

This chapter explains the procedure for the research. The research design is discussed, as well as how the sample was selected and approached. An explanation on the design of the instruments that were used in the study is made. The procedure of the study is explained and the ethical considerations that had to be made for this research are discussed. Finally, how the data was analysed will be explained. The research is presented in three phases. The first phase reviews the relevant company policies in order to understand the specific context of the study. The second phase is an analysis of the depot's safety incidents and incidents over a certain period of time. Here, the number of different types of safety incidents/incidents are examined and are later compared with what the drivers report. Phase three looks specifically at the interviews that take place where contrasts and similarities are drawn together.

3.1. Research design

The design of this research can be classified as exploratory, qualitative, descriptive and interpretive. Vogt (1999, p.105) defined exploration as "a broad ranging, purposive, systematic, pre-arranged undertaking designed to maximize the discovery of generalizations leading to description and understanding of an area."

Qualitative methods are difficult to precisely define, as they are at best a *pot-pourri* of interpretive techniques (Hari Das, 1983). In general, several approaches including, but not limited to; participant observation, case studies, projective techniques, role plays, contrived and unobtrusive observations, one-on-one, and focus group interviews all come under the label of qualitative research (Hari Das, 1983). The task of the researcher is to sensibly describe, and come to an understanding of the meaning of certain phenomena occurring in the social world. Wertz et al. (2011) argue that qualitative research addresses the question of 'what'. To understand something completely, we must be able to conceptualise the matter under discussion as a whole and by its parts, we need to know how these work together as well as independently (Wertz et al., 2011).

According to Neuman (2000, as cited in Lipshitz, 2012), the main aim of exploratory research is to attain new insight into an existing area of research. Exploratory research is conducted

to investigate an issue or topic in order to develop insight and ideas about its underlying nature (McNabb, 2010). Exploratory research is also conducted in order to gain insight into a fairly unfamiliar territory or new phenomenon (McNabb, 2010).

Descriptive research serves the purpose of describing phenomena and does not intend to explain, predict or control them (Colman, 2009). Its main purpose is description of the state of affairs as it exists at present; therefore, it describes the situation as it is and concerns itself with conditions or relationships that exist, opinions that are held and processes that are going on (Colman, 2009). In this study a case study approach was used. A case study is an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident (Yin, 2003). The need for case studies arises from the desire to understand complex social phenomena. The case study method allows researchers to retain the holistic and meaningful characteristics of real-life events (Yin, 2003). This research focuses specifically on one company, which allowed for data to be collected conveniently. Common methods in case study research include interviewing and collection of artefacts and texts (Yin, 2003). This research employed both methods by collecting data through interviews as well as requesting materials used by the employees of the company being studied.

3.2. Sample

3.2.1. Phase 1.

No human sample was necessary for this phase as this part only required a review of documentation. However, the review did focus specifically on one organisation where all phases of the study were conducted. This was a transport company which allowed access to their employees. The company that was approached for the research provides contracted transport services to clients in the corporate and educational sector. Therefore, they do not focus on fare paying passengers. The results that were collected from this study could differ from results collected from a transport company that relied on collecting fare paying passengers. Only one company was approached due to time constraints of the research. The research focused on one specific depot of the company. This depot was selected due to its unique characteristics. There is a limited number of employees working at this depot.

Furthermore, there are specific and consistent inner city routes that are driven. The documents reviewed for phase 1 include:

- The Safety Management Systems Handbook (SMSh)
- The induction training manual of policies and procedures
- Practical drivers' training manual
- The drivers' incentive programme (Appendix E)
- Driver Incentive Key Performance Indicator 16 Jan To 15 Feb 14 (too sensitive to include as an Appendix. This is because names of drivers and reasons for discipline are included in this document)
- The disciplinary procedure and code of conduct document (Appendix F)
- Employment contract (Appendix G)

3.2.2. Phase 2.

This phase analyses the depot's safety incidents over a certain period of time. Here, a number of different types of safety incidents are looked at and contrasted with what the drivers report. The documents that were looked at for this phase of analysis is a report of accident statistics over a period of time.

3.2.3. Phase 3.

The sample used in this study was bus drivers from the transport company as explained previously. In order to obtain background data, two individuals who were in management positions within the organisation were also interviewed. However, they were not considered part of the sample as they are not bus drivers and were not under study in the research.

As there is a limited number of drivers employed at the depot that was used in the study it, was possible to approach all drivers for a potential interview. All participants were employed full-time as professional bus drivers in the participating organisation and are Black males. As only males were part of the sample only male terminology has been used throughout the study. Additional biographical data was not collected due to the sensitive nature of the study and the need to ensure confidentiality and anonymity. Twenty-nine drivers were approached over the interview period. Of the 29 drivers approached 14 consented to an interview (48.27%). The 15 drivers (51.73%) who did not consent to

interviews gave varying reasons as to why they were uncomfortable to consent to an interview. Eight drivers (53.33%) claimed that they were “too busy to talk and had to get back to work”. Five drivers (33.33%) refused an interview without stating any specific reason, mostly stating that they did not want to talk. The remaining two drivers (13.33%) believed that the researcher was a member of press and “refused to speak to the press” even when documentation was provided to prove that the interviews were being used for academic purposes. It was difficult to schedule interviews due to the drivers’ limited free time. Furthermore, there was limited time to complete the research. There was a response rate of 48.28 percent which can be considered acceptable. For this reason 14 responses were considered enough to start considering themes in the data. However, saturation was considered to have been reached as recurrent themes were continually identified.

Non-probability sampling was used in this study. This is because the research focused on a very specific sample; bus drivers from a particular company at one depot. As every attempt was made to interview every driver at the depot, the criteria of random sampling was not met. Due to the location of the depot, convenience sampling was employed. Whilst probability methods are suitable for large-scale studies concerned with representativeness, non-probability approaches are more suitable for in-depth qualitative research in which the focus is often to understand complex social phenomena (Small, 2009). Criticisms of this approach include whether one can understand complex social phenomena by taking only the most convenient expressions of that phenomenon into consideration, and the assumptions about homogeneity that one must make to justify such assertions. However, this approach is appropriate as the research focuses on a specific case and does not attempt to make generalisations and infer causal relationships from the analysis.

3.3. Instruments

3.3.1. Phase 1.

The documents that were reviewed for phase one include:

- The Safety Management Systems Handbook (SMSh)
- The induction training manual of policies and procedures
- Practical drivers’ training manual

- The drivers' incentive programme (Appendix E)
- Driver Incentive Key Performance Indicator 16 Jan to 15 Feb 14
- The disciplinary procedure and code of conduct document (Appendix F)
- Employment contract (Appendix G)

These documents were provided at the request of the researcher and were furnished by the company. All documents were created by the company.

3.3.2. Phase 2.

- Accident Statistic spread sheet (not included as an appendix due to sensitive nature of information included in the document, which cannot be made anonymous without losing the context of the document.)

3.3.3. Phase 3.

The study made use of a self-developed semi-structured interview schedule. This schedule included questions that explored the variables of interest including organisational justice and perceptions of safety. The schedule includes twelve questions (Appendix D) regarding the themes of organisational justice, safety, and equality. The questions regarding justice were adapted from a nine item justice instrument which was part of survey developed by Cheng, Huang, Li, and Hsu (2011). As nine questions were considered too many, some of the questions from the original schedule were deleted and others were adapted so that they formed one question. Questions regarding safety and equality were self-developed. The interview schedule went through numerous revisions to attempt to eradicate any potential for leading questions. Leading questions should be avoided, as they run the risk of altering the validity of the responses obtained and discourage the participants from using their own language to express their sentiments (Seidman, 1998). Where possible, questions were developed and adapted to create an open-ended question. This would allow for potentially wider range of responses from the drivers.

Structured interviews have a rigorous set of questions which does not allow one to divert. A semi-structured interview is open, allowing new ideas to be brought up during the interview as a result of what the interviewee says (Moore, 2014). For this reason, the semi-structured interview method was decided upon. This allowed for more freedom during the interview

process. If a topic of interest emerged during the interview this could be explored and discussed deeper rather than having to follow a rigorous structure of questioning. The development of an interview schedule helped to focus the interview on the topics at hand without being constrained to a particular format. This allowed for the questions to be tailored to the specific situation and context, as well as to the respondent (Seidman, 1998).

Qualitative Interviewing has many advantages. Possibly the greatest advantage of Qualitative Interviewing is the depth of detail that can be obtained. Interviewing participants creates a picture of what happened in a specific event, tells us of a perspective of such event, as well as giving other social cues (Weiss, 1994). Social cues, such as voice, intonation, and body language of the interviewee can give the interviewer extra information that can be added to the verbal answer of the interviewee on a question (Weiss, 1994). This level of detailed description, whether it be verbal or nonverbal, can show an otherwise hidden interrelatedness between emotions, people, and objects, unlike many quantitative methods of research (Moore, 2014). During the interview process, this was evident in the responses of many of the drivers. When questioned about certain subjects, the drivers showed differing ranges of emotions. For example, when speaking about pay levels, there was often an increase in the volume of the answers and hand gestures became more animated. When the drivers were asked about specific safety incidents, they often broke eye contact and looked away, speaking more towards the floor.

There are disadvantages that must be considered when using the Qualitative Interviewing method. First, there can be complications with the planning of interviews. Not only is recruiting people for interviews hard, due to the typically personal nature of the interview, but planning where to meet them and when can be difficult (Seidman, 1998). One of the difficulties experienced is that participants can cancel or change at the last minute. During the actual interview, a possible weakness is missing some information. This can arise from the multitasking that the interviewer must do. Not only do they have to make the respondent feel very comfortable, they also have to keep as much eye contact as possible, write down as much as they can, and think of follow up questions (Weiss, 1994). After the interview, the process of coding begins and with this comes its own set of disadvantages. First, coding can be extremely time consuming. Second, the nature of qualitative research

itself does not lend itself very well to quantitative analysis. Some researchers report more missing data in interview research than survey research. Therefore it can be difficult to compare populations (Weiss, 1994).

There are also certain factors that can bias the interviewer. Prior information can cause the interviewer to have a favourable or unfavourable attitude before meeting an interviewee. The contrast effect refers to how the interviewers evaluate a particular applicant depending on their standards of comparison, that is, the characteristics of the applicants they interviewed previously. Interviewers' prejudices can influence the interviewers' judgement based on their personal likes and dislikes (Ellis, West, Ryan, & DeShon, 2002).

3.4. Procedure

3.4.1. Phase 1 & 2.

In order to receive the necessary documentation meetings were scheduled with two managers. These meetings took place separately. The first meeting was introductory; at this meeting, permission was requested in order to speak to the bus drivers in the organisation. During the second meeting, the required documents of interest were requested. These documents were sent via email at a later stage. These meetings followed an unstructured method and specific questions were prepared. The individuals were asked to explain their experiences regarding the bus drivers and the organisation. Any responses of interest were manually recorded in writing.

3.4.2. Phase 3.

The researcher and a representative from the organisation met in order to discuss the best way to approach the drivers. Initially it was thought that it would be best for the researcher to discuss the research with the drivers at a meeting. However, it was discovered that this would not be possible as the drivers very seldom come together as a group in order to hold meetings. It was then decided that the researcher would be introduced to a representative of the drivers (shop steward) by the company's representative. The research was explained to the representative who agreed to speak to other drivers about participation in the research. The representative was given participant information sheets (Appendix A).

In order to conduct interviews, the researcher approached drivers that were on break between shifts or their routes. The drivers had previously been briefed by their representative and were expecting to be approached. When the researcher approached individual drivers to request their participation, the purpose and nature of the study was explained again. Before the interview, started a participant information sheet (Appendix A) was given to the driver to further explain the research as well as give the driver any contact details if they wished to follow-up with the researcher. Consent was obtained from the driver and an informed consent form (Appendix B) was signed once the driver agreed to participate. Finally the researcher asked if the driver was comfortable for an audio recording device to be used. If the driver was comfortable then consent for audio recording (Appendix C) was signed. Only three individuals consented to an audio recording. The drivers did not feel comfortable being recorded. Another problem with the audio recording was the nature of the environment where the interviews took place. There is background noise where the busses are parked. This made listening to the playback of the recordings very difficult. Due to the combination of drivers being unwilling to be recorded, and the actual quality of the recordings, it was decided to discontinue audio recording the interviews. The responses were recorded manually in writing during the interviews.

All interviews took place in the drivers' busses whilst they were in the bus holding area. No passengers or other people were in the busses during the interviews. This venue was chosen because it provided privacy, did not inconvenience the drivers or interfere with the timing of their 'loops' and the drivers were most comfortable there. Apart from the convenience factor it is suggested that boundaries should be respectfully maintained during the interview process (Seidman, 1998). With the interviews taking place on the busses, the drivers felt more comfortable and willing to share as they were in an environment that they knew. This made it easier to explore the participant's experience rather than probe for information. It is also possible that the participant may become defensive or unwilling to share if too much time is spent dwelling on minute details or if too many follow up questions are asked (Moore, 2014).

The interviews took place on a one-on-one basis. The interviews ranged between fifteen and forty minutes. Whilst initially it was thought that interviews may take up to an hour, the

length of the interviews depended greatly on the drivers' schedule and the answers that were received for the questions. The drivers' schedules also dictated the length of the interviews, as the researcher generally could only use the break between drivers' 'loops', as drivers were not willing to spend time on interviews once they had finished their shift and were ready to go home as this was often very late at night.

It was very difficult to get drivers to talk freely and openly about what could be viewed as sensitive issues for them. This was particularly evident when asking about specific safety incidents. Drivers were visibly unwilling to share their experiences with the researcher in this area. When asking about safety incidents, the researcher started by asking open-ended questions. This was due to the sensitive nature of safety incidents and it was thought that this approach would be less threatening. If a positive response was received, then questions were asked about any specific safety incidents the drivers may have been part of. A second issue was language difficulties. The interviews took place in English as it was the common language between the drivers and the researcher. However, English is generally not the first language for the drivers and there was often difficulty in understanding the question on the part of the drivers, as the initial wording may have been too complex, and the questions needed to be simplified further.

3.5. Ethics

Ethics approval was obtained from the University of the Witwatersrand's Ethics Committee on 5 May 2014 (protocol number MORG/14/008 IH). The following ethical considerations were adhered to; voluntary participation in this study, followed by participants' informed consent. Anonymity could not be guaranteed as the researcher collected responses directly from the participants during the interview process. There were no foreseeable risks or benefits related to participation in this study, although the researcher was aware of the sensitive nature of the data and therefore took steps to ensure confidentiality. Participants were informed that they could withdraw from the interview at any point if they felt uncomfortable.

None of the data received was tampered with in any way. All data that was collected for the research was kept in a secure, password protected database. The data will be destroyed

upon final conclusion of the research. All participants were given the contact details of the researcher. If they wish to know the outcome of the study or have any questions or concerns regarding the study.

3.6. Data analysis

3.6.1. Phases 1 & 2.

There was no specific technique used when analysing these documents. A frequency count was made for the number of accidents that had occurred and were recorded in the accident statistics.

3.6.2. Phase 3.

Thematic content analysis was used to analyse the data. Thematic analysis is a method for identifying, analysing, and reporting patterns within data. Thematic content analysis emphasises pinpointing, examining, and recording patterns (or "themes") within data (Braun & Clarke, 2006). Themes are patterns across data sets that are important to the description of a phenomenon and are associated with a specific research question, and become the categories for analysis (Fereday & Muir-Cochrane, 2006). Thematic analysis is performed through six stages of coding to create established, meaningful patterns. These phases are: familiarisation with data, generating initial codes, searching for themes among codes, reviewing themes, defining and naming themes, and producing the final report (Braun & Clarke, 2006). These phases are explored below.

Stage 1: familiarising yourself with the data

The data collected in this study was in the form of hand written notes for 11 interview cases and audio recordings for three of the interviews. The three audio recordings were transcribed verbatim into written notes. The recordings were listened to again whilst reading the transcribed notes. After the researcher was certain nothing had been left out of the notes the audio recordings were destroyed. The hand - written notes were read and written out fully immediately after the interview was conducted so that no information was forgotten or lost. The written forms of the interviews were used to conduct the thematic

content analysis. In order to become familiar with the data, the notes were read multiple times. Furthermore, a reflective journal was kept in order to note and remember any ideas surrounding the data. The moods and attitudes of the drivers were recorded in the journal after interviews were conducted. This helped contextualise the responses given by the drivers. Another example that was recorded is a potential reason as to why some of the drivers were unwilling to participate. Two drivers stated that they would not be willing to speak to the press. This may have been due to fact that earlier in the year an article concerning the bus drivers was printed in a local newspaper. There may have been potential consequences for drivers that had been interviewed for that article, and therefore, drivers were unwilling to be interviewed for any reason after that.

Stage 2: generating initial codes

This step involves generating initial codes within the data. After the researcher was familiar with the data, he began coding interesting features of the transcribed data in a methodical way across the whole data set. This was done in order to bring together pieces of data that were relevant to one another and allowed the researcher to organise information into meaningful groups (Braun & Clarke, 2006).

Stage 3: searching for themes

The researcher brought the data together into potential themes, making sure that all the related data was in the same theme (Braun & Clarke, 2006). From the transcripts, data that was similar was clustered together under the same theme.

Stage 4: reviewing themes

In this stage, the researcher had to check if the themes worked in relation to the coded data in stage 2. This allowed the researcher to generate a 'thematic map' of the analysis of the data (Braun & Clarke, 2006). Each of the 4 themes was reviewed, and the transcribed data was revisited as the researcher clustered relevant information under the different themes formulated. Under each theme, the researcher also mentioned the protective and risk factors.

Stage 5: defining and naming themes

In this step, the researcher had to refine the specifics of each theme and the overall story that the analysis tells, generating clear definitions and names for each theme (Braun & Clarke, 2006). This is when the researcher had to name each theme and clearly define the themes in relation to the data.

Stage 6: producing the report

This is the final step of the analysis as it is the final opportunity for the researcher to select information that is rich and compelling and compile the final report (Braun & Clarke, 2006). The researcher had to identify the themes and relate them to the research topic.

This does not necessarily mean the frequency at which a theme occurs, but in terms of space within each data item and across the data set. It is ideal that the theme will occur numerous times across the data set, but a higher frequency does not necessarily mean that the theme is more important to understanding the data (Guest, MacQueen, & Namey, 2013). A researcher's judgement is the key tool in determining which themes are more crucial.

A theme represents a level of patterned response or meaning from the data that is related to the research questions at hand. Determining what can be considered a theme is usually identifying the prevalence of a phrase or word in the data set (Fereday & Muir-Cochrane, 2006). A response that provides new insights into the research may emerge from one interview. However, due to its limited frequency across the data set it may be disregarded. Although it is not necessarily a theme, it is important to be aware of these potential responses and the impact they may have on the research. A potential data analysis pitfall occurs when researchers use the research question to code instead of creating codes, and fail to provide adequate examples from the data. Themes need to provide an accurate understanding of the "big picture" (Braun & Clarke, 2006).

There are different levels at which themes can be identified—semantic and latent (Boyatzis, 1998). A thematic analysis generally focuses wholly or mostly on one level. Semantic themes attempt to identify the explicit and surface meanings of the data. The researcher does not look beyond what the participant said or wrote. In this instance, the researcher wishes to

give the reader a sense of the important themes (Boyatzis, 1998). Therefore, some depth and complexity may be lost. However, a rich description of the entire data set is represented. Conversely, latent themes identify underlying ideas, patterns, and assumptions. This requires much interpretation of the data, so researchers might focus on one specific question or area of interest across the majority of the data set (Boyatzis, 1998). This research made use of the latent level of data analysis.

3.7. Reflexivity

Reflexivity is a method that can be used in qualitative research and has been accepted as a qualitative method researchers can and should use to legitimize, validate and question research practices and representations (Alvesson & Skoldberg, 2009). Reflexivity in qualitative research will allow the researcher to look inward and outward while exploring the relationships between existing knowledge, our experiences and the world around us (Alvesson & Skoldberg, 2009). Reflexivity mainly focuses on revealing hidden agendas as these have an impact not only on how the research is carried out but also on the whole research process from start to finish (Alvesson & Skoldberg, 2009).

Throughout the research a reflective journal was kept by the researcher. This was to record thoughts and ideas that were related to the research. The reflective journal was used to contextualise certain response and reasons for non-responses. Notes about what occurred during specific interviews were also recorded, such as moods of the individuals, as well as certain gestures that were made during a response, and voice inflections. These assisted during the coding process, as well as during data analysis.

Chapter 4: Results

This chapter provides an in-depth analysis of the data. All identifying information has been removed from responses in order to maintain confidentiality. The results follow the three phases of the research. This chapter specifically analyses the documented policies and procedures of the company in phase one. Phase two provides a summary of the reported accident statistic related to the specific depot under study in this research. Finally, phase three focuses on the responses received by the bus drivers that were interviewed. Themes that were discovered in the analysis are reported and commented upon.

4.1. Phase 1

The documents that are reviewed in phase 1 are in order to understand the context of the company as well as gain an understanding of all policies and procedures that occur within the company. The documents reviewed for phase 1 include:

- The Safety Management Systems Handbook (SMSh)
- The induction training manual of policies and procedures
- Practical drivers' training manual
- The drivers' incentive programme (Appendix E)
- Driver Incentive Key Performance Indicator 16 Jan to 15 Feb 14 (too sensitive to include as an Appendix. This is because names of drivers and reasons for discipline are included in this document.)
- The disciplinary procedure and code of conduct document (Appendix F)
- Employment contract (Appendix G)

from the information that was included in these documents, three themes arose that were related to what drivers reported in the interviews; safety, the incentive programme, and disciplinary issues.

The organisation is motivated to create a safety culture. This is evident from the organisations mission statement and visions as cited in the employment contract (Appendix G):

- *Our MISSION is to be the top provider of safe, quality, cost effective and reliable bus transport services to the benefit of all our clients and stakeholders.*
- *To embrace safety at all levels in our organization and to maintain our exemplary safety record.*

The document further states that drivers are responsible for maintaining the safety record of the organisation as well:

- *To ensure that personal conduct, duties and actions are executed in a responsible and safe manner and is in accordance with all Legislation, in accordance with the Company Disciplinary Code, Code of Conduct and all Standards and Procedures as required by the Company and its Clients from time to time.*
- *To drive busses and other company vehicles in a manner that promotes road safety and the positive image of the company.*

The employment contract gives a comprehensive list of what is permissible and what is not for the drivers, such as Adherence to Road speeds, Damaging a Vehicle, Unauthorised stops, Deviations from routes or time tables. The contract creates provision for a weekly safety meeting, as well as making the organisation's policy regarding safety known. The document also sets out the procedure for accident reporting if any damage has occurred to the bus.

The organisation makes use of a number of different training manuals and handbooks which create guidelines and emphasise the need for safety in the organisation, as well as the need for the continuous improvement in attitudes towards safety. These documents include: The Safety Management Systems Handbook (SMSH) . The need for a Safety Management System is explained to the drivers as:

A Safety Management System (SMS) is an integrated set of work practices and procedures for monitoring and improving the safety of our bus operation. It is designed to assist operators to identify risks and to develop procedures to manage those risks. It also encourages operators to take responsibility for the safety of their operation and to ensure that all staff are aware of their safety responsibilities.

The definition of a safety incident can be found in the SMSH:

For the purposes of the SMS an incident is defined where an operator is required to report such occurrences under the conditions of the bus operator accreditation as follows:

- *Injury incurred to any person or persons, [sic]*
- *The event is serious enough to prevent the vehicle from continuing the journey, or the event is likely to arouse public concern. (Safety Management System Handbook)*

The Induction training manual of policies and procedures which aims to continuously make drivers aware of safety in the workplace, safe driving practices and to reinforce the Company Rules, Regulations, Policy and Procedures. The Practical drivers training manual ,which sets out practical guidelines and policies for safety, and dictates when and how training should occur in the organisation.

Should there be a disciplinary issue that arises from a safety incident, the disciplinary procedure and code of conduct are implemented . This document provides guidelines regarding behaviours that are considered discipline - worthy, and the disciplinary actions that are appropriate for these actions. It protects the employees from potential dismissal if a minor event occurs.

The company's policy on safety is reinforced throughout many of the documents that were reviewed. Furthermore, three documents dealt specifically with safety; the Safety Management Systems Handbook, the Induction Training Manual of Policies and Procedures, and the Practical Drivers' Training Manual.

Of interest in the SMSH is *Annexure 1: Policy, Commitment and Objectives* which summarises the company's approach to safety. This policy states:

What we are trying to achieve from our SMS;

Our aim to achieve this objective; and

The responsibilities of people in our organisation, particularly management, in relation to safety.

Our Safety Policy is a statement of commitment by the company to the safety of its employees, clients and members of the public in direct contact with the service we render.

The SMSH explains how the company implements this:

We developed a Policy and discuss the content of the policy with our employees.

The Policy is signed off by senior management and placed in a prominent area of our workplace so that staff can view it.

The company incorporate the Policy into employee handbooks, induction and training materials so that management and staff are aware of and understand the Policy's, Rules and procedures.

These final points are stated by the company in the document as their safety objectives;

- *Active involvement and commitment by managers.*
- *Consultation and communication with employees on safety issues.*
- *Ongoing identification and control of hazards*
- *Development and implementation of procedures for all activities that pose a risk.*
- *Ongoing assessment of transport safety employees' fitness for duty.*
- *Provision of all necessary information, training and supervision.*
- *Investigation and reporting of all accidents and dangerous incidents.*
- *Provision of emergency procedures.*

The SMSH explains what is expected of the drivers in order to maintain the safety policy:

Employees are responsible for operating and maintaining busses in a manner that ensures the safety of staff, passengers and pedestrians, which abides to the requirements of the company's SMS requirements

It is unclear what is meant by employees in this previous quote. It does not state whether drivers alone are responsible for the maintenance of the busses and how this occurs.

The Induction training manual of policies and procedures sets out certain requirements of the drivers:

- *To promote and act in the best interests of the company at all times.*

- *To ensure that personal conduct, duties and actions are executed in a responsible and safe manner and are in accordance with all legislation, in accordance with the Company Disciplinary Code, Code of Conduct and all Standards and Procedures as required by the Company and its clients from time to time.*
- *To treat all Clients, Road Users and Pedestrians with respect and dignity at all times.*
- *To drive busses and other company vehicles in a manner that promotes road safety and the positive image of the company.*

The importance of safety for the drivers, and by extension the company, is repeated throughout the document, with the procedure for different scenarios explained. The importance of safety in the document is reinforced in by this extract:

INTRODUCTION BASIC SAFETY RULES

Safety. A way of life. Is it afforded this though?

Today we place much emphasis upon survival. Survival in our jobs, and survival in living, so as to be able to put food on the table.

Compliance with company safety rules and regulations is just as important as this need to survive and live for without safety rules and regulations, our continued survival in the workplace cannot be assured.

The Practical Drivers' Training Manual provides the practical training for implementing safety policies in the company. In this document the defensive driving method is recommended for drivers. Why this method is used is explained to the drivers:

Explain to the driver that the defensive driving system is designed to ensure everyone's safety on the road, and must become second nature. It involves being alert to potential hazards and performing the appropriate actions to maintain safety. Potential hazards include intersections, pedestrians, animals, vehicles and structures. The purpose of appropriate action is to maintain a clear space around your vehicle at all times.

There are further practical safety recommendations made in this document. These include the use and maintenance of safety equipment, how to drive in certain weather conditions, and legal and accepted speed limits. Recommended driver attitudes and behaviours are also included in the document:

- *Always be a patient driver, don't take risks/chances it will only endanger the lives of your passengers.*
- *Be polite to other road users: it makes a good impression on everybody and it is good advertisement for the driver and the company.*
- *Remember that patience and politeness will keep your passengers calm and comfortable.*
- *It is not permitted for a driver to get involved in traffic arguments, or display any signs of aggressive behaviour towards other road-users or pedestrians.*
- *Avoid conflict situations at all times by moving away from a vehicle that is driven aggressively or incorrectly, or by not making eye contact with argumentative or aggressive drivers.*
- *An aggressive driver endangers the lives of your passengers and that of other road users and makes passengers extremely uncomfortable.*
- *It is not permitted to use foul or inappropriate language in a bus, or in the presence of passengers.*

These documents emphasis organisational and operational safety. Furthermore, they highlight the importance of the drivers in achieving the requirements for safety. The driver is required to play a primary role in safety practices. The information about safety and how to achieve this is disseminated to the drivers through the training that they receive and by the safety officer on a daily basis.

The drivers' incentive programme is explained in Appendix E. The second document that was analysed with regards to the incentive programme is the Driver Incentive Key Performance Indicator between 16 Jan To 15 Feb 2014. This document is an example of how the incentive scheme is recorded and implemented on a monthly basis. This document includes the driver's name, the amount of the incentive bonus, the amount if there is no transgression in the recorded period, the number of transgressions for that period, the description of the transgression and the balance of the incentive that the driver will receive at the end of the period. This data is recorded in a table format as follows:

Name	Coy Number	Incentive Bonus	No Trans	Total Transgressio	Description	Balance
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The document also explains how the driver may lose a portion of the incentive:

First Offence team will receive a Yellow card and the offender will lose an amount based on the seriousness of the transgression, but the remaining members will still keep their full amount

Second Offence team will receive a red card, offender will lose an amount based on the seriousness of the transgression and the remaining members will then lose half of the amount of the penalty

The incentive scheme is based on individual performance but the 'team' is also affected by individual offences.

Over the one month period analysed, 22 transgressions were recorded. These included: late coming (six), absence without leave (six), damage to vehicle or property (four), expiration or non-renewal of professional driver's permit (three), not wearing company uniform (two), and rudeness to passengers (one). Of these offences, only four can be considered safety issues. The remaining 18 offences are disciplinary issues and did not arise from unsafe driving practices.

The disciplinary procedure and code of conduct document, employment contract, SMSH, and the induction training manual of policies and procedures all give reasons why disciplinary action may occur and sets out disciplinary procedures.

4.1.1. Discipline.

The disciplinary procedure and code of conduct document includes categories of offences and the appropriate disciplinary action for each offence. The document states that;

The penalties listed in the different categories serves as a guide only. The intention is not to prescribe rigid rules, but to create just, fair and as far as possible, consistent disciplinary action. When implementing disciplinary action it is important to bear in mind that the conduct and working conditions of employees differ.

There are three categories of offence;

CATEGORY A

Offences in respect of which a competent penalty for a first conviction may in appropriate circumstances be dismissal of the employee without a prior warning having been issued

CATEGORY B

Offences in respect of which a competent penalty may in appropriate circumstances be imposed.

First offence; Final written warning, or dismissal if the nature and circumstances of the offence should warrant it.

Second offence; Dismissal, if a final written warning of which has not yet expired, was previously issued in respect of an offence in this category. A written warning lapses 6 (six) months from the date of issue thereof.

CATEGORY C

Offences in respect of which dismissal, is usually preceded by two written warnings and a final written warning. A warning issued in respect of an offence in this category will lapse 3(three) months after the date of issue thereof.

The document also sets out the procedure for a disciplinary hearing from point 94 of Appendix F. This includes investigation of the charge, the task of the investigator, the evaluation of evidence, preparation of charges, duties of the chairman, requirements for a venue, how notice is to be served to the employee, the employees' rights, the correct way to conduct the hearing, and finally the appropriate penalty.

The Induction training manual of policies and procedures complements the Disciplinary Procedure and Code of Conduct document. This document reinforces the approach that certain offences will result in a disciplinary hearing. The document also states that training takes place to reinforce the code of conduct;

Induction Training is the responsibility of Contract Managers, and it is important to conduct the training in a positive and non-confrontational manner. However, the

training topics will reinforce the code of conduct and drivers must be made aware that non-compliance thereof will result in disciplinary action.

Again the accident policy and procedure is repeated, with the consequences of not reporting an accident stated;

Any accident/incident no matter how small or insignificant it may seem, is to be reported to the operations manager, via the supervisor and or security guard on duty, as soon as possible after its occurrence.

Failure to report an accident is a serious offence and may lead to severe disciplinary action, (including dismissal) being taken against the employee concerned.

The employee contract reinforces that offences will result in disciplinary action, specifically if due process is not followed in accident reporting;

Any accident/incident no matter how small or insignificant it may seem, is to be reported to the operations manager, via the supervisor and or security guard on duty, as soon as possible after its occurrence.

Failure to report an accident is a serious offence and may lead to severe disciplinary action, (including dismissal) being taken against the Employee concerned.

Therefore the following procedures should be strictly adhered to in case of an accident. These procedures are internal company requirements and do not supersede the normal legal procedures as required by the Road Safety Act

The SMSH states two instances for which a driver may be disciplined;

The company advise drivers of any issue (including work outside the organisation and the use of medications) that may impact on fatigue levels. Failure to report such issues may result in disciplinary action. The driver should also report if they feel particularly fatigued prior to a shift.

And

Live satellite tracking in vehicles to monitor speed with disciplinary actions against offenders.

4.2. Phase 2

This phase of the research analysed accident statistics related to the depot. These statistics were provided by the company. This is a four year period that these statistics cover between 2011 and 2014. Accident statistics that are included are:

- Area of accidents
 - Intersection (traffic light)
 - 4 way stop street
 - Highway
 - In town
 - Special trip
 - Wet conditions
 - Night time
 - Parking
 - Normal conditions
 - Traffic circle
 - Downhill/up hill
 - Poor visibility
- Type of damage to the vehicle, which includes:
 - Broken Mirrors
 - Rear ending
 - Left / Right side
 - Broken side windows
 - Broken side windows: Driver error
 - Broken rear window
 - Damage windcreens: 3rd party
 - Damage windcreens: Driver error
 - Damaged Tyres
 - Burned out clutch plates: Driver error
 - Vehicle damages: Driver error
 - Vehicle damages - 3rd party error

- Type of accident
 - Minor 0 -20 000 (Rand in damage)
 - Serious 20 000 -100 000 (Rand in damage)
 - Major 100 000 - written off
 - Bus Defect
 - Driver error
 - Third party error / climate (weather conditions)
 - Injuries sustained
 - Fatalities
- Number of accidents per year
- Drivers involved in accidents

For reasons of confidentiality and anonymity, the data relating directly to individual drivers involved in accidents was not considered for this research.

There were no recorded accidents for 2011 for the depot under study in this research. Therefore there is also no data relating to areas of accident, type of accident, and type of damage to the vehicle for this year.

There was only one recorded accident in 2012. This accident was attributed to driver error. Damage occurred on the side of the bus, and the accident took place at a traffic intersection.

For 2013, there were three recorded accidents. One accident was attributed to driver error, the other two were a result of a third party or climate influences. The damage that occurred was one case of rear-ending, one case of a broken windscreen, and one case of a broken side window. All the accidents were reported to have occurred in normal driving conditions.

For the period recorded for 2014 (until November), there were 24 recorded accidents. Seven accidents were attributed to bus driver error and 17 accidents were attributed to third party or climate (weather) influences. Damage that occurred was; broken mirrors (1), rear ending (11), side damage (6), broken side windows (1), damaged tyres (1), and vehicle damages: driver error (3), vehicle damages - 3rd party error (1). Eight accidents occurred at

intersections, one accident at a 4-way stop street, five during in-town driving, one at night, one while parking, seven during normal conditions, and one on a downhill/uphill.

There has been a clear increase in accidents over the recorded period. 2014 had a high number of accidents, a total of 24 reported incidents were recorded. This is six times the number of accidents of the other three years combined. Thirty percent of accidents that occurred in 2014 were attributed to driver error, the other 70% to third party accidents, or conditions that were caused by weather. Of all the accidents that occurred during the recorded period, only 32% of accidents were attributed to driver error. It is unclear why there is such a significant increase in incidents. There may potentially have been a case of underreporting in the depot in the previous years. This may lead to inaccurate figures for 2011-2013.

4.3. Phase 3

This phase of the research focused on interviewing the bus drivers regarding their perceptions of safety and related organisational issues. The drivers were asked specifically about safety incidents and therefore it was expected that this would be a theme in the study. Additional themes included: the relationship between drivers and management, drivers' satisfaction with the organisation, and justice and fairness.

4.3.1. Theme one: Attitude towards safety.

The interview schedule had questions related to safety and for this reason every respondent touched on safety to some degree. From this major theme, two subthemes can be identified; safety incidents and safety culture.

4.3.1.1. Safety Incidents

It must be stressed that getting the respondents to speak candidly about specific safety incidents was difficult. This may have been for a number of reasons. The sensitive nature of reporting specific safety incidents to a relatively unknown individual, in the form of the researcher, may be difficult. Secondly, fear that reporting any incidents may result in some form of consequence could have created reluctance to speak about incidents. Of the fourteen drivers interviewed, four spoke about incidents that they had been directly

involved in, four mentioned that incidents had occurred but not involving them, two stated that there were no safety incidents that they were aware of, and four respondents declined to answer the question. This clearly influenced the findings of the study, and the drivers' high level of reluctance to speak about incidents highlights the sensitive nature of the area.

Two examples from drivers who reported that they were involved in incidents are;

'I can't really comment on the safety incidents of other drivers ... for me, one complaint was on ... road, you know that part by the ...? At that intersection it is two roads and then it merges into one. The private cars there think because they can be faster than the bus they just push past. But when the bus changes gear from lower to high it gets faster, then the cars get scared because they look like they will hit the bus and ja' - Respondent One

Unfortunately the driver did not elaborate further on what the actual incident was.

A second driver reported what he considered a small incident in which no-one was hurt and only property damage occurred:

'The roads around here are very small, now they have painted in these green lanes on some of the roads [green lanes are dedicated bicycle lanes that have recently been designated around town] so now the cars have to park in the road and they are parking close to the driving. One day a car started moving out and moved, I tried to move but I knocked the car side mirror off. There was nothing I could do. It was the car driver's fault for not looking, my bus is not small he could see me.' - Respondent Nine

The two drivers who had not heard about any specific incidents stated;

'No. There are no problems with us drivers at here, the other day there was an accident on ... road with a bus but that isn't us, we are good and we must be safe because we have the [passengers] on the bus.' - Respondent Six

'I have not heard about anything, I am a good driver and have not been in an accident.' - Respondent Twelve

Examples of responses by the drivers that stated that incidents had occurred but not with them are;

'No there are no incidents that I have been part of, sometimes the people on the road will call to complain about how you are driving, like you will miss a robot, or you'll make another car swerve' – Respondent Ten

'There are not many things that happen, if there are accidents that happen then they are not big accidents. They are small things, like if a bus goes into a car it is small, the busses can't go too fast when there is traffic. This is when the accidents happen. There are a lot of cars at this time and they drive very recklessly around the busses. They will come in front of the bus when it is stopping and then there is less space to stop.' – Respondent Eleven

'I have not had any of these incidents yet. But sometimes we get complaints from other people that drive on the road, or even pedestrians, they are saying that we almost caused them to crash or that we weren't paying attention and that they have to try move.' – Respondent Thirteen

4.3.1.2. Perceptions of company's approach to safety

The interviews confirmed that the organisation does endeavour to create safety awareness, and also makes an effort to create safety programmes in which they attempt to train the drivers to drive safely. This is confirmed by some of the respondents:

'Ja no at the training they teach us how to be a defensive driver it's about safety for your passengers, you as well and then other pedestrians and motorists.' – Respondent Three

The safety officer checks that we understand all the safety things, sometimes the safety officer will ride in the bus and just make sure everything is going ok.' – Respondent Four

'They teach us how to be a defensive driver, they say that if you [sic] defensive there shouldn't be any problems'- Respondent Seven

‘There is a safety officer around, he makes sure that you understand what the company safety is all about and that you are doing it when you drive. The company is good about safety, they tell us that we can’t have too many passengers on the bus so the safety of the passengers is the most important thing for me’ – Respondent Eight

‘We get training when we join the company, they tell us about the busses and that we must drive safely, then they show us how to do everything’ – Respondent Ten

‘When I joined the company there was safety training that I must go on, after that when we drive there is a safety officer’ – Respondent Eleven

These quotes are evidence of the emphasis that the organisation places on safety.

Respondent Eight highlights that the safety of passengers has been prioritised. Information about safety is also clearly communicated to the drivers and the need for safety is being emphasised by the safety officer communicating and speaking with the drivers every day. There is also evidence that even before the drivers are allowed to start driving the busses when they join the organisation they are required to go through a training procedure, that includes a safety element.

The respondents are clear that safety is emphasised in the organisation. However, drivers reported some areas that they perceived needed improvement regarding safety training and communication.

‘When I joined the company there was safety training that I must go on, after that when we drive there is a safety officer, he just tells us the same safety things every time it is the same there is nothing new, we know what the safety is but we must still listen and sign’ – Respondent Eleven

‘When we start at the company they make us go on training course. There is also a safety officer, he comes around and explains every week about how we must do things and drive, but it is the same every week. Maybe sometimes if something happens in the company then he will say we must be careful of that’ – Respondent Five

'They teach us how to be a defensive driver, they say that if you defensive there shouldn't be any problems, but sometimes this is not enough.' – Respondent Seven

'Because this is such a big company we get safety talks, but there are complaints from all over the country, so if something happens in [a particular province] then we get told about it in safety talks. But this is pointless to us, we have different issues here. So if we get told more specific things in the safety talks that are for here it would be much more useful for safety.' – Respondent One

There is a perception that much of the information that they are provided with is not relevant to the conditions in which they drive. The drivers also perceive the information that they are receiving as repetitive. Furthermore, there is evidence that some of the drivers do not feel as though they receive enough safety training.

The comments made by respondent One in the previous extracts are an example of why the safety culture is not being achieved. This is because even though the company is discussing safety incidents with the drivers, the drivers do not perceive these incidents as relevant to their situations.

To achieve a safety culture, there must be an organisation wide acceptance and practice of the principles of safety which the company wishes to implement. The company is attempting to implement some form of safety culture. In order to achieve this, the drivers need to be willing to show a continuous desire for learning and dedication to safety.

There was an agreement on one rule that the organisation has implemented. There is absolutely no circumstance that any driver is willing to overload his bus. Every respondent mentioned this in some form. Evidence of the drivers' awareness of this rule is below:

The safety of the passengers is the most important thing for me, they must stay sitting and not shout, if there are too many people at the stop I can only let on as many people that are allowed on the bus. If there are still people at the stop I say I am sorry but I will come back again later and there will be another bus. Sometimes the people get very angry at me and say they will be late but there is nothing I can do. It is for their safety I must do this. – Respondent Nine

Two different responses from drivers regarding the organisations' safety practices and policies are recorded below:

'We receive good safety talks when we join, they make sure we know how to be a defensive driver, then they make sure that you are reminded when the safety officer comes around it is good safety in the company.' – Respondent Thirteen

A driver that has been with the organisation for a longer period reports:

'When I joined the company I had to go on a safety training course, then I could start driving ... the training officer comes around so much and just says the same thing, I always know what he is going to talk of, so I just agree and then I sign.' – Respondent Eight

4.3.2. Theme two: Relationship between drivers and management.

During the interviews, the theme of the relationship that the drivers have with management came through strongly. Nine of the fourteen drivers had a response that related to their relationship with management in the interview. The relationship between drivers and management in this theme refers to the interaction that exists between the two parties within a normal working environment. Management in this instance ranged from their direct, on-site manager, through to higher management positions in the organisation. The prevailing perception was that management was unaware of the experiences and needs of the bus drivers. The drivers tended to have a negative perception of the role of management in the company, as illustrated by statements such as:

'Management is separate, if there is a complaint [from other road users or the client] we get in trouble. It is like they take only one side of the story and the drivers get in trouble. It is like they are trying to keep everyone else happy except the drivers.' – Respondent One

'We have a manager, he is a site manager but I don't know what he is for because he doesn't help us.' – Respondent Four

'... the company must respect the drivers. They don't respect us, they just use us.' – Respondent Two

The perceived lack of trust between management and drivers is important to note. A lack of trust between management and employees has been found to be likely to lead to perceived procedural and interactional justice violations (Esterhuizen & Martins, 2008).

It must be considered that the organisation has very little contact with the drivers. At the time that the research was conducted, the direct contact that the organisation has with the drivers on a daily basis was through an on-site manager. This is because the organisation works on a contractual basis and depots are created close to the sites that the contract services. Because a large number of depots existing in various parts of the country, it is not possible for the head office to be physically close to every depot. The on-site manager acts on behalf of the organisation, attempting to uphold the organisational values and principles, and issuing the directives and orders of the organisation.

Certain respondents discussed the on-site manager directly:

‘They never listen to us, we ask for things but they say we must speak to the manager, this manager, what does he do? He was made here a manager so that the company can control us from him, he is just a puppet for this company’ – Respondent Ten

‘They say we have a site manager but I don’t know what he is for, nothing has changed. He has no qualification, how can someone with no qualification and is the same as us tell us what to do?’ – Respondent Three

When questioning what the respondent meant by ‘the same as us,’ it was discovered that this manager was previously a bus driver in the organisation. A subsequent interview revealed the same information:

‘If I got a problem there is nowhere to go. We don’t have a manager, that manager that they say is a manager doesn’t have a qualification, he’s just a driver like me, they say he is going to be a site manager. I don’t know how a person who doesn’t have a qualification [can] hold a company like this one?’ – Respondent Six

These responses from the drivers indicate that there are potentially low levels of trust in the on-site manager of the depot that was part of this study, as well as his 'credentials' to be a manager.

In an interview with management it was discovered that the reason behind installing a former driver as the on-site manager was an attempt to connect with the drivers on the part of the organisation. In a number of interviews, the researcher noted a resentful manner when the on-site manager was discussed. This was evident in the previously quoted response of Respondent Ten, where it was perceived that the manager was merely a 'puppet' and only acted in a way that was good for the organisation. It is possible that this might not be an accurate reflection on the manager's competence in his role, but may indicate more general issues regarding the acceptance of authority and the agendas of the interviewees. It is cautioned that no evaluations of the manager's performance should be based on these comments.

4.3.3. Theme three: Drivers' satisfaction with the organisation.

During the interviews there were certain grievances that were reported. Pay was commented on in every interview. However, this is explored later in the research. The interviews highlighted that there was dissatisfaction with the organisation amongst the drivers. Four of the respondents (30%) were actively seeking new employment:

'That thing makes me not happy about this job. Because even now I'm looking for another job.' – Respondent Two

'We just have the same shifts the whole year and there is nothing we can do to change shifts, I am looking for another job. The pay here is not enough and we need more.' – Respondent Six

'No, we work too hard for nothing, I don't care about what happens here at this company I will look for a new job when I can.' – Respondent Ten

'No this job we need more money, they don't pay us enough, I will look for a job that has more money for me.' – Respondent Twelve

There is a relatively significant proportion of the sample actively seeking new employment with 30% of the respondents stating that they would look for new employment when possible.

A further issue that was raised in the interviews was the condition of the on-site room that has been provided for the drivers. This room is provided to drivers that are required to do very late or early shifts. If it is not possible for the drivers to go home and return in time for their shifts, they are able to stay in this room and sleep. Drivers were dissatisfied with the condition of the room:

'We have these early and late shifts and I can't see my family, sometimes I must sleep in the room that they have on site so that I will be at my shift on time, but this room is not for humans, you must come see it. It is not clean and everything is broken, I cannot sleep there, but I must sleep there if I will get to work.' –

Respondent Eleven

'Sometimes I stay at the room that they have given us to sleep in if we must work early or late, they say that this room is here to help us, but they must come sleep in this room, it is too hot for sleeping with all the people and then it is never clean, we can't be driving all the time and then be expected to clean the room, I can't think that they would want to be in this room so why is it ok for us to be in this room, it is not fair.' – Respondent Nine

'When I'm working night shift there's no transport to take me home so I can't even say I have time off I must sleep here in that room, in the morning I must go and to go home I must take a train. And even when you sleep here sometimes it's overcrowded, that place is not healthy there is no one that is cleaning that place it's dirty.' –

Respondent Three

The drivers perceive the room in which they can sleep as very important. These conditions appear to be affecting the attitudes of the drivers which in turn may influence their driving behaviours.

4.3.4. Theme four: Justice and Fairness.

A major theme that was under investigation, and therefore was evident in all the interviews, was that of drivers' perceptions of organisational justice in the organisation. The three main components of organisational justice (distributive, procedural and interactional justice) were explored in all interviews where the term 'fairness' instead of 'justice' was used as the drivers related best to this term. The drivers spoke voluntarily about their perceptions of equity and fairness in the organisation and were more candid about these areas than about safety incidents. The respondents were usually fairly animated during this topic and expressed strong opinions.

4.3.4.1. Distributive justice

The issue of remuneration came up in all the interviews. This was not an unexpected occurrence and was anticipated at the start of the research. The subject of pay equity is part of the distributive justice component of organisational justice. It is interesting to note that the respondents would often start speaking about pay equity unprompted when the justice component was reached in the interview, and would often pre-empt any questions that were going to be asked regarding this. At no point were the respondents asked what their salaries were. The following are selected extracts from some interviews:

'I think they must put more for our salary I don't think it's that fair (laughing) even if we are driving we don't know and thinking too much that I am driving but at the end of the month I'm receiving pennies, cents, we must get the salary that will make us happy.' - Respondent Three

'No, it's not worth it, I only do this job for the money and for supporting my family but the money is not enough and I need more.' – Respondent Five

'... we must get more money and then we will be happy. We need more for our families, this is a hard job, even sometimes when we do overtime we don't get paid.'
-Respondent Six

'Sometimes I cannot pay everything I need to at the end of the month, there are sometimes surprises if my family gets sick I must pay for the doctor but I do not have enough money for this, because there is food and that that I must also buy every month. So we must get more for our jobs, we work hard, and we get paid nothing.' –

Respondent Fourteen

All these responses are similar in tone and content. The drivers believed that if they were to receive better compensation for their work, they would be more satisfied with their jobs and lives.

The drivers' perception is that an imbalance exists between effort and reward. There also seems to be a low level of intrinsic satisfaction in their job:

'No, I just drive because it is a job for me, there are lots of people without jobs, but I don't care about driving, it is easy way for money, even when it's not enough.' –

Respondent Eight

'My job is hard, the hours are long, it's lots of stress ... It is boring sometimes too, we just have the same shifts the whole year and there is nothing we can do to change shifts, I am looking for another job. The pay here is not enough and we need more.' –

Respondent Six

'I am not so happy with this job, but what can I do? I must feed my family' –

Respondent Ten

The following quote illustrates the most explicit link that was made between pay equity and attitudes regarding safety;

'For myself, it's useless to take the person to the training every time when you under-pay this person. How can he focus on his job because when we are driving some problems of mine is money we are trying to working overtime to get more money but the company doesn't want to pay you.' – Respondent Two

The respondent is referring to the policy that is set out by the company that states that drivers need to attend safety training sessions at least once a year. This is in order to create awareness of safety and create a platform for a safety culture.

4.3.4.2. Procedural justice

Procedural justice in the interviews referred to the drivers' perceptions of the fairness of 'how things happen' in the company. The drivers expressed opinions and views in different areas they perceived as problems. These problems include; how shifts are decided, the decision-making process in the company and satisfaction with the union, and the ability to hold meetings.

Dissatisfaction with shifts was raised by 57% of the drivers:

'They run a certain shift for the whole year, it's not changing they give you a shift, you work six to six this week next week you work six to three the whole year I'll be off only two weekends and two Sundays the whole four weeks in a month, when I'm working night shift there's no transport to take me home so I can't even say I have time off.' – Respondent Two

'The manager tells us what is meant to be happening, at the beginning of the year we told what the shifts are and that's what it is for the rest of the year.....we don't decide what our shifts are ... sometimes we must do extra shifts.' – Respondent Four

'It's also very hard, we have long hours and the route is always the same, we also always have the same shifts or only two of the types of shifts. It gets long and sometimes boring.' – Respondent Five

'We just have the same shifts the whole year and there is nothing we can do to change shifts, I am looking for another job.' – Respondent Six

'They run a certain shift for the whole year, it's not changing they give you a shift, you work six to six this week next week you work six to three the whole year I'll be off only two weekends and two Sundays the whole four weeks in a month' – Respondent Twelve

The decision-making processes in the organisation were raised by 64% of the drivers.

Respondents perceived that they are not listened to by the organisation. Usually it would be expected that a trade union would represent the drivers in this context and that they would

be able to voice the issues of the drivers. However, drivers expressed dissatisfaction with this process and suggested that this did not always occur:

'Some of the decisions in the company do not involve the drivers even if it affects us, that isn't fair.' – Respondent One

'Ja even, myself I don't know where we should go to fight because we tried to join a union it seems that that union they buying the shop steward because he is not doing nothing. Since from January we put our demand on the table, even now no one, even a single problem is solved. If the problem is solved it's worse.' – Respondent Two

'I joined the union, but we getting nothing from when the union speaks for us, they do nothing for us as drivers, they are playing politics up there and just care for themselves. The union says it protects us and fights for us, but they just protect their money and themselves' – Respondent Eight

'No they will just tell us when things happen, it doesn't matter what it is. They will tell us our schedule at the start of the year and then that is it. Afterwards we get note or the manager tells us what will happen' – Respondent Nine

'No they don't tell us, the management, they make the decisions, when they make it then they tell us and we must listen.' – Respondent Twelve

'No they never tell us anything or ask us for anything, we join the union but the union is not getting anything for us, we need more money, that is what we care about, but these things are never coming. The union says it fights for us, but we see nothing as drivers here so what is the point?' – Respondent Thirteen

This could potentially lead to an attitude of despondency as is illustrated in the final response.

The subject of being able to hold meetings was raised by 57% of the drivers. Drivers' perceptions are that they are unable to hold regular meeting in which to discuss and voice opinions, ideas, and issues. This lack of a forum for the drivers is an issue;

'There is no time to work and hold meetings, there is no time to hold meetings there is no time to even discuss our problems, the only thing that the company is looking

for is that you do your job that all. In the other place Maybe once a week in the morning they hold a meeting with the drivers, they complain then they try solve the problem, but not here, since January they never hold even a single meeting.’ –

Respondent Two

‘No there is never any meetings to discuss our issues all the time, we just must come to work and do our job, that’s what the company wants from us, they tell us what we must do and then we must just do it. They don’t think about us as drivers and they don’t want to hear complaints’ – Respondent Five

‘No the company never asks us, we don’t have many meeting too, we just come to work early and must start our shifts, then we have a long shift and are tired and have no time for meetings’- Respondent Seven

‘The company doesn’t care about us, we never have time to meet’ – Respondent Eight

‘No they don’t ever include us, we don’t have meetings as drivers, there is no time for meetings, we cannot get together because we are always driving’ – Respondent Eleven

The drivers perceive the ability to hold meetings as important, however, they also understand that they have no opportunity to meet. This may have led the drivers to perceive that they have no opportunity to be involved in decision making within the organisation.

During the interview process, it emerged that the perceptions of the drivers is that little to no procedural justice is present in their own context. The inability to make, or even be part of the decision-making process on the part of the bus drivers may lead to a perceived powerlessness amongst the drivers.

4.3.4.3. Interactional justice

Interactional justice refers to the treatment that an individual receives as decisions are made. How these interactions take place are important. During the interview process, drivers did not mention any specific interactions that had occurred between themselves and

management. This may suggest that the tone of daily interactions is generally acceptable to the drivers.

There appears to be a perception from the drivers that interactions between managers and drivers are largely transactional in the form of direct instructions which drivers are expected to obey:

'We just must come to work and do our job, that's what the company wants from us, they tell us what we must do and then we must just do it. They don't think about us as drivers...' – Respondent Five

'The only thing which they are doing they just firing the people see in {is it February, or march} they fired ten drivers in one month I don't think that that managers that's here in the office is the right person to do the job because he doesn't know the job its only after a person is working, they are looking at your mistakes only, they don't worry about what the things that we do for the company.' – Respondent Two

'Why must I do these things? The company doesn't care for me, I must just drive without making problems for the company and do my job with not being late or missing shifts. If you do these things and break the rules the company cares because you are making them look bad. They don't care if you try make them look good.' – Respondent Fourteen

The disciplinary procedure was commented on by 71% of the drivers. The drivers expressed their perceptions of the disciplinary procedure;

'They call you and then they give you a paper like this one [uses informed consent form to explain] with things written down and then they ask you to sign down which I find it not fair because if they say you signed it they must call the complainant to come and explain while you are together and come and explain how was the driving...they always just give you the paper to sign [warning] the complainer is not there to give on their side what happened only you as a driver you are there.' – Respondent Three

'If someone like X complains then we get a warning, also from people on the road, sometimes they phone [the company] and then we get a warning, but it is not fair because we must have a meeting. The person that complained must come in and we must come in and then there must be both stories, but this doesn't happen. It's like the company is just trying to keep [others] happy.' – Respondent Four

'They call us in if someone complains or something happens we have to sign a warning, but it's not fair, they tell us we must sign the warnings otherwise we lose our vouchers but they don't let us tell our sides of the story, so someone can just complain and then we will just get a warning. I heard this year in one month ten drivers were fired and I don't know why.' – Respondent Five

'If someone complains then we must come in and look at the warning, when I have had a complaint [against me] it's not fair because we must both come in and tell the story, but I must get a warning if someone complains. We get in trouble if something happens it's always our fault.' – Respondent Six

'Sometimes the company doesn't hear about these things, but sometimes the people will report you and say this and this bus made me nearly crash today, because you see we have the number in the back of the bus so people can call, and then they know you drive that route and so they know it was you in the company. You must come in and they give you a paper and say you nearly caused an accident and then you get the warning.' – Respondent Eight

The drivers' perception seems to be that they are unable to do anything during this procedure, and the most likely outcome will be a warning. The researcher was unable to attend any disciplinary meetings, or receive the minutes of any disciplinary hearing. Therefore, what is occurring in these meetings is influenced by the drivers' perceptions and reporting of these events, which limits our understanding.

A link that can be drawn between distributive and interactional justice is the drivers incentive programme. This programme was implemented in late 2013 and includes amounts of R200 and R100. The amount of R200 is based on the individual's performance, whilst the extra R100 is based on the performance of the team the individual is part of.

This programme was implemented to try and improve safety in the organisation. If there are no incidents reported, the drivers are rewarded with the incentive. However, it seems to have been implemented in a different manner. Rather than receiving the incentive as a reward at the end of the period, the drivers start the period with the incentive already credited to them. If, during the period there are any incidents related to a driver, this driver will lose their incentive. In this manner, the incentive acts more as a punitive measure rather than a reward to the drivers.

Drivers have also come to rely on this incentive at the end of the month, rather than seeing it as a reward they see it as their right to receive.

‘We do get something that they give us it’s like a voucher they give you a 200 [rand] voucher so that we can buy something every month they give each and every driver but if there was a mistake if maybe there was a complaint about you that on the way you didn’t give someone the right of way or you drove recklessly you know that sort of complaint there’s a thing that you won’t get the voucher.’ – Respondent Three

The drivers have come to expect this incentive at the end of each month and therefore take for granted that they will be receiving an extra R300. They have come to rely on this extra money monthly;

‘We get this also [Incentive], we need it because we can buy this and that with it, but sometimes we don’t get it if there were complaints against you and we need it.’ – Respondent Seven

When drivers lose their incentive they see this as the company taking away something owed to them, almost as though they have been ‘short changed’ on their salary. This is counter to what is trying to be achieved by the organisation. The drivers do not see this as a reward for safe driving.

4.4. Summary of findings

Phase one of the research looked at the policies and procedures that have been implemented by the company. It is evident that the company has considered the implications of safety to the success of the company. This is evident in the reinforcement of

safety policies throughout many different documents provided by the company such as in the SMSH, The Induction Training Manual of Policies and Procedures, and the Practical Drivers Training Manual. The analysis of these documents found that training is stressed in the organisation. Furthermore provisions have been made for the renewal of training on a yearly basis for the drivers. The procedure for disciplinary hearings is set out in the Disciplinary Procedure and Code of Conduct. This document has a comprehensive list of offences, the category these offences fall under, as well as the appropriate penalties if these offences are committed. There is evidence throughout the documents that the drivers are responsible for maintaining a good safety record in the company.

Phase two was focused on the accident statistics of the depot under study in this research. Even though there were limited data to consider there were still significant findings. The number of accidents for 2014, the year the research was conducted, was 6 times greater than all three years preceding it combined. However, it was found that only 30% of the accidents in 2014 could be attributed to driver error, and 32% of accidents over the entire recorded three year period could be attributed to driver error. The nature of the accidents could not be considered 'serious' as all damage was considered less than R20 000,. Additionally there were no recorded injuries that resulted from these accidents.

Phase three was dedicated to interviewing the bus drivers. It was found that getting drivers to speak candidly about safety incidents is very difficult. Whilst some drivers were willing to speak about incidents that they were involved in, others were nervous about the topic and admitted to incidents occurring, but not with themselves.

The drivers acknowledged that the company does emphasis safety practices. The need for safety is communicated well between the company and the drivers. The drivers also recognised that training when they first join the company is comprehensive. However, once the driver has been part of the company for a longer period of time there is a perception that the management's insistence for a constant need for the updating of training becomes repetitive. Furthermore, there is a perception that not all information that they are being provided with is relevant to their everyday driving scenarios.

The relationship between drivers and management was found to be a theme after analysis. The prevailing perception was the feeling that management was unaware of the

experiences and needs of the bus drivers. It was discovered that the drivers had a particular issue with the on-site manager, who they considered 'under-qualified' as he was a former driver himself. The responses of the drivers indicate that there is a potentially low level of trust in the on-site manager.

The next theme that arose is the perceived satisfaction of drivers in the organisation. There are a significant number of drivers actively seeking new employment, with 30% of the drivers stating that they are looking elsewhere for jobs. Furthermore, there was a perceived dissatisfaction with facilities provided by the company for the drivers, specifically a room provided for the drivers to stay on-site and sleep. This room is utilized by the drivers if they are required to perform a very late, or early shift.

In terms of justice and fairness, the research looked at distributive, procedural, and interactional justice. The distributive aspect focused on the effort-reward balance. 100% of the respondents stated that they were dissatisfied with the balance, perceiving that the rewards that they received were not in balance with their efforts. The drivers' perception is that an imbalance exists between effort and reward. There also seems to be a low level of intrinsic satisfaction in their job.

Procedural justice manifested itself in different ways in the interviews. Firstly, the drivers perceive that they have no control over their shift allocation with 57% of respondents stating that they were dissatisfied with the current shift arrangement. Of the respondents, 64% perceived that the decision-making process was unfair. Respondents perceived that they are not listened to by the organisation. The subject of being able to hold meetings was raised by 57% of the drivers. Driver's perceptions are that they are unable to hold regular meeting in which to discuss and voice opinions, ideas, and issues.

Finally, in terms of interactional justice there is a perception from the drivers that interactions between managers and drivers are largely transactional in the form of direct instructions which drivers are expected to obey. The disciplinary procedure was commented on by 71% of the drivers, with dissatisfaction being displayed by the drivers. However, there were no reported incidents between drivers and management. This may suggest that the tone of daily interactions is generally acceptable to the drivers.

The money provided by the incentive programme is relied upon by the drivers. The driver's perception is that this money is part of their monthly salary, and perceive it as unfair when they do not receive this incentive. The drivers do not perceive this incentive as a reward for safe driving practices.

Chapter 5: Discussion

The focus of this study was to understand bus drivers' perceptions of organisational justice and safety in a particular bus transport company. This consisted of a case study approach. A three-phase approach was used to collect and analyse data. Phases one and two focused on policies and procedures, as well as the accident statistics of the company, in order to gain an understanding of the context in which the drivers operate. Phase three focused specifically on interviews with the bus drivers. In this chapter, the data from all phases is combined to achieve the research aims. Safety in the organisation, perceptions of organisational justice, the relationship between drivers and management, and drivers' satisfaction with the organisation are discussed.

The research questions were:

1. How does the organisation define safety incidents and accidents?
2. Based on the organisation's policies and procedures, what emphasis is placed on safety and developing a safety culture?
3. What safety incidents have been reported at the relevant depot between 2011 and 2014?
4. How, if at all, has the frequency of safety incidents changed between 2011 and 2014 at the depot concerned?
5. What are bus drivers' perceptions of safety in the company?
6. What are bus drivers' perceptions of organisational justice in the company?
7. Does the perception of organisational justice influence attitudes and behaviours towards safety in the organisation?

5.1. Safety in the organisation

The motivation for this research is based on South Africa's poor road safety record. Busses were the focus of the study due to the potential for a disproportionately high number of injuries or fatalities to occur in accidents due to the volumes of people they carry.

Furthermore, research by Bjornskau and Longva (2009) showed that bus drivers displayed the poorest safety culture in their study and the authors suggested that these results reflected the different external conditions of the different transport modes. In the current

study, Reason's Swiss Cheese Model (1998) and the Systems Theory Model of Accidents were used. Both these models adopt a systemic approach to safety incidents, and acknowledge that safety incidents occur within a broader context. Therefore in addition to understanding perceptions regarding safety in the organisation, the study also focuses on aspects which could relate to attitudes and behaviours associated with safety. Accidents in this discussion refer to any incident which has caused a form of physical damage or injury to any party involved in the incident.

The importance of safety is reiterated throughout the company's policies as is evidenced by the inclusion of the importance of safety in each document that was analysed. Safety culture is the way in which safety is managed in the workplace, and often reflects the attitudes, beliefs, perceptions and values that employees share in relation to safety (Cox & Cox, 1991). Therefore, an organisation that is committed to operating within the framework of a safety culture encourages employees to perform their duties in a safe manner, within the normal operating procedure (Pidgeon N. , 1998). It is evident that the company in the current study is attempting to create a safety culture within the organisation. As stated earlier, this research focuses only on selected components related to safety. These include the behaviours, attitudes, beliefs, values and norms that are expressed in policies and those held by the drivers.

It is noted that mission statements tend to reflect the company's' aspirations rather than necessarily reflecting states that have already been achieved. In addition, the way in which these values and beliefs translate into company practices can be understood through the behaviour and attitudes of the company's managers and employees. Therefore it is possible that some aspects of the policies are not always reflected in the practices that occur in the organisation. This study focuses specifically on drivers' attitudes and behaviours through interviews that were conducted at one specific depot.

It must be stressed that it was very difficult to get drivers to speak candidly about specific safety incidents and that there was a large discrepancy between the number of safety incidents as reflected in company records and the number of incidents that drivers described. In addition, it is possible that the company's accident statistics for the depot provided conservative information regarding the actual number of accidents that took place

for the four-year period concerned. This is based on Bird's (1969) theory of safety incidents ratios, whereby for every major incident that is reported, there is a larger number of less serious incidents that are not reported (O'Neill, Martinov-Bennie, Cheung, & Wolfe, 2013). For this reason, it would have been preferable for drivers to be candid about specific safety incidents that may have occurred regardless of whether they had been reported or not.

The drivers were reluctant to speak about safety incidents that they or their colleagues had experienced. This may be due to several factors. The first factor may be mistrust of the researcher. The drivers may have been uncertain about the specific reason why the information was required by the researcher, and what was going to happen with the information that they discussed. Therefore, the drivers may have been unwilling to speak about these safety incidents. A second factor may be that the drivers were unwilling to discuss these safety incidents due to professional embarrassment. The drivers may have felt that having been involved in any safety incidents may diminish their credibility as professional drivers. This lack of openness may have implications for the company's attempt to converse with drivers about safety if the company officials experience the same lack of openness as the researcher. There may also be implications for conducting academic research in this area. Research may not portray accurate descriptions and understandings of the area if the drivers are not open about safety incidents that have been experienced.

It was found that the drivers believe that the need for safety in the company is communicated well. The bus drivers acknowledged the need for safe operating conditions, as well as the importance of passenger safety to the company. Recognising the importance of safety is one of the steps in creating a safety culture, but that this does not necessarily translate into safe behaviours. Based on the SCM, numerous other factors also influence the occurrences of incidents (Reason, Hollnagel, & Paries, 2006). Some of these factors are discussed in subsequent sections. The drivers perceive that safety is important to supervisors and managers through the way that the information is communicated and reinforced via a range of interactions. This includes the documents they receive, such as their employment contract, the SMSH, and the training documents. The inclusion of a safety officer in their day-to-day functioning also reinforces the importance of safety in the company. The results of this study found that drivers perceive that safety is important,

However, they were critical of aspects of the safety training. There is a perception that much of the information that they are provided with during training and safety briefings is not relevant to the conditions in which they drive. The drivers also perceive the information that they receive as being repetitive.

The behaviours that relate to safety in the organisation can be considered through the number of accidents the drivers have been involved in. Phase two analysed the number of accidents that the drivers have been involved in over the last 4 years. Consistent with previous research by af Wahlberg (2004) who found that most accidents occur at intersections, this study found that over the recorded period 36% of the accidents were at intersections. A further 36% of accidents occurred under 'normal driving conditions.' No explanation was provided by the company as to what this means, but it is likely to indicate accidents at places without dangerous features such as intersections or merging lanes.

It may be concerning to the organisation that the number of recorded accidents for 2014 was six times greater than the number of accidents of the three previous years combined. However, only 30% of the accidents were attributed to driver error for 2014, which is lower than the 50% attributed to driver error in the previous years. Therefore, there may be more recorded accidents for 2014, but the rate of accidents that can be directly attributed to errors on the part of drivers has actually decreased. This decrease in driver attributed errors may be for different reasons. There may be better reporting of incidents that occurred during 2014, coupled with underreporting of incidents in the three years before that. Finally, this may be a statistical phenomenon, because there are a greater number of recorded incidents there is a greater potential for these incidents to have occurred for different reasons.

The 'Swiss Cheese Model' (SCM) is a framework for describing the interactions that occur when a complex system suffers a breakdown (Reason, Hollnagel, & Paries, *Revisiting the Swiss Cheese Model of Accidents*, 2006). In particular, it conveys the fact that no single human or technical failure is sufficient to cause an accident (Reason et al., 2006). Rather, accidents involve the unlikely and often unforeseeable combination of several contributing factors arising from different levels of the system (organisational influences, unsafe supervision, preconditions for unsafe acts, and unsafe acts). Each level contains gaps which

are created by active failures - the errors and violations of those at the human-system interface and by latent conditions arising from the failure of designers, builders, managers and maintainers to anticipate all possible scenarios. This framework will be used to consider the organisational potential for accidents to occur. The SCM makes it clear that organisational accidents are rare events and require the lining up of the gaps to permit a brief trajectory of accident opportunity.

Using the SCM it would be difficult to isolate one single event that led to an accident for the company. At the highest organisational level, the company has implemented policies and procedures that create an awareness and understanding of the need for safety and safe practices in the company. The results of the interviews show that the drivers seem to understand this and do perceive safety as important. The company has put into place procedures for supervision of the drivers, in the form of a safety officer who is in contact with the drivers on a daily basis. The safety officer reinforces the need for safety and makes sure the drivers are aware of the required safety practices. Isolating the conditions for unsafe acts can prove difficult because these conditions change constantly. One potential condition that was identified was driver's dissatisfaction with certain aspects of the company. For example, the drivers voiced dissatisfaction about the 'rest room.' If a driver is required to stay there overnight and does not receive adequate rest, the potential exists for an error to be made due to sleep deprivation. This is supported by Blower et al. (2008) who found that professional drivers are more likely to be involved in a safety incident if they are unable to concentrate due to sleep deprivation. Finally, unsafe acts must be examined.

There was no evidence from the data that the drivers were consciously and willingly engaging in unsafe driving acts. The drivers did not make any mention of any acts that could be considered unsafe. This may partly be due to reluctance in admitting that they do potentially engage in unsafe driving practices, especially as the interviewer was unknown to them.

Complex Systems theory states that accidents are likely to result from interactions amongst various components in the system instead of a single variable in the system (Leveson, 2004). Systems theory examines the error that occurs within the system's operation to see what caused the accident to occur. Under normal circumstances the chances of an accident

occurring are low. The number of safety incidents recorded between 2011 and 2014 stands at four, whilst there is a significant increase in 2014 with 24 incidents being reported. When using systems theory to regard this situation the statistics would indicate that in 2014 conditions may have changed resulting in a significant increase in reported incidents. However, this research cannot identify what any potential change may have been as there is an insufficient knowledge of historical context.

5.2. Justice

The second concept that was considered in this research was that of organisational justice. The three-factor model of organisational justice was used (DeConick, 2010). The factors that make up this model are distributive, procedural, and interactional justice. Justice was considered important in this study as the implications of perceptions of injustice can impact on the effectiveness of employees (Tabibnia, Satpute, & Lieberman, 2008) and could potentially influence drivers' behaviours. This section discusses each factor separately.

5.2.1. Distributive justice.

When considering distributive justice, a common factor is often pay recognition. The allocation of shifts is also considered a significant factor when studying professional drivers (Tse et al., 2006). In this research both these factors were perceived as issues by the drivers. None of the drivers was satisfied with their current pay. Secondly, the drivers' perception is that they have little or no control over how shifts are allocated. Drivers stated that they are told what their shift schedule is going to be at the beginning of the year and this does not change. The drivers said that they are then required to work these shifts until indicated otherwise. The combined dissatisfaction with pay and shift allocation has led to 30% of the drivers in the sample actively seeking new employment. This is consistent with research by Colquitt et al. (2001) which states that negative perceptions of justice may lead to low levels of job satisfaction. The low level of job satisfaction may manifest in high absenteeism rates, high job turnover, and organisational resistance. This was evident when studying the Driver Incentive KPI document. Over a period of four weeks, 22 transgressions were recorded. Of these 22 transgressions, six were recorded as late coming, six were absenteeism, and two could be considered as organisational resistance. Assuming that there is a close link

between organisational justice perceptions and these transgressions, it is possible that up to 64% of the recorded transgressions were related to the perceived injustice. However, it is likely that other factors were the primary causes of some of the transgressions.

The incentive scheme is based on individual performance but the 'team' is also affected by individual offences. This may be aimed at getting colleagues to encourage good performance and safe driving amongst each other. However, driving busses is essentially an individual and not team task. Therefore, the structure of the incentive scheme may have the potential to cause conflict amongst drivers. Of the recorded transgressions, only four can be considered as safety issues, and the remaining 18 are issues of discipline. However, both types of offences are included in the incentive scheme. There is a fine boundary between safety and disciplinary issues, and this line is blurred when drivers are disciplined in the same way for both types of transgressions. Therefore, the incentive scheme is less likely to be perceived as rewarding safety when drivers are punished for disciplinary transgressions in the same scheme. This is likely to have contributed to the difficulty in discussing and researching safety issues in the company.

The incentive programme can be considered an extension of distributive justice in the organisation. Drivers are incentivised to not commit any transgressions during a certain period. If they successfully maintain this, they are rewarded with vouchers for a specific monetary amount. However, the drivers perceive these vouchers as their 'due' and have come to rely on the financial value of the vouchers each month. The drivers do not view this scheme as a reward for safe driving practices. Instead the drivers perceive it as a form of punishment. If the driver does not receive his voucher at the end of the period, he consider himself as having lost part of his monthly due, rather than viewing the scheme as a reward programme and receiving a 'bonus' amount at the end of the month.

5.2.2. Procedural justice.

Research by Fischer and Smith (2006) found that greater perceived procedural justice was associated with higher satisfaction and greater commitment to the organisation. In the current study, the procedure used to allocate shifts was perceived by the drivers as unfair. The drivers were dissatisfied with how the shifts are allocated. They perceived that they are 'told' what the shifts will be rather than actively being a part of the decision making process.

This can be considered a violation of the representativeness rule that was conceptualised by Leventhal (1980). This rule states that the needs, values and outlooks of all the parties affected by the allocation process should be represented in the process. The rule requires that when a decision is made the interests of all the stakeholders are taken into account. There may be unintended consequences of driving a single route for an extended set period of time. In the drivers' case, having to drive the same route may lead to a complacent attitude. The term complacency originated in the aviation community to refer to accidents or incidents in which pilots and Air Traffic Controllers supposedly did not conduct sufficient checks of the system's state and assumed "all was well" when in fact a dangerous condition was developing that led to the accident (Parasuraman & Manzey, 2010). Repeatedly driving the same route under similar conditions may lead to the driver losing his critical focus on the road. For example, a side road that is always empty and which the driver has never witnessed any form of traffic in, may over time become 'invisible' to the driver. However, the driver may one day experience traffic in this side road which is unexpected, as the driver has not created a relationship between traffic and this side road. This unexpected occurrence may lead to the potential for an incident to occur. This is an example of how perceptions of justice may influence safety in an organisation.

The results found that not only was there dissatisfaction with the shift procedures, but also with decision making procedures in general in the company. 64% of respondents perceived that they are not listened to by the company. This may be associated with the decision making process as the drivers may potentially be making suggestions for the organisation that are not being heard. Furthermore, the drivers may be raising objections to certain decisions that are being made within the organisation, if they drivers perceive that these objections are not being listened to then they may feel as though they are not included in the decision making process of the company. The issue of not being able to hold meetings was raised by 57% of the respondents. However, it is not certain what the drivers meant by not being able to hold meetings. The SMSH makes provisions for meetings to be held between employees and management, and requires that a weekly safety meeting is conducted. Some respondents claim, however, that meetings do not take place as often as they are required to. If this is what is occurring it is potentially a violation of Leventhal's (1980) consistency rule, which states the allocation procedures should be consistent across

persons and over time, as there is the requirement for meetings but they are not being fulfilled. Research by Cohen-Charash and Spector (2001) found that if a process that leads to a certain outcome is perceived to be unfair the reactions of the employee are predicted to be directed at the whole organisation, rather than at their tasks or the specific outcome. This is consistent with the findings of this study, where the drivers perceived that the organisation is to blame for these injustices.

5.2.3. Interactional justice.

Interactional justice is the final aspect of organisational justice that was considered. Esterhuizen and Martins (2008) state that perceived interactional justice violations are evident in the reported lack of trust between management and employees. It was found that the drivers do not perceive the interactions between themselves and management as a cause for great concern. There was no report of any relationship between the drivers and management. However, there appears to be a perception from the drivers that interactions between managers and drivers seem to be largely transactional in the form of direct instructions which drivers are expected to obey. Furthermore, there is a perceived lack of trust between drivers and the on-site manager. This manifests in the driver's perceptions that the manager is 'underqualified' to manage them as he is a former driver himself. Additionally, some drivers perceive this manager as acting as a 'puppet' on behalf of the organisation. The drivers did not mention that there was a lack of respect shown by management towards them.

5.3. Relationship between drivers and management

As discussed in the previous section the relationship that exists between drivers and management can be linked to organisational justice. The relationship between the on-site manager and the drivers was raised by certain respondents. The drivers perceive management as 'separate' from them, reducing opportunities for a relationship to be created between the drivers and management. Consequently, the drivers may perceive the relationship between themselves and the organisation as 'top-down'. This is evident in the responses of the drivers who perceive the management as telling the drivers what to do

rather than discussing with the drivers what will occur. This perception may be strengthened in the way that information is communicated with the drivers. The drivers are expected to consult a noticeboard which conveys any important information to the drivers, rather than management communicating this during meetings orally with the drivers. However this communication style may be considered necessary as it is difficult to gather the drivers at a single point and time to meet due to time schedules. The relationship between the drivers and management lacks trust as a consequence. This lack of trust may be contributing to the perceived injustices in the organisation. As Reason (1998) stated, trust is essential in the creation of a just culture, as there must be acceptance of the concept at all levels.

5.4. Drivers' satisfaction with the organisation

Based on the results in the research drivers' perceptions of key processes in the company could lead to dissatisfaction. As has already been discussed, the perception of distributive justice has led to dissatisfaction in the drivers, including dissatisfaction with pay and how shifts are allocated. This dissatisfaction has reached a level where the employees are willing to leave the company in order to seek employment elsewhere. A further issue that was raised in the interviews was the on-site room that has been provided for the drivers. Drivers were dissatisfied with the condition of the room. These conditions appear to be affecting the attitudes of the drivers which in turn affects their driving behaviours. The drivers may perceive the condition of the room as indicating a lack of concern from the company. The condition of the room cannot be commented on as the researcher did not visit it. However, it is important to consider as these perceptions may still influence the drivers behaviours. This is because the drivers' reality is shaped by their perceptions and their behaviours are likely to be influenced by their perceptions.

5.5. How perception of organisational justice may influence attitudes and behaviours towards safety in the organisation

Research by Esterhuizen and Martins (2008) based in the South African context found that perceived injustices would result in rejection and resistance, as well as moral outrage which may lead to anger and resentment towards the organisation. Furthermore, perceived

procedural and interactional justice violations are evident in the reported lack of trust between management and employees. The results of this research found that there is a lack of trust of management displayed by the drivers. The results found that the drivers may be demonstrating potential resistance against the organisation in different ways, such as late coming for shifts, unaccounted for absenteeism as well as non-compliance of the uniform policy, and a high turnover rate, this we can assume from the large number of employees actively seeking new employment. Whilst these actions may be examples of resistance, this interpretation should be treated with caution. There may be a host of other factors that led to these disciplinary transgressions rather than drivers displaying resistance against the organisation.

The data showed that there were 24 safety incidents in an 11 month period. This is an average of 2.2 incidents a month. Whilst this may not seem like a large number of incidents, there has been a significant rise in incidents in 2014. This is because there was an average of 1.33 incidents a year between 2011-2013.

This research cannot claim to find any causal relationships due to the nature of the design of this study. However, this research has found evidence that drivers perceive organisational injustices within their company. Furthermore the data revealed that there has been a significant increase in reported safety incidents during the last year compared to previous years. Causes of the increase in incidents are unknown. There is a possibility that the drivers' perceptions of organisational justice may have influenced attitudes and behaviours towards safety, as a possible explanation of the increase in incidents.

Chapter 6: Conclusion

This study provided a qualitative assessment of the perceptions of organisational justice of bus drivers and how these perceptions influence attitudes and behaviours towards safety in their organisation. This was achieved by dividing the research into three phases. Phase one and two analysed documents provided by the organisation under study in the research. These documents included policies and procedures as well as statistics related to accidents that had occurred within the company, specifically the depot under study. Phase three recorded the perceptions of the bus drivers regarding organisational justice as well as safety. These perceptions were explored in-depth and discussions arose as to how the perceptions of drivers may influence their attitudes and behaviours. The research sustained the importance of both a just, and safety culture within the organisation. Whilst there exists a plethora of research focused on safety culture in the transport industry, specifically in the field of aviation and to a lesser extent long-haul drivers, there is very little research focusing specifically on bus drivers' perceptions. This research was conducted because there is a lack of readily available research in the South African context. The author did not find any published research in the South African context specifically looking at the perceptions of bus drivers with regards to organisational justice and how this is related to safety in the organisation.

6.1. Limitations of the study

There are certain limitations that must be noted with regards to this study. The sample size may have been a potential limitation, and a larger number of participants may have enriched the data. The greater the sample size the more varied and rich the level of responses will be. Although it must be noted that the population in the study was very limited, no more than 35 individuals made up the population. Of this population, 29 individuals were approached for interviews. There was a response rate of 48.28 percent which can be considered acceptable.

Semi-structured interviews provide both positives and negatives for this research. Positive aspects included the fact that interviews were very informal and the respondents usually felt at ease. Furthermore, the interviews followed a natural course of discussion and this

allowed for more information to be shared. Negative aspects of this technique meant that often the respondents would follow a different thought process and would have to be guided back to a more appropriate response for the research topic.

Unfortunately some of the participants did not adequately comprehend some of the questions. This potentially influenced the depth and quality of the responses from these participants for these questions. Language was often an issue. The interviews were conducted in English as this was the common language between interviewer and the participants. However, English is not the first language for most of the participants, and in fact, may be the third or fourth language spoken by many of the participants. This made some of the language used by the interviewer difficult to understand and therefore simplifications to many questions had to be made in these instances.

The location where the interviews took place caused concern. The interviews took place on the drivers' respective busses during their breaks. This was done for convenience as it was impossible to interview the drivers before or after their shifts, as well as the fact that the drivers have no break room and feel more comfortable staying on, or around, their busses. The busses were often noisy, making hearing and speaking difficult, and audio recording almost impossible. However, the bus can be considered the drivers' comfort zone. Because the drivers were more comfortable in the busses, and felt as though they had some sort of control (as the researcher would have to leave immediately at the request of the driver) the drivers may have been less defensive than if a neutral meeting spot been used.

There is limited research of this type in the South African context. This study aimed to enrich the understanding of how perceptions of organisational justice can affect the level of safety incidents in a meaningful and realistic way. The use of qualitative data allowed for actual perceptions to be noted and how these perceptions affected attitudes and behaviours of individuals in front line safety situations.

6.2. Recommendations for future research

Future research in this area should conduct this study in different environments. This study focuses on very specific types of driving patterns, namely short route based inner city driving. Future studies should focus on long haul, and extended route transport. Extended

route transport was specifically mentioned by some respondents, and highlighted as a problem area in their opinion. This is confirmed by the Road Traffic Report (RMTC, 2011), in a South African context, many fatal accidents occur on intercity routes. An analysis of different depots would be suggested for future research as the inclusion of only one depot makes the generalisation of these research findings very difficult.

It is suggested that focus groups should be used in future studies. This may allow for a greater amount of information to be collected by the researchers. Being part of a focus group may put the drivers more at ease. This may allow for better collection of safety related information as drivers may feel more open to discussing incidents if they hear other individuals discussing these incidents. However, there is a chance that this may have the opposite effect as drivers would not want to portray themselves or their colleagues in a poor light.

Future studies may also consider adding a quantitative aspect to the research design. This may complement any qualitative information that may have been recorded as well as allow for specific tests to be run that would allow for a greater and more in-depth understanding of the crucial nature of safety incidents.

It is also suggested that future studies include observation of driving behaviour (either from another vehicle or on-board). The researcher may consider observing the drivers while they are driving in order to collect more data. This data could help the understanding of conditions that the drivers experience as well as actual driving styles and behaviours.

6.3. Conclusion

This research explores drivers' perceptions of organisational justice and their possible link with safety incidents. The literature focuses on the importance of safety culture, as well as organisational justice. Reason's (1997) Swiss Cheese Model, as well as the Systems theory of safety were used as the overarching framework in this research. In order for an organisation to create and operate in a just culture, it is necessary to create an environment where safety incidents are seen as opportunities for learning. Safety incidents do not occur due to one isolated factor as has been seen in the safety models.

The perception of organisational justice may affect the attitudes and behaviours relating to safety of the drivers. Of the three components of organisational justice, there were strong perceptions that distributive and procedural justice are being violated in the organisation where the study was conducted. However, it was not found that the drivers perceived that interactional justice was violated. The drivers' perceptions of an unfair remuneration levels and dissatisfaction with shift schedules were issues for the distributive justice component. In terms of procedural justice, the drivers perceive the disciplinary procedures as unjust, as well as how decisions are made within the organisation. A lack of communication has created an environment for mistrust between management and the drivers which also plays a role in affecting attitudes of drivers. There is a key challenge in trying to address safety issues and develop a safety culture in an environment where there is not a just culture. In these circumstances, it is difficult to hold open discussions regarding safety. Despite the legal implications of accidents, the company in this case study may need to change its organisational culture to address safety issues.

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