

7 INSIGHTS INTO SAFETY LEADERSHIP



AMERICAN SOCIETY OF
SAFETY PROFESSIONALS

Puget Sound Chapter



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David Libby – Partner

Rebecca Timmins – Managing Director, Americas

Agenda

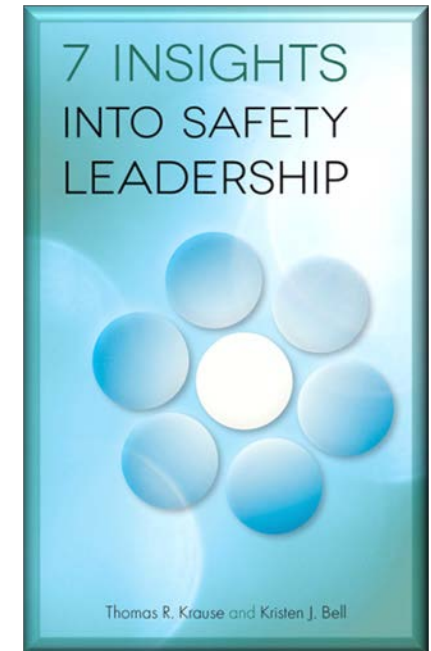
- Objectives
- 7 Insights into Safety Leadership - Insights 1, 2, 3 & 4
- Q&A / Open Discussion

Objectives

- Learn new ideas and innovative safety improvement concepts.
- As a team, begin to think about establishing a baseline current state assessment around the *7 Insights into Safety Leadership*.
- Identify obstacles and challenges to moving towards better practices in sustainable safety improvements.
- Begin to align on an enterprise safety vision, improving organizational collaboration, and begin to move the organization forward.

7 Insights into Safety Leadership

1. Safety performance leads business performance.
2. Safety leadership starts with attention to serious injuries and fatalities.
3. Leadership sets safety improvement in motion.
4. Culture sustains performance - for better or for worse.
5. Leading safety starts with understanding safety.
6. The role of behavior in incident causation is important, but it is only one piece.
7. Decision making plays a critical role in SIF prevention.



7 Insights Work

- About 20 years ago, Dr. Thomas Krause and others came together to quantify clients' safety improvements and examine their results over a long period of time.
- They found more variation across the 73 organizations studied than was anticipated.
- They conducted a series of studies designed to understand the factors most likely responsible for the success or failure of organization-wide safety improvement efforts.
 - *The primary differentiating factor was the strength of safety leadership.*
- The 7 Insights work is about the acumen that every leader must understand and employ in order to reach safety leadership excellence.
 - *Strong motivation to lead safety.*
 - *Strong understanding of what to do to achieve their goals.*

Scenario

During a discussion, a high-level, deeply experienced manager who you respect and who has a reputation for doing excellent work says: “I can give you safety, or I can give you cost and productivity, but I can’t give you both.”

How would you respond?

Insight 1

SAFETY PERFORMANCE LEADS BUSINESS PERFORMANCE

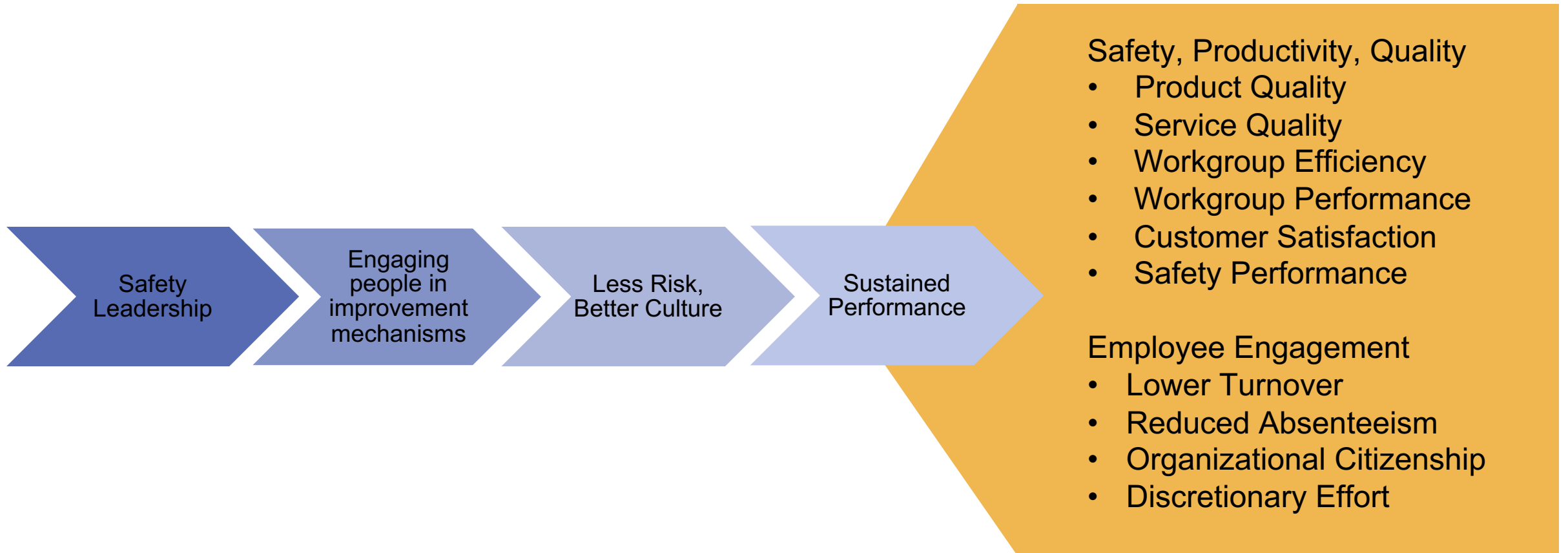


“If you want to understand how Alcoa is doing, you need to look at our workplace safety figures.”

— Paul O’Neill

Insight 1

RESEARCH BASIS



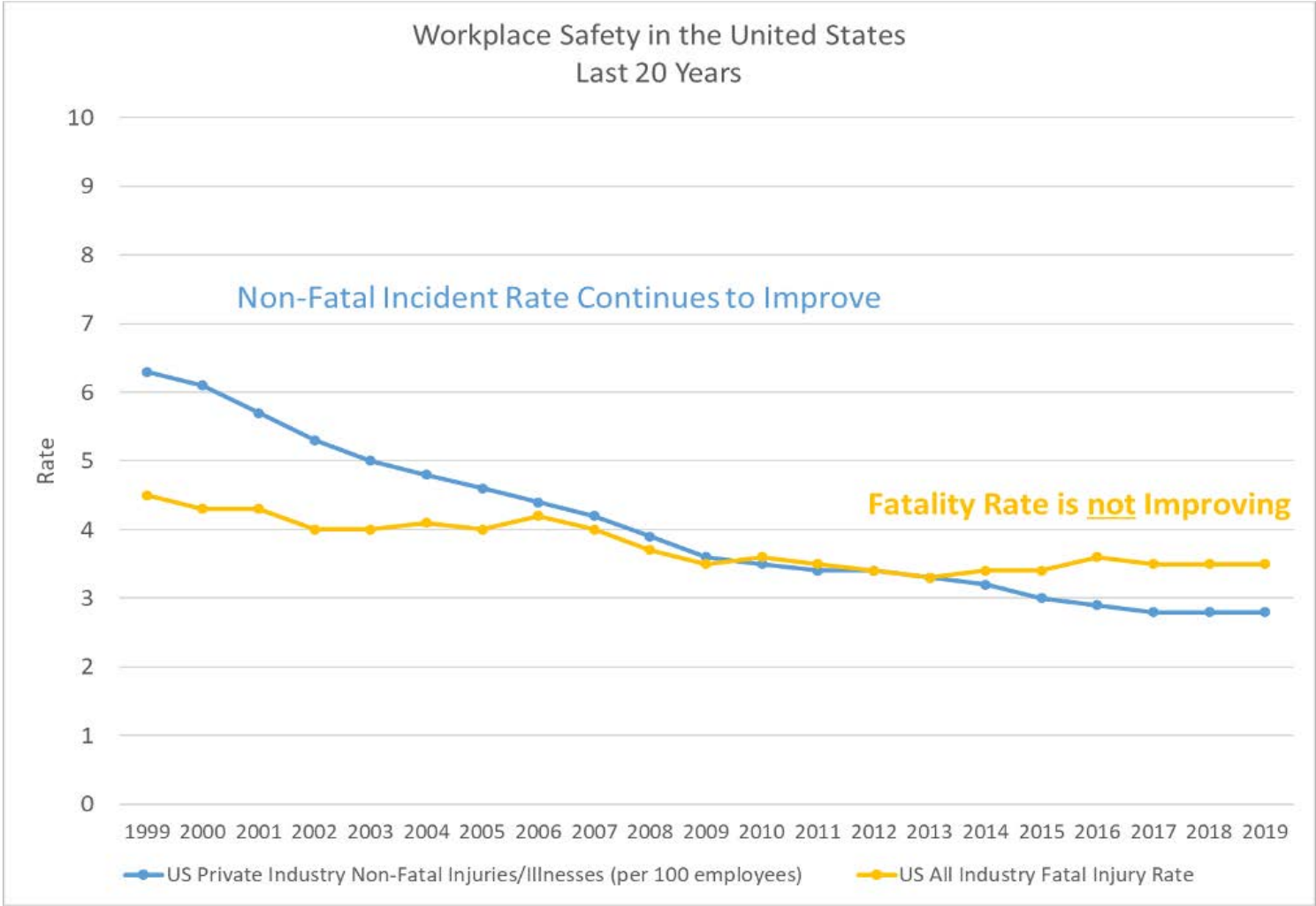
Insight 2: Scenario

- A. Carpenter smashes his thumb with a hammer and sustains a deep cut requiring eight stitches.
- B. Carpenter's thumb contacts a hand grinder and sustains a deep cut requiring eight stitches.

Discussion Questions - How does your organization...

- Report these events?
- Investigate these events?
- Follow up on these events?

Serious Injuries and Fatalities



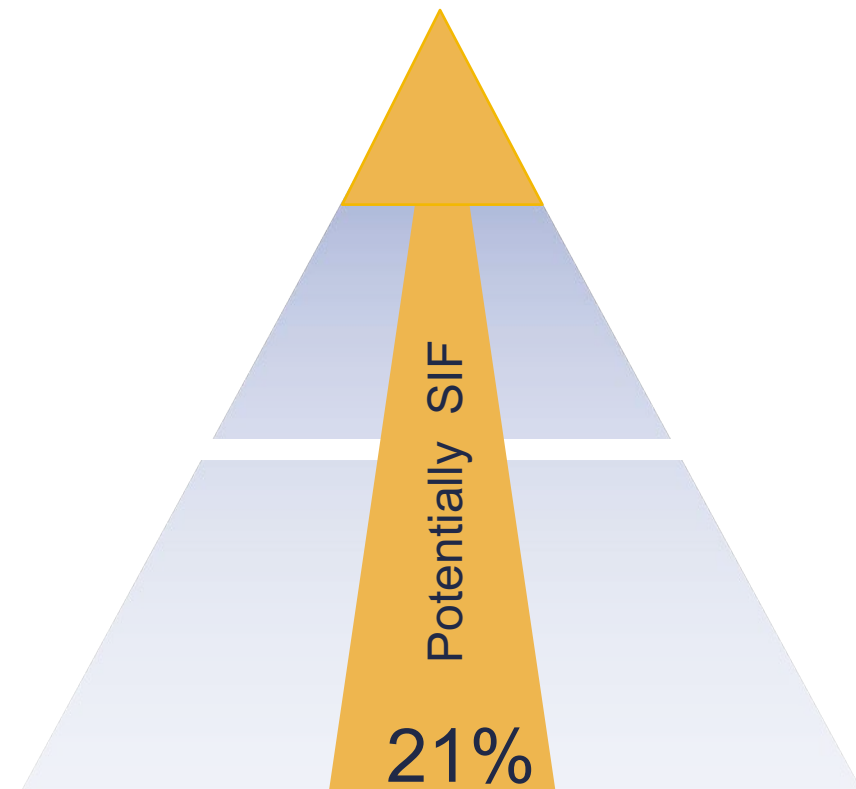
Insight 2

SAFETY LEADERSHIP STARTS WITH ATTENTION TO SERIOUS INJURIES AND FATALITIES

Key Learnings from the SIF Study

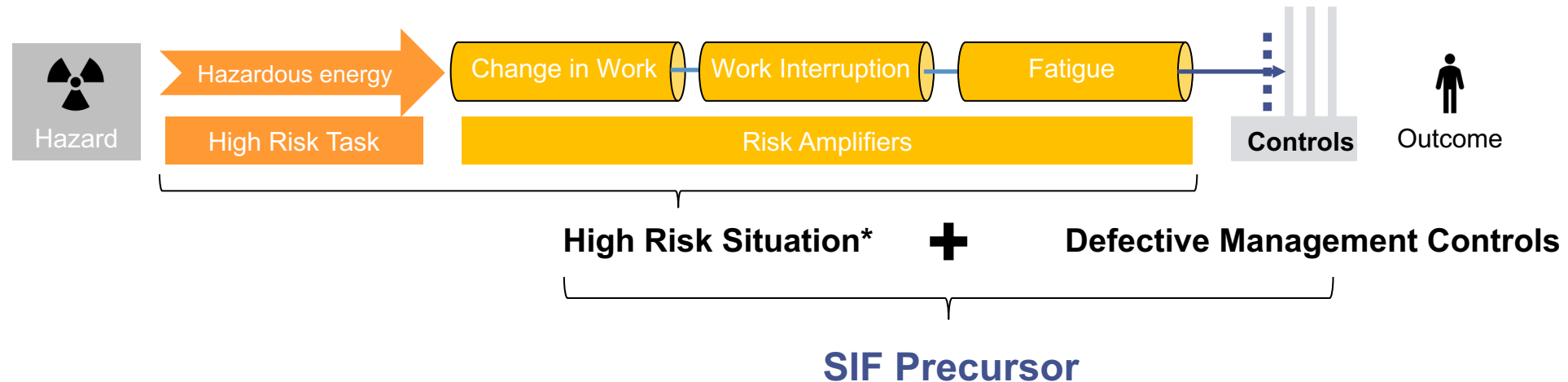
- Frequency and severity are inversely correlated.
- Not all injuries have SIF potential.
- Reducing injuries at the bottom of the triangle will not necessarily reduce injuries at the top of the triangle.
 - Injuries of differing severity have different underlying causes.
 - All minor injuries are not the same. Some low severity injuries are associated with *SIF precursors*.
 - Reducing serious injuries requires a different strategy than reducing minor injuries.

Of 300 sampled injuries,
64 had the *potential* to be SIFs



SIF Precursors

- *A SIF precursor is a high-risk situation (a high-risk task along with risk amplifiers) in which management controls are either compromised, absent, or ineffective.*

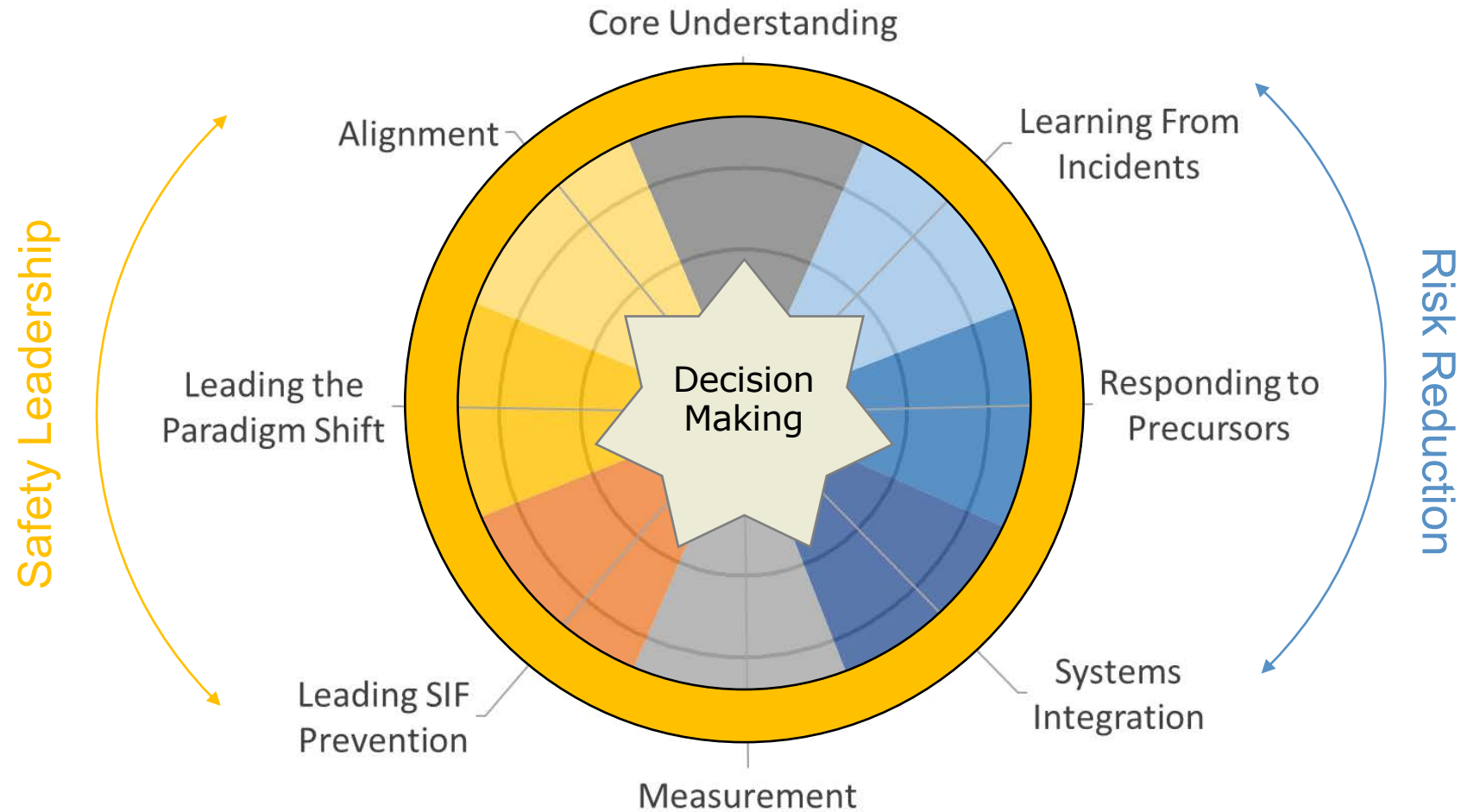


*A high-risk task is sufficient to create a high-risk situation. **Amplifiers** simply increase the likelihood of an incident or the severity when it happens.

Lessons Learned Since the Study

1. Reducing recordable injuries does not assure a reduction in SIFs.
 - Organizations need to shift focus from actual outcomes to potential outcomes. This requires leadership.
2. If you want to reduce SIF potential, you need to build your capability to identify and reduce SIF precursors.
 - Precursors are not well understood.
 - Hidden precursors are even more difficult to grasp.
 - This can't be relegated to the safety function.
 - This can't be limited to post-injury investigation.
 - Latent decisions can become precursors.
3. A reliable SIFp rate can tell you if those efforts are working or not.
 - SIFp rates are rarely reliable at first.
 - Leadership is needed to balance the tension between improving, reporting, and managing SIF potential.

SIF Maturity Model



Insight 3: Scenario

You are the VP of the business group and are visiting a plant that has mediocre safety performance. The plant manager is holding a town hall meeting, and you sit in along with the area operations manager (plant manager reports to this person). During her one-hour talk, she spends the first 5 minutes on safety. Further, she brings no energy or enthusiasm to the topic, but when she speaks about her process improvement initiative, she is dynamic and highly effective. You are seated next to the area ops manager and as the talk ends, he says to you, “Great talk!”

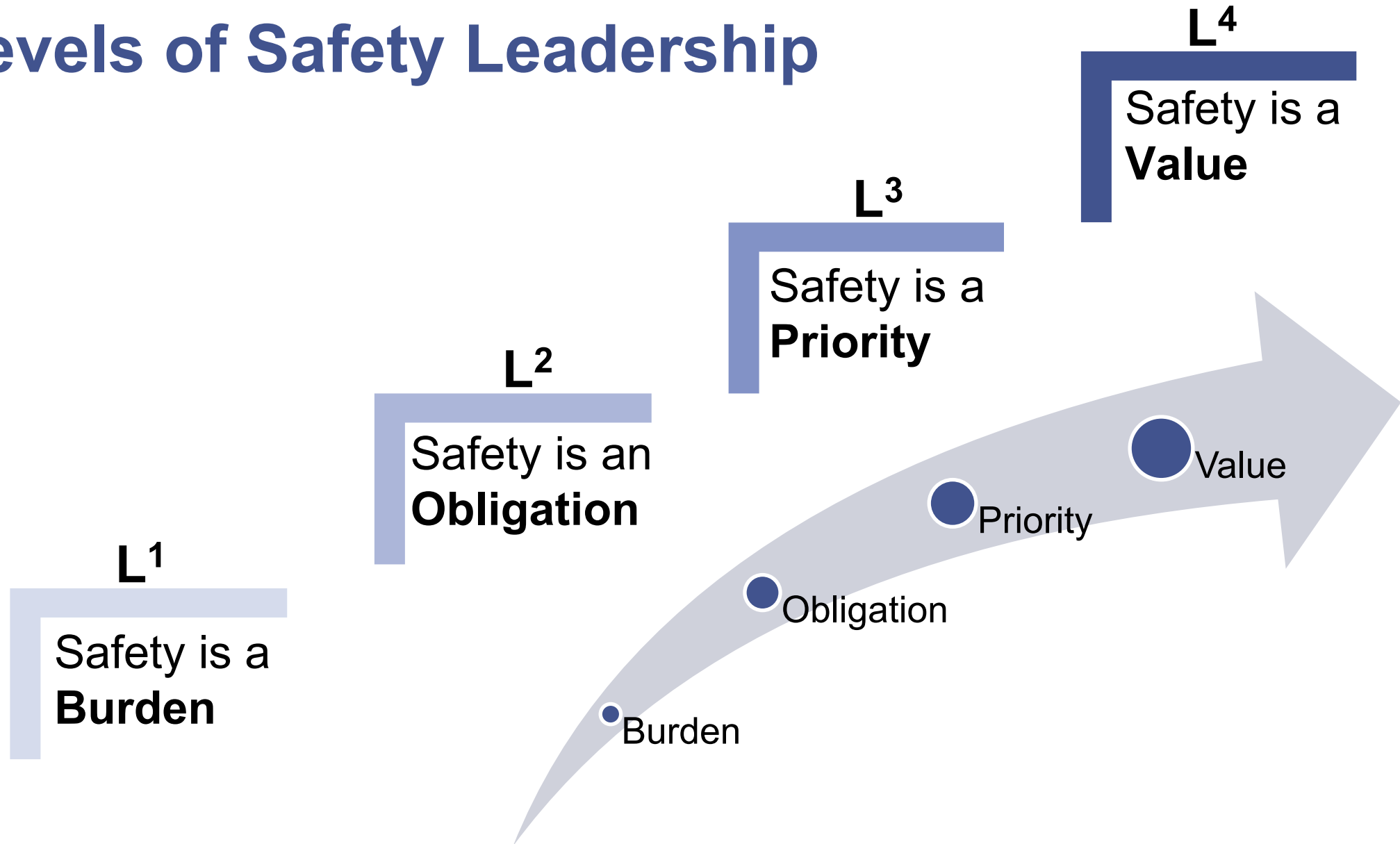
What should you do and how would you approach it?

Insight 3

SAFETY LEADERSHIP – THE SINGLE MOST IMPORTANT THING AN ORGANIZATION CAN DO TO SET IMPROVEMENT IN MOTION

- Leadership is where you go first. It will drive everything else.
- Leaders demonstrate a personal value for safety...
 - They take responsibility for their decisions and actions.
 - They hold themselves to the same high standards that they hold others to.
- Safety leaders have a strong safety vision. They:
 - Articulate a vision in a compelling way.
 - Convince people they can and will be successful.
 - Recognize progress.
- Safety leaders have credibility...
 - Their words and actions are consistent.
- Leaders are always creating culture...
 - For better or worse, whether they intend to or not.
 - What matters is what people see and experience. If you don't believe it, you can't hide it.
 - Leadership and Culture are best studied in front of a mirror.

Levels of Safety Leadership



Insight 4: Scenario

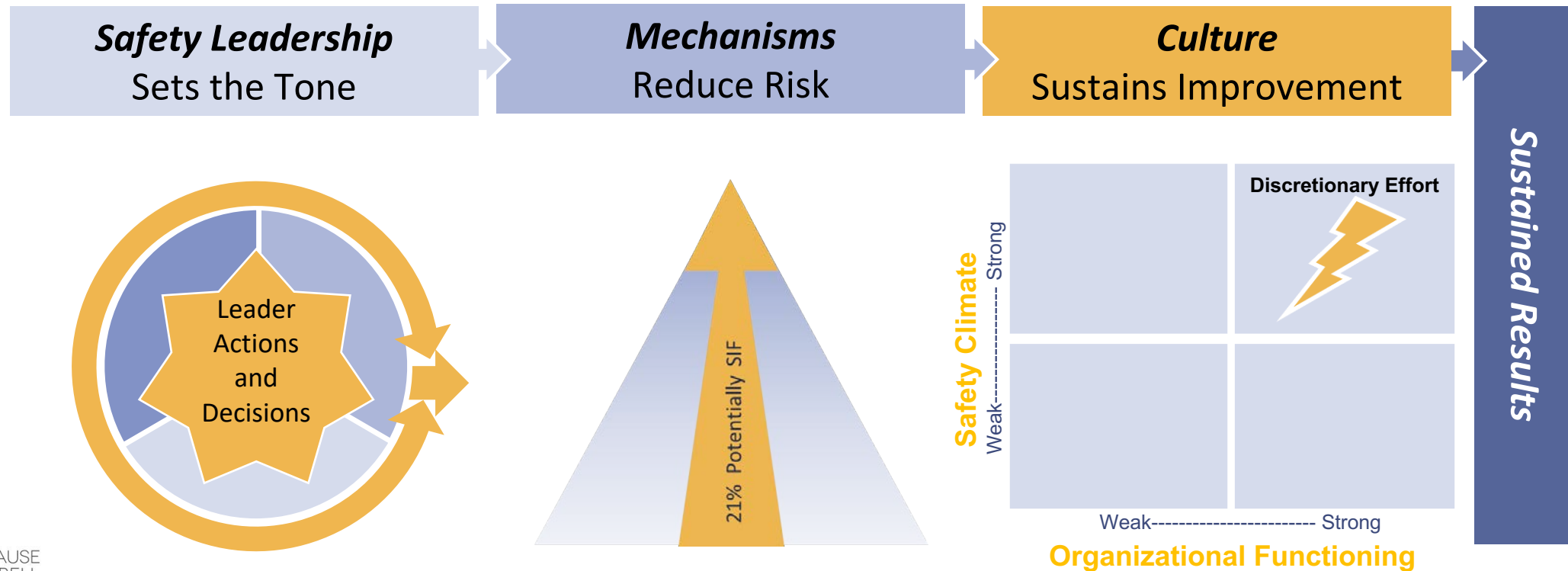
During a tour of one of your plants, you notice a great deal of risk tolerance: Five forklifts passed a supervisor who was standing next to a “stop” sign. Four of the five forklifts did not stop. The supervisor did not acknowledge the operator who did stop and did not speak with the operators who did not stop.

What should you do and how would you approach it?

Insight 4

CULTURE SUSTAINS PERFORMANCE FOR BETTER OR WORSE

- Leadership stimulates safety improvement, but culture sustains performance.
- Safety Climate and Organizational Functioning combine to influence both behavior and performance.



Insight 4

CULTURE SUSTAINS PERFORMANCE FOR BETTER OR WORSE

Strong safety climate...

- The organization truly values safety.
- Everyone acts in a way that demonstrates that safety is important.
- Focuses people on what's most important.

Strong organizational functioning...

- All employees trust and respect each other.
- Leads to better engagement, teamwork, and discretionary effort.
- Increases motivation to perform.

Strong safety climate and strong organizational functioning leads to...

- Stellar performance in safety, organizational efficiency, and effectiveness.

Closing Thoughts on Culture

- Culture is often defined as the shared values, beliefs, and assumptions that govern behavior.
- Leadership and culture is best studied in front of a mirror.
 - It requires great reflection.
 - As leaders, the change starts with you.
 - Be the change that you want to see in others.
- Leaders need to recognize the connection between what they do as leaders and the cultural attributes that they want to instill in the organization.
 - They are always creating culture in what they say, do, focus on, and the decisions they make.
- Research has shown that trusting, reciprocal relationships between all employees and the organization combine to contribute to a positive working environment and high levels of organizational functioning, leading to a stronger culture.

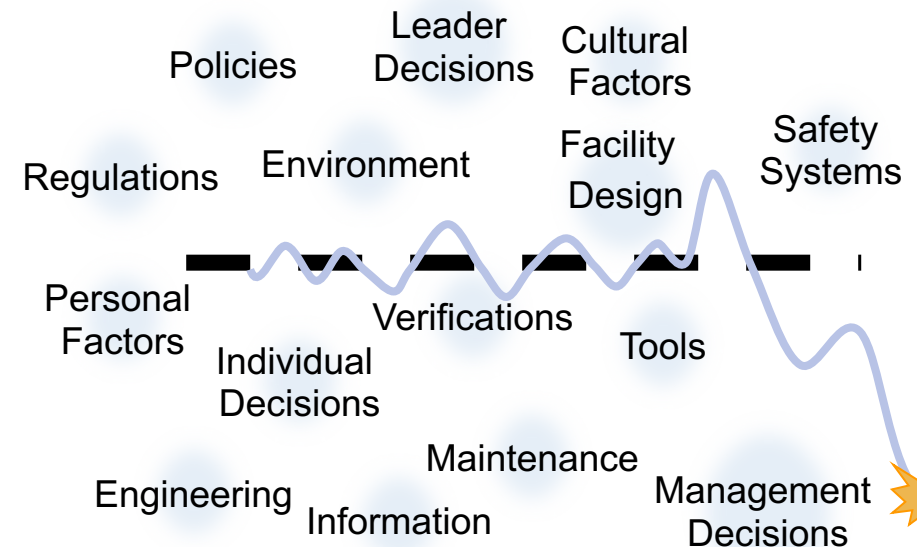
Insight 5

LEADERS NEED SOME SAFETY FUNDAMENTALS

Leaders who understand this insight show evidence of understanding general concepts:

- Systems views vs. singular views
- Standards & management system
- Role clarity & accountability
- Best practice sharing & innovation
- Leading indicators

In addition to general concepts, leaders need to understand the specific, evidence-based mechanisms of safety improvement.



UNDERSTANDING SYSTEM VIEWS

Insight 6

THE ROLE OF BEHAVIOR IN ORGANIZATIONAL SAFETY

Behavior ... A Different Role than Most Expect

1. Identify and define safety critical behaviors

2. Gather data through observation

3. Give/receive feedback

4. Use the data to identify, prioritize & solve problems

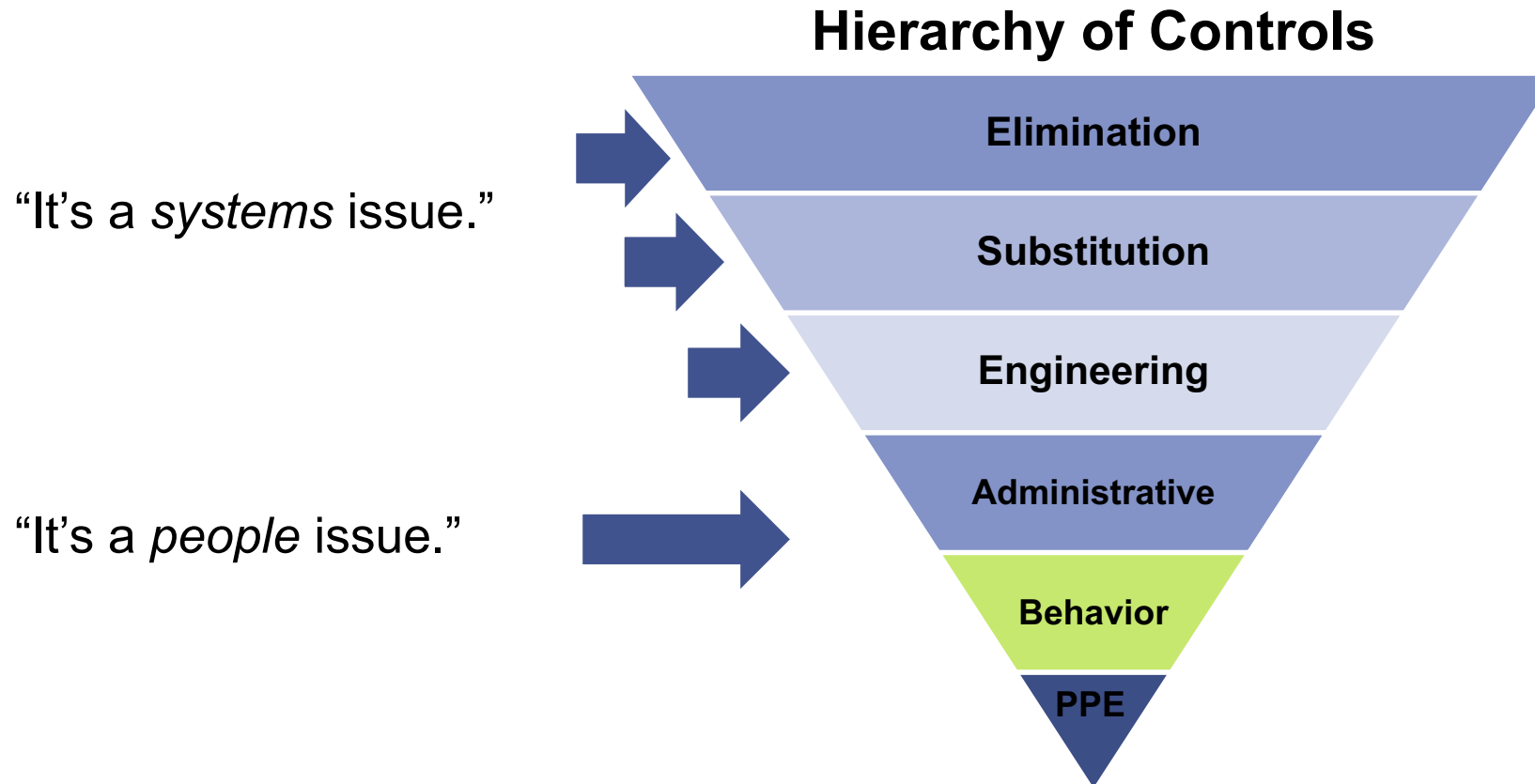


Insight 6

THE ROLE OF BEHAVIOR IN ORGANIZATIONAL SAFETY

- The role of behavior in incident causation is important, but it is only one piece.
- Safety incidents are caused by a network of factors including design, safety systems, leadership, culture, and behavior.
- Senior leadership decisions drive culture and systems, which in turn drive organizational behavior and performance.
- Organizational Reliability, an organization's ability to assure consistent behavior across the organization, is crucially important.

A systems view of injury causation leads to more effective prevention strategies.



Insight 7

DECISION MAKING PLAYS A CRITICAL ROLE IN SIF PREVENTION

Decision Making...

... as a strategy to improve culture and prevent fatalities.

Krause Bell Group's 2015 Safe Decision Making™ Study

- EHS executives from six companies actively participated.
- Each contributed in-depth information from serious and fatal incidents.
 - Documentation – What was already learned.
 - Interviews – Context and additional information.
- Also included well-documented, publicly available, fatal injury investigation reports.
- **16 total companies, 60 total incidents, 600+ decisions**

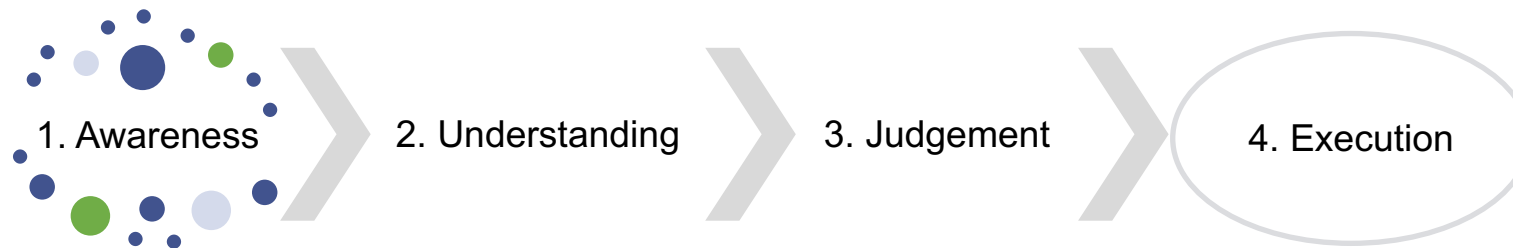
Three Key Findings from the Longitudinal Analysis

1. The **majority** of safety decisions were made above the front line.

64% of all decisions.

86% of **pivotal** decisions.

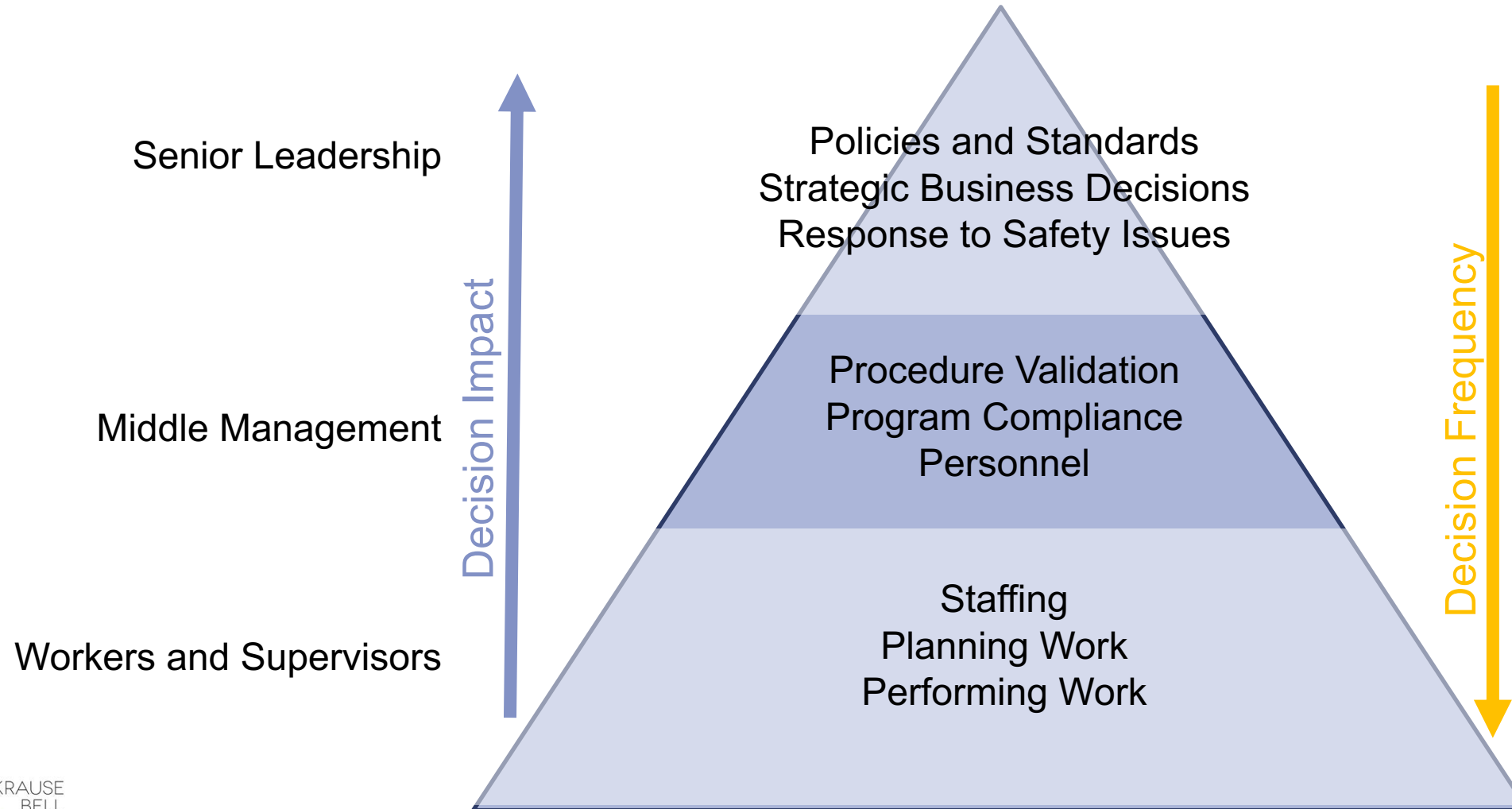
2. Decision-making is a **process**, not an event.









3. Cognitive bias undermines our decisions.

Majority of Safety Decisions Were Made Above the Front Line

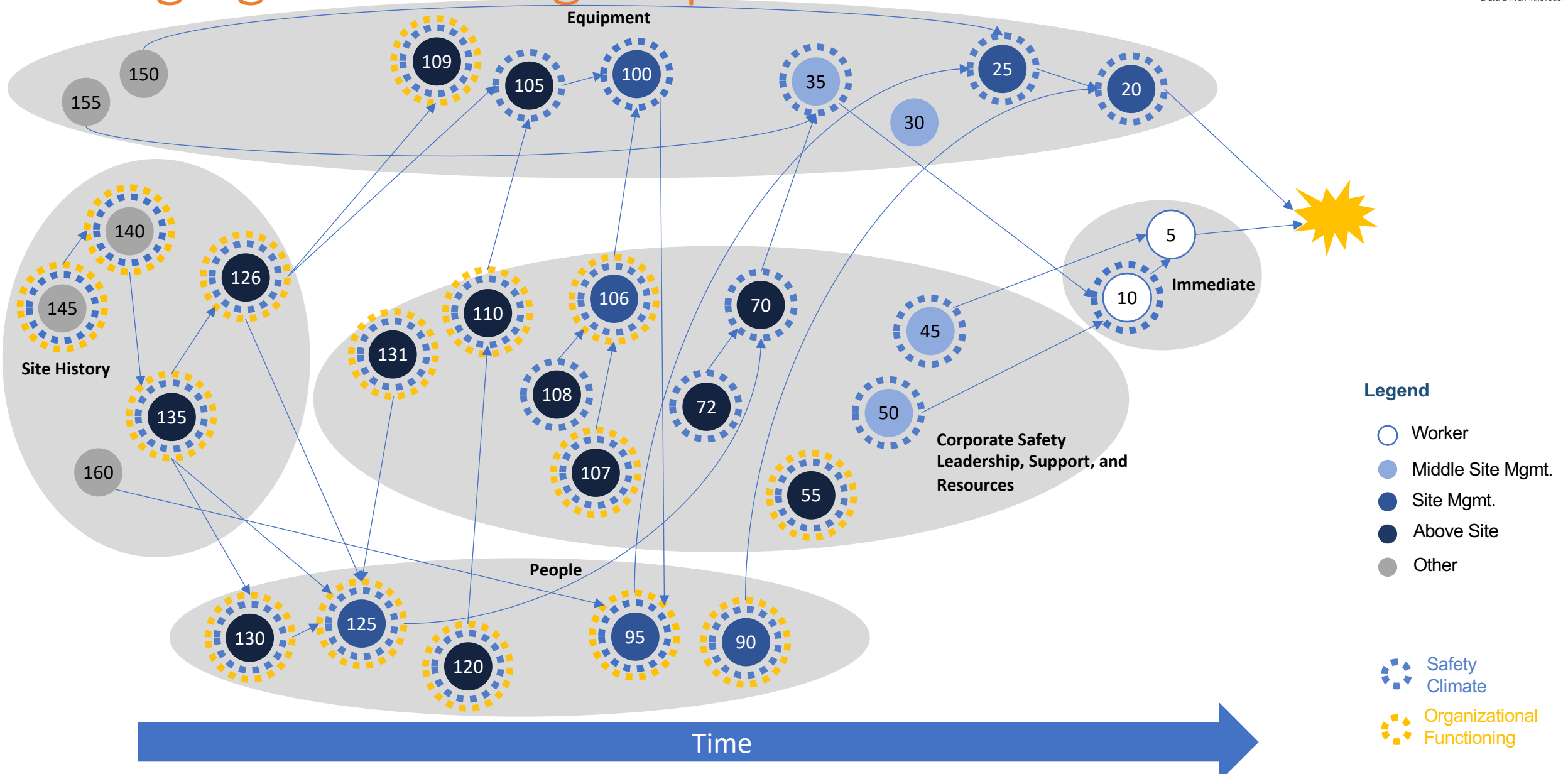
Safe Decision Taxonomy



Common Cognitive Biases

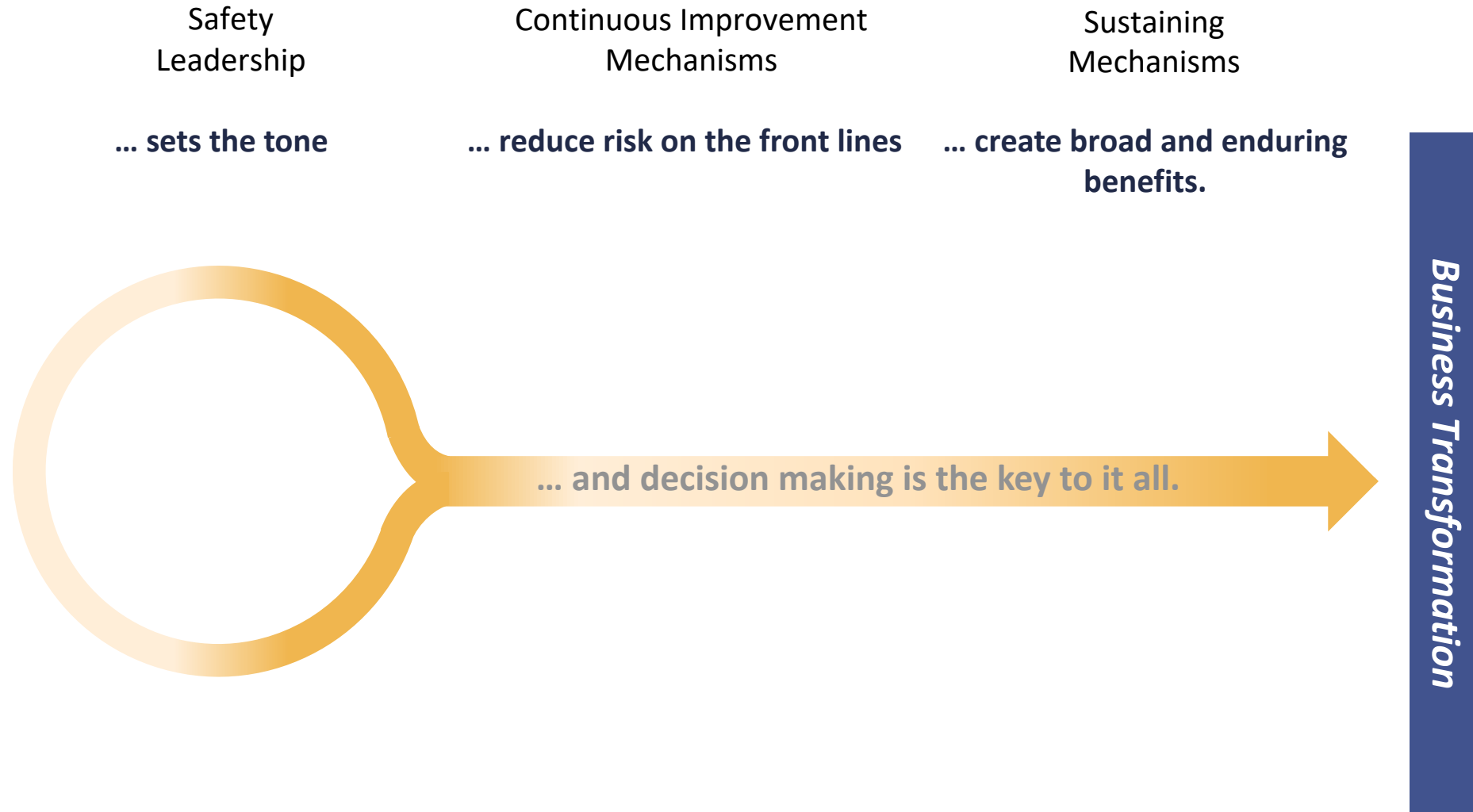
Type of Bias		Description
	Selective Attention	When people focus on one thing, other information gets filtered.
	Availability	People depend more on information that is more accessible in memory: emotionally charged or recent, for example.
	Confirmation	The tendency to look for information that confirms our expectations.
	Normalization of Deviance	Unacceptable practices become the norm.
	Overconfidence	The tendency to overestimate one's own knowledge, and/or the accuracy of information.
	Status Quo	People tend to stick with a previous decision and don't scrutinize the default options closely.

Managing Risk During Acquisitions & Consolidations

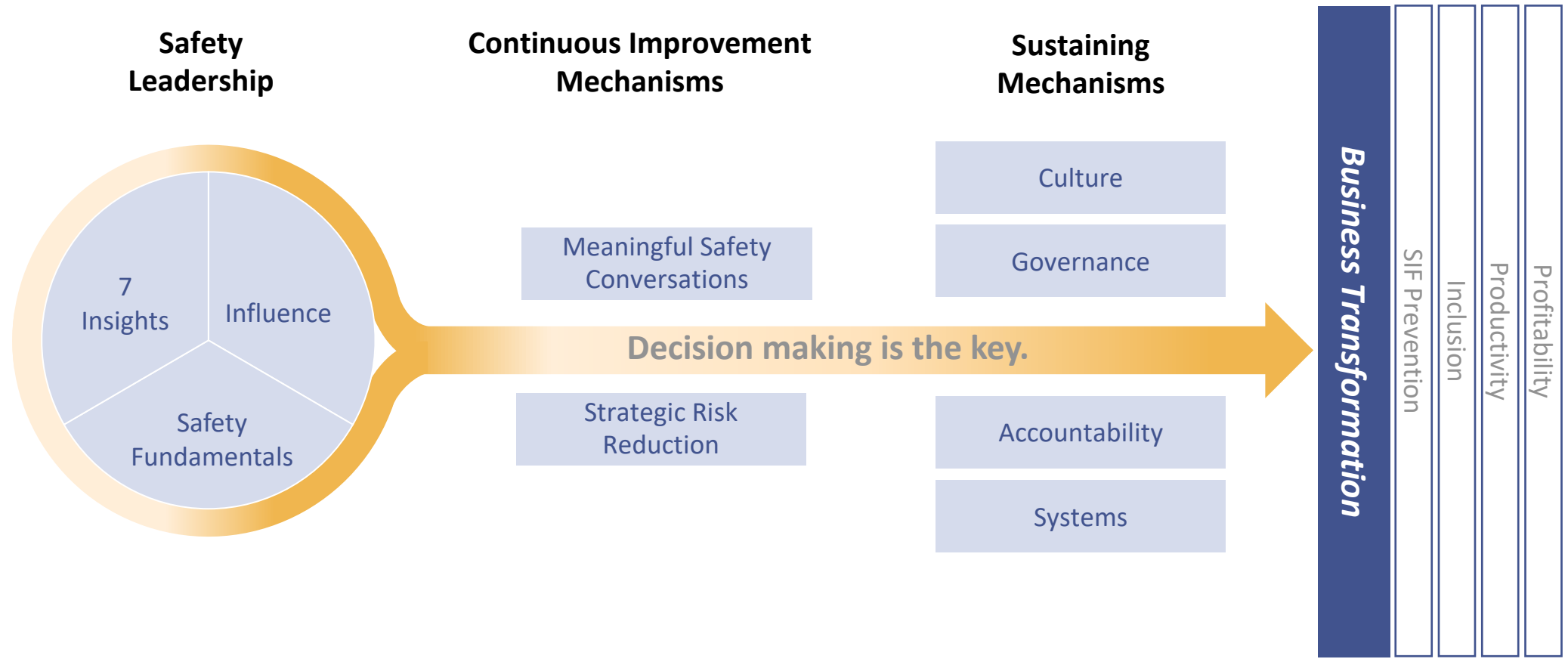


PUTTING IT ALL TOGETHER

How Safety Improvement Works



How Safety Improvement Works



THANK YOU

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