HASANZ
HEALTH & SAFETY ASSOCIATION NZ

OVERVIEW OF HASANZ WORKSHOPS WITH DR JOHN GREEN

Wellington 16 October (pm) and Auckland 19 October (pm)

Many organisations are now on a journey where it becomes willing to accept that errors do happen: practice is not perfect, risks have to be taken. This obviously clashes with a vision of zero-harm (which indeed is more of a vision than a realistic goal). A couple of things happen with a slavish commitment to zero-vision and the idea that errors do not happen:

- People will be motivated or incentivized to hide errors and their consequences. This creates shame and guilt and stigmatizes both error and those involved;

- All incidents, no matter how small and inevitable, were once likely to be investigated without regard to their relevance, impact or inevitability, potentially distracting and wasting resources that are better spent on deeply analyzing "the incident of the month" for example;

- Learning and improvement can be eroded by a zero vision, as it is based on having *nothing* negative happen. With nothing happening, what is left to learn from? Resilient organizations do not focus on reducing backward-looking negative events, but on the positive, forward-looking capabilities of people and teams to recognize, adapt and absorb even those challenges that lie outside the predictable scope or design envelope. As a commitment, zero visions are not necessarily harmful (just like commitments to a healthy lifestyle or successful marriage), but as an assumption of statistical probability, they become nonsensical and translate into unrealistic and possibly counterproductive policies.

Similarly this journey requires the acknowledgement that distant, administrative control of safety practices are not generating additional returns on investment. They seem ready for devolving power back to the projects. This involves *trust* on part of leaders to give this power back, and *confidence* on part of the projects to receive it. It has implications for supervisory skills and middle-management skills. Companies needs to be assured of the ability of those operational levels to recognize, adapt to and safely absorb challenges that fall outside the prediction, outside the design envelope, the procedural base. There is a basis in the resilience literature for ways to do that, which can be discussed.

Many now have acknowledged the existence of data that strongly suggests there is little empirical connection between AAFR and FAR (Fatality Accident Rate): that one does not predict the other and that efforts to reduce overall AAFR may in fact be harmful to efforts to reduce FAR because of the ("perverse") incentives and organizational policies it helps generate. A focus on *leading positive indicators*, rather than lagging negative ones, probably needs to start perfusing not only the conversation at a company level, but its relationship with contractors, clients, insurers and others as well.

What are some of the implications of this new vision?

1) Errors are not failures of character, but normally and systematically connected to features of the complexity of your work environment -- its tools, technologies, tasks, organization, and coordination.

2) Errors are not causes of trouble, but (often predictable) symptoms of psychological, logistical, organizational and engineering design issues.

3) Failures are often preceded by long periods of "drift," where borrowing against safety margins is increasingly accepted and expected and goes largely unnoticed—by workers, supervisors, managers, directors, regulators—because it makes sense and has few overtly negative consequences.

4) Resilient organizations do not invest in fine-tuning their lagging indicators of negatives (weak signals), but rather invest in identifying and bolstering their strong signals of resilience—the ability to keep harmful influences at bay without knowing in detail what those might be or when and where they might appear.

5) Organizational conditions that make disclosure and reporting of signals of danger and error (to supervisor, colleagues, client, and contractor) possible can be put in place. This involves managerial decisions around confidentiality, honesty, legality, protection of data, and practicality.

6) A just culture is one where learning *from* failure and accountability *for* failure work in each others' favor, not against each other. This is possible if accountability is forward-looking and restorative, not backward-looking and punitive. Restructuring of an organization's accountability mechanisms, so as to favor learning, is possible. This involves a critical look at sanctions, incentives, but also trust and confidence. Aligning this across contractors and assuring consistency with client expectations is an interesting challenge for organisations.

Workshop breakout sessions

1. Traditionally people are seen as a risk to control in organisations. They are controlled by limiting their choices and behaviours or by placing constraints between them and the actual work. What would happen if we saw people as part of the solution? What are the behaviours and language associated which either option? Do you see some of these in yourself? What do you /we/LOR need to do to shift this paradigm?

2. Safety performance gets confused with Accident rates. What if we measured some else? What would it be? How would we know if it was working? What would the target be or would there be one?

3. Paperwork has grown and the bureaucracy around safety is now a significant problem. What do we ask the projects to do or what do we do that adds little value? What's the dumbest thing that we get people to do?

4. Where are we and why are we here? What's stopping us from getting what we want? What's standing in our way and where are the difficulties in achieving this new future?