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How the ABC's of Leadership Behavior Impact Safety Management Systems

Steven Boydston, CSP, ARM, ALCM
Senior Consultant
Det Norske Veritas
Denver, CO

Introduction

"What you do speak so loudly that I cannot hear what you are saying?"
--Ralph Waldo Emerson

A number of years ago I met a senior operations executive whose favorite phrase concerning safety was "It's all about behavior." He was a strong supporter of safety in the workplace and demonstrated that support by providing significant resources in time and money to support behavior based training for the workforce. There is a certain degree of merit in the executive's statement if the statement is applied to behaviors at all levels of the organization. Not just employee behaviors while performing their jobs, but also supervisor behaviors in providing guidance and setting a positive example in supporting a safe work environment, and most importantly, leadership behavior in leading by example and providing the necessary resources to support a strong safety management system. As a front line employee so succinctly stated it, "If safety is really so important to them, they need to walk the talk."

The basic ABC's of traditional employee based behavioral safety programs are well imbedded within the safety community. The use of Activators stimulating Behaviors and the use of Consequences to reinforce safer behaviors or provide coaching to correct undesired behaviors has been implemented in organizations worldwide with varying degrees of success. A major factor in the overall success of organizations safety efforts is dependent upon how well an organization balances the communications aspects of their behavioral safety efforts and the safety management systems that provide the technical knowledge, training, systems, standards and measurements to provide a safe and healthy work environment.

Using a broad definition, this paper discusses how Leadership Behaviors provide the Activators and Consequences to achieve the goals and objectives of an organization whether it is related to production, quality, safety or other business goals. The Activators and Consequences by Leaders take the form of behaviors that may me observed directly or are evidenced through communications and allocation of resources.

"Of all the influences on human behavior in the workplace, I have seen none as strong as positive, visible Leadership." --Bill Lacy

This paper focuses on how leadership behaviors as Activators and Consequences support or undermine an effective Safety Management System. Several components of a comprehensive Safety Management System will be reviewed using real life examples to illustrate how leadership behaviors as activators and/or consequences can make or break a successful Safety Management System.

The examples provided are representative of similar observations made during Safety Assessments over the past 26 years at companies in various industries, of various sizes, privately and publicly held, in various countries.

*How critical are leadership behaviors in supporting an effective Safety Management System? Frank Bird, Jr. and George Germain introduced the safety profession to what they referred to as the 12 Fundamental Truths or Principles that impact the implementation and success of a safety management system. (*Practical Loss Control Leadership, *Bird, Germain, Det Norske Veritas, USA) In this paper, we will focus on three of these principles, The Principle of Leadership Example, The Principal of the Key Advocate, and The Principle of Basic Causes and their relationship to behaviors that impact the success or failure of safety management systems.*

The Principle of Leadership Example

The Principle of Leadership Example – People tend to use their leaders as models. (Bird, Germain) This principle not only encompasses the overall safety culture but also has a direct impact on individual components of a safety management system. This principle concerns the impact of management actions on organizations. It is based upon the belief that workers want to please their leaders and do so by following their example.

As an Activator actions of leaders are magnified, usually in proportion to the leader's position in the organization. When leader's behaviors are consistent with the Safety Management Systems supervisors and employees follow their lead in and achieve strong results, when leaders' behaviors are inconsistent the quality of the Safety Management Systems performance deteriorates significantly. To illustrate this, below is the actual response given by employees in two separate organizations when asked the following question as part of safety management system and cultural assessments. The number one response in each example involved one specific act by company Presidents.

Give a specific example of management demonstrating their commitment to safety in the workplace.

Company One response: Nine out of ten employees and supervisors referred to the same incident in response to the question.

The president of the company and the safety manager were conducting a facility tour with several customers when the safety manager's pager went off. He looked at the pager and asked the President to excuse him to go take care of a situation. The president said "Go ahead, I'll finish the tour." The president then watched as the safety manager went around the corner and then he turned to the customers and said," Ok, he's gone; you can take off those silly glasses and hardhats if you want to."

It was determined only two employees witnessed this statement; yet based on a sample of 10% of the workforce. 90% saw this as representative of management's commitment to safety. The story gets worse. Additional assessments were conducted at four other facilities across the country. At every facility, when employees were asked the question above, a number of respondents referred to the above incident. In some cases the story had mutated and been applied to the local management.

Company Two response: In response to the above question 100% of the employees referred to this story at the facility where it occurred and at many of the company's 11 other locations during assessments.

When the president of the company pulled into the administrative parking lot at a facility, got out of his car to go into the office, an hourly employee stopped him. The employee told him he was breaking the site PPE rule by not having on his hardhat and safety glasses. The president of the company thanked the employee for pointing out his caring about his safety and proceeded to the site manager's office. The following actions then occurred. The employee received positive recognition for demonstrating his commitment to safety by pointing out the safety rule to the president in the form of a gift certificate to a local restaurant and a written note of thanks from the president. The joint safety committee was tasked with reviewing the PPE requirement resulting in the sign being moved to the entrance of the process area. This change was viewed positively by employees and management.

The obvious **activator** in the first example and **consequence/activator** in the second example was the leadership behavior of the company Presidents. Based upon the Principle of Leadership Example, this **Leadership Behavior** as an activator contributed to the measurable **behavior** at the two companies related to PPE usage. At Company One, employee **behavior** showed use of PPE was weak as measured through workplace observations and employee interviews. Employees interviewed as to PPE usage referenced "complying with the rules" as the number one reason for wearing PPE. The ultimate **consequence** involved employee injuries in which inadequate PPE usage was identified. At Company Two PPE usage was strong using the same measurements with few incidents involving inadequate PPE usage. Employees at company two referred to the protection provided by the PPE as the number one reason for wearing PPE.

One of the major challenges of studies in actual workplaces is the multiple variables that exist. In terms of management systems, no significant differences could be found between the two companies in respect to PPE training (amount of training and content), availability and selection of PPE and written rules. Differences were identified in workplace compliance & coaching and perceived risk. At Company One employees had low perceived risk for hazards associated with PPE. At company two employees had a high level of risk awareness and referenced it when asked why they wore PPE.

Have you ever heard the excuse for not wearing PPE? "Well (fill in the blank) does not wear their PPE either." When the person named is in a leadership position the impact is greatly magnified.

The Principle of the Key Advocate - The Accident Repeater

Incident Reporting and Investigation

What would you do if an employee reported 25 incidents in two months?

When a cafeteria worker at a public school reported 25 incidents in a 60-day period, the school district made a decision to terminate the employee even though none of the incidents required medical treatment beyond a couple band-aids and an icepack. Before making a final decision, the district requested their insurance safety consultant and legal department review the case to determine the risk of a wrongful discharge case. The incident review proceeded as follows:

Safety Rep: "This accident report says she tripped over a pipe sticking out from under a steam table. Is that true?"

Cafeteria Manager: "Yes, but everyone knows that's there."

Safety Rep: "This report says the employee slipped on ice where the walk in freezer defroster isn't working. Is that true?"

Cafeteria Manager: "Yes, but everyone knows the defroster isn't working."

The review revealed 23 of the 25 incidents involved known hazards related to lack of maintenance, housekeeping and organization. The review provided strong evidence of a deficiency within the management systems (Inspections, Hazard Reporting, and Preventative Maintenance.) A unique solution was proposed and implemented. Since the employee had demonstrated an ability to find hazards, the employee was assigned to do inspections at campuses across the district to identify hazards and assist cafeteria managers in completing maintenance request.

As the project proceeded, other employees came forward reporting they had also had near misses and minor accidents related to similar hazards across the district but had been reluctant to report them in fear of retaliation from their supervisors.

The manager in this case was assigned responsibility for investigating incidents but had not received training (Basic Cause: Lack of Knowledge, Inadequate Resources). The manager focused on the intermediate causes (employee behavior) resulting in blaming the employee for not avoiding hazards. Leadership behavior in this organization failed to provide adequate monitoring of the Preventative Maintenance and Incident Investigation System (Basic Cause: Inadequate procedures). With these basic causes identified, the district took the following action.

- Conducted in-services for managers and supervisors in all departments on incident investigations. The in-services included instruction on the importance of **encouraging, not discouraging reporting, investigations focusing on basic causes to develop corrective actions to make the workplace safer and not placing blame.**

- Increased management review of the inspection and maintenance programs. (This corrective action was extended to all facilities including transportation, workshops and school campuses.

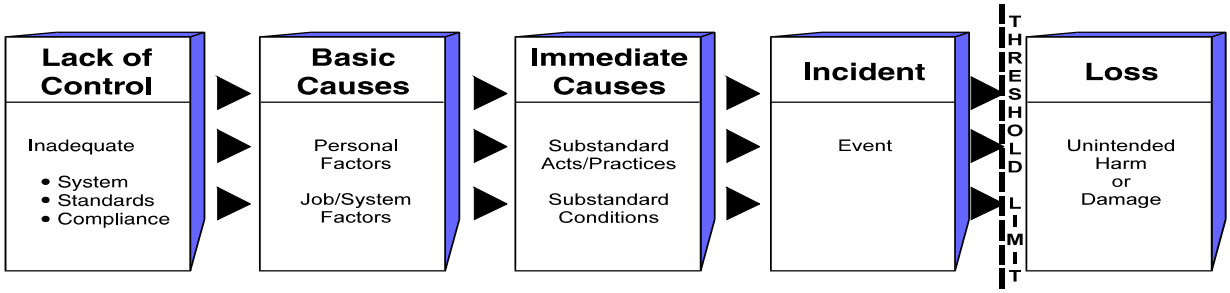
The Principle of Basic Causes

In order to identify basic (root) causes of incidents it is necessary to conduct investigations that go beyond immediate causes or symptoms and identify failures or deficiencies in management systems.

Most organizations have an accident reporting policy to the effect of, **"All incidents must be reported regardless of severity."** This includes serious, moderate, first aid and near misses." While most organizations have **formal** disciplinary action for failing to report incidents resulting in injuries or property damage, near miss reporting is driven more through positive reinforcement (rewards and recognition) than through disciplinary action.

Reporting of all incidents in theory allows organizations to conduct an assessment based upon the potential severity and provide appropriate resources to investigate, identify basic causes and implement corrective actions to prevent reoccurrences. In the following case we examine how **The Principle of the Key Advocate** has a strong influence on the effectiveness of an incident reporting process. Front line supervisors and managers behaviors serve as the **activator,** which determines employees' ultimate **behavior** in reporting incidents. What leadership does with the reports (Consequence of Reporting) is also a critical factor in the sustainability and value of the reporting process.

Applying the Loss Causation Model developed by Bird for problem solving to the above case study various issues are identified.



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The initial manager's investigation focused on Substandard Acts/Practices or Immediate Causes by the employee. While the reports also identified Substandard Conditions in the employee statements, the supervisor's corrective actions focused on "fixing the employee."

The 3rd party review looking into trends acknowledged the employee had failed to work around known hazards in the workplace. Job/System Factors of Inadequate maintenance and inspections, inadequate follow up and the Personal Factors of Improper Motivation, Inadequate Training, and Inadequate Leadership Training were identified. The Manager involved in this had come to accept the hazards in the workplace due to poor past response to maintenance request. Additional interviews determined the above Basic Causes existed throughout the district.

For the purposes of this paper, intermediate causes represent unsafe actions and unsafe conditions that can be observed with the five senses. Basic Causes (Root Causes) are more

directly related to management actions and management systems. (Frank Byrd, Jr., George Germain)

It is recognized that other authors and safety consultants represent unsafe behaviors of employees as root causes (one author cited at-risk behaviors as the root cause of 97% of all incidents). While unsafe or at-risk behaviors contribute to incidents they are frequently symptoms of deficiencies in the management systems content and/or execution. Unfortunately, the continued promotion of employee behaviors as the main root cause of accidents continues to support blame cultures in industry. While unsafe or at-risk behaviors should be addressed on an individual to correct immediate causes, it is in this author's opinion that often the quick fix of blaming the employee simply treats the symptoms and discourages further investigation which could have revealed opportunities to improve the overall management systems for sustainable safety improvement.

In seminars and classes one of the concepts participants most readily recognize is the "trap of the quick fix" in which a corrective action is focused on training, disciplining employees or fixing the specific hazard only to have the same issue arise over and over.

The Principle of the Key Advocate (Bird, Germain)

Self -Fulfilling Prophecies - Near Miss Reporting

"The Activators, Beliefs, Behaviors and Consequences model is an ongoing cycle which is influenced by the management system. That is, the management system as it is 'lived' by leaders, not necessarily the way it was designed. A well designed management system supported by positive, visible leadership is the foundation for encouraging correct behaviors." --Bill Lacy

<u>Strong Site Performance</u>
A significant component of the risk identification and assessment process at a large company involved a healthy near miss reporting program including a risk rating process to sort out the High Potential incidents to be fully investigated. The most successful sites produced measurable results including improvements in physical conditions as evidenced by lower incident rates, a review of maintenance logs work orders generated from near miss investigations and employee/management interviews, and physical condition tours. Sites tracked the number of near miss reports and calculated the ratio of near miss reports to Medical and Lost Time cases utilizing the traditional incident ratios to benchmark the near miss reporting activity. The most successful sites practiced **The Principle of Behavior Reinforcement,** supervisors were trained to thank employees for all reports with an emphasis that all reports were important as an **consequence/activator to increase reporting** the safety committee publicized the number of **near miss reports and promoted reporting in various ways providing feedback as an additional consequence/activator** communicating positive results from the employee participation. Management gave recognition to individuals and/or groups for near miss reporting. Specific near miss reports, investigations and resulting corrective actions were publicized to "close the loop" communicating back to the workforce the value of their near miss reporting.

Senior Management at the successful sites served as **Key Advocates** through active participation and providing necessary resources to support the program. Beyond signing off on a policy and procedure, the senior management participated in training and education for employees, supervisors and the safety committed tasked with administering the program.

(At another organization, over-reporting was encouraged with rewards occasionally given for the most outrageous report, this was done to overcome negative comments about silly reporting, they made it fun, curiously some entries in the "silly" reports contest led to meaningful improvements, not so silly after all.)

At companies with robust and effective Near Miss Reporting programs, **The Principle of Leadership Example** and **The Principle of the Key Advocate** were strongly evidenced by the behaviors of the local management. In terms of a Leadership Activator Behavior Consequence (LABC) analysis:

Leadership Behavior Activators: Leadership provided tangible resources to support the programs. They remained engaged in the program visibly participating in the reporting process (an anecdotal observation was at sites with the most robust programs, employees told stories about the local management reporting near misses personally). Leaders provided positive feedback personally to employees and funded official recognition programs.

Employee Behaviors: Employees in seeing the value placed on the program by leadership followed their example and actively participated. The safety committee analyzed reports, conducted investigations on HIPO's, developed corrective actions and followed up on completion. The number of near misses reported were tracked and published along with incident rates. In most cases increases in reporting of near misses were matched by decreases in medical and lost time incidents.

Consequences: Corrective actions based on the near miss reporting system were completed in a timely manner. These actions were publicized **(Leadership Activator)** emphasizing they were a result of the near miss reporting in an effort to prevent actual accidents. A corresponding reduction in workplace hazards (inspection report analysis) and incidents (Incident Rates) were validated.

Feedback loop: The positive consequences above were communicated regularly to the workforce in posters, meetings and newsletter serving as a system based antecedent and consequence for increased reporting.

Weak Site Performance

All sites had access to the same resources for their near miss reporting system yet an audit identified one site as having a weak near miss reporting program based upon low numbers of near misses in relation to the number of first aid, medical and lost time incidents. In addition, the safety review committee rated almost no near misses as HIPO incidents. In a review of the near miss reports submitted, several HIPO incidents had been classified as minor or moderate potential involving vehicle backing, working at heights and objects dropped from height with employees underneath.

An interview with the safety manager revealed a violation of the Principle of Leadership Example and Improper Motivation as the basic (root) causes for the weak program. The site safety manager stated, "I have never seen a near miss reporting program that brought any value to an organization." Interviews revealed this sentiment had been conveyed to the safety staff and safety committee responsible for the near miss reporting program. Members of the committee stated that the program was mostly to meet the "Corporate" directive to have a program. Staff members expressed a belief that the program was a waste of time.

LABC Analysis:

Leadership Behavior Activators: The manager assigned responsible for initiating the program specific message that the program was to meet a corporate directive filtered down to his staff. Specific statements about the program "bringing no value" were made on repeated occasions.

Staff and Employee Behaviors: Improper classification of near miss reports by the safety committee. Few investigations resulted in action items for improvement. No trend analysis was conducted and little to no feedback was provided to the workforce.

Consequences: First aid, medical and workers compensation claims remained constant. Audits/inspections had sub-par results. A decreasing trend in near miss reports was evident.

While the site was able to "tick the box" for corporate compliance, unfortunately the manager was correct, the program as it existed, "brought no value to the organization."

Conclusions

Companies have a moral and legal obligation to provide a safe workplace while employees, given adequate support and resources have the same obligation to work safely. Management develops systems in order to identify risk, control risk and then monitor the effectiveness of these controls. These systems, if executed properly provide a safer physical environment in the workplace, education and training so employees know how to avoid risk while performing their jobs, and promote safe employee behaviors in the workplace.

While there are many factors impacting the success of a company, based on The Principle of Leadership Example and The Principle of the Key Advocate, Leadership Behaviors are a critical link that determines whether or not management systems achieve their desired results, whether or not inspections are completed to identify hazards and get them corrected or forms are filled out, whether an employee takes a few more minutes to lock out, get the proper tool, or get help to move a heavy object.. Leadership Behaviors are the activator for employees to perform their job to earn a paycheck, Leadership Behaviors set the example of how to do their jobs properly, and Leadership Behaviors, reinforced through Consequences provide recognition of employees' efforts which determine the sustainable success or failure of the organization.