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Why Safety Efforts Fail: Four Serious, Common, and Persistent Mistakes in Safety Management

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Introduction

Over and over again many well-intended and otherwise well run companies fail to achieve even modest safety goals. Some of these organizations expend disproportionate amounts of time and money in futile – and sometimes counterproductive – safety efforts. Why do they fail?

Nearly 40 years of developing, implementing, and, perhaps most instructively, assessing safety programs and activities, has convinced me that there are four repetitive – and fatal – mistakes that prevent safety "success." Although there are undoubtedly an infinite number of mistakes an organization can make in managing safety, my experience has led me to view the following missteps as the most common and damaging. This presentation will discuss these pitfalls in considerable detail – including how to avoid them.

Mistake #1: Safety is different.

The management team of a large federal agency recently asked me why it was so difficult to attain, and sustain, safety goals and objectives. I answered with a question, "How do you manage anything successfully?" My point was that the same techniques used to achieve other goals, such as schedule or production, also work for safety. Why treat safety differently than other important organizational objectives? The late and revered safety management consultant, Dan Petersen, reinforced this point during a 2007 interview in *Professional Safety*. When the interviewer asked Dr. Petersen to name his favorite book on safety management he declined to name one. Instead he recommended basic works on management (Williamson 58). Dr. Petersen's position was, simply, why not apply to safety the same "plan, do, check, act" management approach recommended in basic management texts? Thirty years earlier Dr. Peterson also told us, "we don't really want safety first any more than we want safety last. In other words we do not want to think of safety as separate from other aspects of production." (Petersen, Techniques of Management 27) Surprisingly, however, even today safety is often treated as a gimmick, left to staff personnel or committees (rather than line managers) with little follow-up or management accountability for

results – good or bad. No amount of contests, slogans, jingles, posters or promotions can substitute for integrating safety into the work and actively managing it in concert with other objectives important to the organization. Yet we continue to try.

The missing safety system

Webster tells us that a system is "a regularly interacting or interdependent group of items forming a unified whole." Since most organizations want to stay in business, they have long recognized the importance of nurturing such a system for their business imperatives. As a result many companies generally do a fine job of managing their production targets, budget, and a whole spectrum of business goals and objectives. They identify plans and actions considered necessary to meet their goals. Then they establish effective methods to measure their progress, hold managers accountable, and take appropriate corrective action where indicated - continuously. They meet routinely to discuss progress and problems and to develop new or modified strategies for success based on this feedback. In short, these organizations have a management *system* to help them achieve their critical business goals and objectives. Inexplicably, however, many of these same organizations fail to manage safety in the same manner – even organizations that say (and often believe) that safety is a top company priority. Even worse, these organizations often devote considerable time and money on safety staffs, promotions, training and gimmicks yet do not achieve even average safety performance, all the while sincerely proclaiming that safety is "first." The reason they fail is that no amount of effort that isn't incorporated into a management system to guide, measure, adjust, and demand accountability for results (on an ongoing basis) is doomed.

Signs of trouble

If any of the following symptoms look familiar to you, your organizational safety system is most likely incomplete.

- Management is not visible in the safety effort. There may be considerable safety activity but it is led by staff (e.g., safety staff) personnel and/or various disconnected committees. Safety inspections, walkarounds, accident investigations, safety meetings, etc. are typically performed by non-line management personnel, if they are preformed at all.
- The safety supervisor/staff (not line management) is seen as the leader of the organizational safety effort.
- Management initiates very little corrective action and is slow to act on corrective actions initiated by others. Corrective actions typically address localized conditions rather than employee behavior and safety system deficiencies.
- Safety promotions such as contests, special training and behavior based safety (BBS) programs are started with great fanfare then fail to obtain the anticipated long-term results and are dropped. This "flavor-of-the-month" approach to safety comes at a great price to organizational credibility. Employees ultimately lose confidence and interest in all safety activity. It is painful to see serious money spent on programs such as BBS only to watch them run as standalone programs (gimmicks) outside of any management process to drive the desired results or to integrate them into the overall safety effort.
- Safety committees exist but add scant value and are often little more than gripe sessions for frustrated employees. If managers just took care of the basic management functions like developing policy and fixing accountability, it is not clear that safety committees are even necessary. **Note:** A clear exception to this take on safety committees is the *Management*

Safety Committee as designed many years ago by DuPont and since adopted by many other organizations with "best in class" safety performance. In these committees each level of management convenes with the next level of management at least monthly – all the way to the top. At the meetings each supervisor (not the safety staff) discusses (with his or her boss) recent accidents, feedback from personal safety walkarounds, and their ongoing safety activities supporting organizational safety goals and objectives. These "committees" are chaired by the top ranking manager and attended by his or her direct reports. Such meetings serve as (among other good things) excellent tools for establishing safety accountability and policy. Feedback and improvement are standard meeting outcomes. How do these committees compare with those in your workplace?

A better answer – integrating safety into the work

Years ago when I was the safety director for a large nuclear power plant, my plant manager asked me to get him the figures for how much our safety effort was costing us and compare them to best in (safety) class companies. I made a serious stab at it for our facility and then contacted the safety director of a nearby DuPont facility to get his cost figures. I was politely but promptly informed that there was no way any DuPont facility could provide such figures because they treated safety as an *integral part* of their work - from employee selection and training, to work planning, to procurement. It was no more possible to isolate the "cost" of safety than it was to put a monetary figure on quality. Safety, like quality, was completely imbedded into their work. Furthermore, DuPont was committed to doing work safely regardless of the cost. If the work couldn't be done safely (and at a profit) they simply wouldn't do it. I remain grateful to my DuPont friend for this simple yet powerful message.

The importance of feedback

Time and again I've seen companies start on a safety management system only to bog down in the details without completing the process. Most commonly they falter in developing an effective "check" step. This step goes by many different names but is absolutely essential for any functioning system. Dr. W. Edward Deming, often credited as the father of the plan, do, check, act cycle, actually preferred "study" to check but eventually yielded to the preferences of his Japanese customers. Six sigma programs use terms like "measure, analyze and improve." The ANSI standard for health and safety management systems (ANSI/AIHA Z10-2005) calls for an "evaluation and corrective action" step and the DOE uses the term "feedback and improvement" for the same process. I tend to call it the "how's it going" step. Whatever you call it, this step is vital for establishing accountability, as well as for acquiring the feedback necessary to fix and continuously improve the entire system.

Unfortunately some organizations just don't get around to asking themselves how it's going in safety. Therefore, even companies that establish excellent safety goals and objectives, complete with comprehensive (and often expensive) implementation schemes, fail in their efforts. They fail because they lack a process to measure and analyze their progress. Safety assessment is left to the safety staff, if it is done at all. As a result, managers may know their accident rates but have little understanding of how well (or poorly) they are doing in regard to their organizational safety goals and objectives. Metrics are either lacking or limited to accident rates that often represent little more than statistical glitches and luck rather than true indicators of management *action* to drive safety performance. Even in the absence of strong metrics, any process that provides routine feedback on safety problems and ongoing safety activities – by subordinate managers to their bosses – has great value. But I have found such safety checkups the exception rather than the rule.

Accountability is, therefore, impossible – much less any hope for implementing needed corrective actions and safety system improvements. There is a serious gap in the system and, as a result, it doesn't function as a system ("unified whole") at all. I've seen this "don't ask don't tell" safety approach so often I've come to describe it as the plan, do, hope, pray process. Whatever you call it, ultimate failure is assured.

What a safety system looks like

It's a safety mantra that "management involvement" is critical to the safety effort – but involvement in what? Too often we finally succeed in getting managers involved only to force them into a set of separate, unrelated and unintegrated activities that are little more than a collection of "stuff," often called a safety program, but certainly not a functioning management system. Until we develop a systems approach to safety (See Table 1) that includes goals, objectives, measurement and feedback, accountability and routine tweaking for continuous improvement (like exist for other important organizational objectives) we'll continue to consume valuable management time on traditional safety efforts that add little value and may counterproductively isolate safety by treating it differently from other important management objectives.

Steps	**Actions**
Plan	Establish safety goals and objectives (e.g., reduce "at-risk" employee behavior, increase the quantity of employee safety inputs, increase management involvement in safety) and the specific actions necessary to achieve them (e.g., develop an employee hazard identification process; initiate a management safety walkaround program, etc.).
Do	Implement the planned actions and processes.
Check	Measure progress of actions and processes toward meeting goals and objectives (e.g., hazard identification process established, # of employee safety inputs, # of procedures modified based on employee input, management walkaround system established, # of management walkarounds). Evaluate measurement data as well as feedback from manager walkaround and accident investigations, employee feedback, accident data, independent assessment results, etc. and determine if modification to any of the system steps is indicated.
Act	Modify system steps based on the above analysis (e.g., modify "plan" objectives to include increased hazard recognition capability and the training needed to accomplish this goal, modify the "check" step to add a quality measure for management walkarounds, include safety performance measures in the manager appraisal process. etc.)
Line management repeats the process	System implementation, evaluation and modification are ongoing.

Table 1. This table illustrates an abbreviated model of a plan, do, check, act safety system.

Mistake #2: Compliance is safety.

Far too often I see organizational safety policies and goals that center on providing employees a safe and healthy workplace – without reference (or at least equal time) to actually performing work safely. Since federal law already mandates that employers provide a safe and healthy workplace, these goals are hardly a stretch. Even worse, compliance with the law is no guarantee of exceptional, or even adequate, safety results. Compliance goals passively focus on conditions and requirements rather than safety system performance. Instead of emphasizing safe work practices and viewing compliance as a byproduct of an effective safety effort, legalities (many of minor importance) take center stage. Imagine having a production goal that is limited to providing a workplace with all the tools and equipment necessary to produce a quality product and nothing more. Obviously you won't ever see such a goal. Any organization that hopes to stay in business understands that you don't just provide the conditions necessary for production and merely hope you get it. You must establish and proactively work toward production goals with plans and actions that keep you competitive and profitable. Yet, when it comes to safety, even organizations claiming that safety is "number one" frequently stress compliance over goal directed actions to drive safety excellence.

<u>The compliance legacy</u>

I recently went on line to a safety employment web site and saw firsthand the out sized importance of compliance in the safety profession. The following "safety responsibilities" are all from the posted job ads of large organizations that should know better and represent just a sample of what I saw in my brief search. Keep in mind that as a staff function safety personnel aren't responsible for, and therefore really can't, *ensure* anything done by others in the line organization.

- This position (ES&H Manager) will ensure complete site compliance to all OSHA, EPA, RCRA, local, state and federal regulations.
- (The Health and Safety Engineer) ensures compliance with all H&S regulatory requirements and (Company name omitted) Policies, Procedures and Standards.
- (Health and Safety Manager) is responsible for the development, implementation, and monitoring of Occupational Safety and Health programs, policies and procedures for ensuring compliance with OSHA, EPA, DOT, CDC standards. (Career Builders.com)
- (HS&E Manager) is responsible for managing occupational health and safety and related compliance, environmental compliance, loss prevention and Workers' Compensation programs in compliance. (safetyemployment.com)

Much of the past (and present) emphasis on safety compliance can be explained by well-intended regulators such as OSHA, the EPA, and the Department of Energy (DOE). These regulators helped make compliance paramount by issuing mind numbing quantities of requirements (often as verbatim adoption of existing consensus standards) then inspecting solely against those requirements no matter how inconsequential to safety overall. As a result much safety time was, and still is, spent dealing with regulatory nits such as keeping MSDSs current for a host of common and well understood substances like vinegar, kerosene, baking soda, etc. I've seen even relatively small organizations devote hundreds of hours yearly just to keep their MSDS lists current. When I asked the safety director at one such plant how often employees actually looked at the MSDSs he told me no one had ever asked to see one. Well, you gotta do what you gotta do

but given the typically sparse budgets allocated to safety it doesn't seem logical to strive for excellence in compliance minutia at the expense of safety overall.

Happily, some regulators are coming around. The Nuclear Regulatory Commission, for example, has moved their focus from compliance to "performance-based" assessment (see discussion below). This change in approach coincided with a threefold improvement in the industrial safety record at its commercial nuclear sites. (Nuclear News 25-27). OSHA has likewise stepped back from its former emphasis on administrative minutia like the proper placement of OSHA posters to deal with more serious issues and hazards that genuinely affect safety. In an address to congress in 1995, OSHA head, Joe Dear, promised a more hazards-focused and performance-based agency, and to a considerable extent the agency has delivered (Joe Dear). OSHA, for example, no longer uses the number of citations issued as a basis for inspector pay raises and has made considerable progress in moving away from their former emphasis on red tape issues such as where employers put their OSHA posters. The (DOE), long known for its compliance focus, has also moved toward a more productive approach. The reasoning behind this change is well stated in a DOE guidance document on assessments. "Assessments focusing primarily on compliance with requirements run the risk of ignoring behavior and the effectiveness of systems and, therefore, may offer little added value to safety and performance improvement. Focusing solely on compliance can limit the assessment benefits to correcting individual deficiencies rather than raising the overall level of safety….This approach has been referred to as doing just enough to get by." (DOE 2)

Regulators may be coming around but the same cannot be said for some safety organizations. I continue to meet safety professionals that take excessive pride in their encyclopedic knowledge of safety and health related regulations. This knowledge is, of course, good but it is often used inappropriately to leverage safety staff power. After all, who else knows all the rules? Just leave everything to us. Even worse, these safety professionals often demonstrate their comprehensive regulatory knowledge through conduct of "wall-to-wall" compliance inspections. These inspections inevitably focus on facilities and conditions (as do the most of the regulations) rather than much more important aspects like employee behavior and the effectiveness of the safety management system. More often than not they overwhelm their organizations with innumerable "nits" that actually divert valuable organizational time away from more profitable safety activities - and trivialize the safety effort in the process. Even if it were possible to inspect in safety (it isn't), compliance inspections would, at best, inspect in compliance.

Performance-based vs. compliance-based

There is a better way. Performance-based evaluations, for example, start by looking at the work – especially the most hazardous and/or consequential work. Although conditions and regulatory compliance aren't ignored, employee behavior and safety system effectiveness are of principal interest. Where a compliance inspection might cite a ladder with a missing or defective foot and call for its replacement, a performance-based approach is more productive, and more difficult. A performance-based inspection would first look for workers using ladders rather than looking for ladders to inspect. If an unsafe ladder was noted, however, the inspector would seek to determine how such a ladder got into the workplace and why it was tolerated by the workforce. Was a safety check made of the ladder before it was issued? Are the ladders ever checked? Why wasn't the deficiency identified and corrected by employees? Is there an effective system to report and correct such deficiencies? Do employees understand basic ladder safety? Does the organizational

safety culture make it acceptable for employees to use defective equipment? The answers to these questions will provide far more useful information than reams of compliance data.

So what's wrong with compliance? Not a thing. It's just a lousy goal. Not only is it uninspiring (follow the law), but it is also unlikely to get you even the compliance desired, much less the continuous safety improvement that every company should covet. So compliance is not the enemy. It is, in fact, a by-product of good safety performance. Firms with excellent safety records typically attain high levels of compliance as well. (Loud, Compliance inspections unhealthy for your career 36) They get there, however, not by fixating on compliance, but by their commitment to doing work safely and continuous safety improvement.

Mistake # 3: Employees are the problem.

A senior manager at a high-hazard research organization once told me that his safety problems were largely the result of "bad employees." After all, he told them to work safely; even had procedures detailing safe work requirements, but some employees just wouldn't follow the rules. He always took strong disciplinary action after an accident, including (in some cases) terminations, but somehow he couldn't get everyone on board. In a later safety assessment of this organization I found hopelessly long, complicated, and in many cases incorrect, procedures. Furthermore the workers using the procedures had not been involved in their development and often found them unusable. Not surprisingly, these workers developed shortcuts and ad hoc procedures to bypass what they considered unworkable requirements. When they got the job done in a timely manner they were rewarded, even though they consistently violated the "official" procedures. Knowing that accidents could trigger disciplinary action, every effort was made to hide mistakes and problems. As you would expect, the safety record for this organization was abysmal. There is hardly any excuse for such ineffective and counter productive safety management but I've seen (and continue to see) this type of bad example over and over again.

How serious is this safety error? Consider what happened to a commercial nuclear facility where I worked during the eighties. Already long over schedule, this plant was preparing to start generating power in just a few weeks. Problems kept surfacing, however, including inaccurate procedures and equipment that didn't match the design drawings, as regulators scrutinized the plant more closely prior to granting it an operating license. Eventually it became obvious that there were simply too many errors in the facility and its design to allow startup. Construction was halted for what the Nuclear Regulatory Commission characterized as a "pervasive failure of the quality assurance program." (Tolchin) The subsequent investigation showed that construction management had a longstanding policy of mandating disciplinary action for any discovered employee error – even those as simple as an unintended arc strike while welding. The disciplinary actions ranged from a letter in the individual's personnel file to termination. The workforce reacted predictably and simply did everything it could to hide any errors. This "get tough" policy contributed to an approximately ten year delay in startup and additional *billions* of dollars spent looking for and correcting hidden deficiencies.

Certainly performing work in a reasonably safe manner should be a condition of employment, but blaming employees every time something goes wrong is, at best, a gross oversimplification. If you believe that an accident was the result of unprovoked employee carelessness (i.e., a "bad" employee) you, in all likelihood, haven't looked far enough. I've come to believe, in fact, that

many managers who are so eager to point to employee failings do so to avoid confronting their own management shortcomings. Furthermore this "blame the employee" approach often overlooks similar behavior by other workers that (by good fortune) did not result in an accident. So what is the message from this approach? Hide your mistakes and don't get caught!

When employees are involved in accidents there is nearly always a reason that goes beyond simple misconduct. Was the employee adequately trained? Were the procedures clear and workable? Did supervision make it understood that they expected safe work behavior? My experience indicates that managers often reward employees for unsafe work habits (i.e., getting the job done on time) only to punish them later when an accident occurs. Even in the relatively effective organizations I've assessed, a large majority of the disciplinary action imposed for unsafe behavior was taken only *after* an accident or incident. Prior to the accident the very same behavior was generally either not noticed or ignored. Wouldn't it be better to deal with unsafe behavior when it could actually prevent an accident?

Almost as damaging as punishing employees in the name of safety is to ignore them. Isn't it obvious that employees are key to any successful safety culture? They are, after all, the ones doing the work you want done safely as well as the ones who best know the details (e.g., hazards) of their jobs and their workplace environment. I have not seen top safety performance in any organization that did not have active and widespread engagement of the workforce in the effort. I have, however, had safety personnel tell me that involving employees in the development of their own work procedures would be a waste of time. The safety folks, after all, know safety best (and are often reluctant to share any of their traditional turf). Top managers (and even some safety personnel) have also candidly told me that they didn't want systems to encourage employee safety input because they just didn't have the time to deal with the issues that might arise. Thus many longstanding safety problems go uncorrected and employees are forced to use (or work around) procedures that don't work because they were written without practical input from the workers involved.

A better way

Many companies recognized years ago that involving employees in their safety efforts was essential for achieving safety excellence. These organizations, such as DuPont and the modern commercial nuclear industry, look to employees to help develop the procedures and identify workplace improvements necessary for safe work performance.

For example, the Institute of Nuclear Power Operations (INPO), which provides highly regarded safety oversight for its commercial nuclear site members, recognizes and promotes a number of employee attributes they view as essential for ensuring a strong nuclear safety culture. These "people focused" attributes are what INPO assessors expect to find during their nuclear site evaluations and include the following:

- A variety of methods are available by which personnel can raise nuclear safety concerns without fear of retribution.
- Employees are expected and encouraged to offer innovative ideas to help solve problems.
- Workers do not live with conditions or behaviors that have the potential to reduce operating or design margins (i.e.,safety). These circumstances are promptly identified and corrected.
- People and their professional capabilities, values and experiences are regarded as the nuclear organization's most valuable asset. (Institute of Nuclear Power Operations 2,4,7)

Employee input to promote nuclear facility safety (and efficiency) is deemed so critical that some commercial plants label their stations "complacent" if they don't generate literally thousands of employee generated improvement inputs each year. This employee input is a major component of the "find and fix" culture considered central to continuous improvement in both safety and efficiency at many nuclear stations. (Loud, Corrective Action Programs 35)

OSHA has also recognized the importance of employee safety involvement *and* ownership. Consider these "advantages of getting employees involved" from the OSHA Safety and Health Program Management Fact Sheets.

- Employees are the ones in contact with potential hazards and will have a vested interest (in their correction).
- Group decisions have the advantage of the group's wider field of experience.
- Research shows that employees are more likely to support and use programs in which they have had input; employee buy-in for the needed changes is more likely.
- Employees who are encouraged to offer their ideas and whose contributions are taken seriously are more satisfied and productive.
- The more that employees are involved in the various facets of the program, the more they will learn about safety, what is causing injuries at their site, and how they can avoid being injured. The more they know and understand, the greater their awareness will be and the stronger the safety of the organization will become. (OSHA, Safety and Health Program Management: Fact Sheets, Module 4)

Mistake # 4: Give it to the safety staff.

My first job after completing graduate school was with a federal agency that, at the time, owned the worst safety record of any such agency. To deal with this dubious distinction, the agency was in the process of greatly expanding its site and corporate safety staffs. Thanks to this "throw money at the problem" approach, even a greenhorn like me, was offered a well compensated position in a gorgeous part of the southeast. I couldn't have been happier.

It eventually became clear, however, that the large increase in safety staff was more of an attempt to "buy" safety than to manage it to success. Inevitably the safety staffs at the various agency sites and headquarters were seen as principally responsible for safety - and management got back to business as usual. Safety staffs (mine included) typically handled all safety meetings, safety committees, inspections, accident investigations, safety procedure development, and just about everything else related to safety. The management role was relegated to lip service, at best. Naturally you need a pretty large staff to handle all these functions so I soon found myself elevated from safety engineer to Director of Safety with a staff of eight. I was working hard and riding high.

It didn't last. Everyone was happy for a while, until it became obvious that, despite all the activity and expense, the agency's safety record was still the worst of the worst. My employer ultimately transformed itself thru a lot of soul searching, hard work, management commitment, and some effective benchmarking. Managers were now trained and led to understand that they alone were responsible for the safety of their workers. Managers began to thoroughly investigate their own

accidents and safety problems rather than handing them off to the safety department. A program to involve all managers in performance of routine safety observations and worker safety interactions (called walkarounds) was initiated. Management started meeting at least monthly to discuss progress toward safety goals and make adjustments to safety activities as necessary. Meanwhile, employees were enthusiastically provided numerous opportunities to help in the safety effort through involvement in procedure development, hazard identification and control, safety awareness efforts, and safety promotions. From a last place safety record the agency eventually compiled one of the best safety records of any industry. It wasn't all fun and it wasn't easy but it was a great learning experience for everyone involved. My staff went from eight to two and I was no longer seen as the site safety leader. That role belonged to my very competent plant manager. Soon, however, I came to greatly enjoy my new role as his trusted safety advisor and confidant. In the meantime, our plant safety performance became the best of any site in the entire agency.

Safety, like production, quality and cost, must be a line management responsibility. This truth is exceptionally well documented in the safety literature and has been for at least 30 years, yet many companies still shuffle their safety responsibilities (including leadership) off to their safety staffs. Compounding this problem, some safety departments eagerly gobble up as many duties, and staff, as they can to enhance their perceived importance to the organization. This "co-dependency" is not only expensive, it is counterproductive. It is simply not possible to control the work (or lead safety) successfully from a staff position. Unfortunately many managers are happy to abdicate their safety responsibility and leadership to staff functions that are often all too eager to acquire what they believe is additional responsibility and power. This fatal safety error is particularly distasteful to me since my fellow safety "professionals" are often part of the problem. Reinforcing this conclusion, I recently saw an article in a leading safety journal (not Professional Safety) extolling the virtues of employee safety committees as the eyes and ears of safety since "the safety staff can't be everywhere." No role for the eyes and ears of line management was even hinted at in the article. Sadly, the traditional "Safety owns safety" view is still very much alive. When are we going to learn?

Consider, for example, how safety staffs have typically (and inappropriately) handled two traditional safety staff "sacred cows" - accident investigations and workplace inspections.

Accident investigations

Early in my safety career I took up the study of accident investigation with a vengeance. After attending every training course I could find from Change Barrier Analysis to Management Oversight Risk Tree (MORT), I was soon leading comprehensive accident/incident investigations. My efforts were uniformly praised, and rewarded, by my management – and they were fun. I enjoyed the detective work and after a few years of experience I believed my investigations were as good as they get. Perhaps due to the pride, enjoyment and rewards I garnered from this work, it took me far longer than it should have to recognize my error. I was cheating my management. After considerable soul searching, as well as some open-minded benchmarking of recognized high-performance safety cultures, I came to realize that the investigation function really belonged to the line managers where the incidents occurred. My investigations were stealing potentially vital knowledge needed by those ultimately responsible for fixing *their* own problems. In addition, I recognized that my corrective actions suffered from a lack of in-depth knowledge and understanding of the organization involved and, as a result, often lacked the insight and buy-in necessary to make them effective. Finally, what difference does it

make how well the safety staff understands the causes of a safety failure if the responsible managers don't share in that knowledge?

It wasn't easy backing out of the incident investigation lead. Change is always hard. But with persistent persuasion my management came to understand the benefits of taking charge of their own problems – and fixes. The safety staff role didn't go away. We now trained and certified managers (and others) to do their own investigations, identify root causes, and to apply appropriate corrective actions. We also typically provided a staff member to the investigation team. Lastly and importantly, we retained oversight of the investigation process, including review of each incident report. Ultimately I had to admit that the manager-owned investigations were as good, or better, than the ones I had conducted. In addition, the line generated corrective actions were generally more actionable and benefited from full management support for timely implementation.

Workplace inspections

Safety inspections are another traditional safety staff function best shared with, and led by, line management. In many companies with outstanding safety records managers are expected to inspect their workplaces (and observe worker behavior) routinely and report on their findings to their peers and next level of supervision at regularly scheduled meetings. Not only does this shared communication inform management of safety performance in the field, it provides an opportunity to identify and correct organization-wide issues as they are reported up the chain. In addition, these face-to-face discussions are especially effective in establishing accountability. No manager wants to look unprepared or ineffective to his or her peers, and certainly not to the boss. (Loud, International System Safety Conference) Compare this manager-led approach to an inspection program run entirely by the safety staff. My experience with safety led inspections has found them considerably more likely to find the same problems over and over again, encounter pushback on findings and/or corrective actions, and to generate a profound lack of interest by responsible line management.

There is, of course, a place for safety professionals in the inspection process. Safety expertise should be welcomed (but not as the lead) on managers' inspections and walkarounds. Technical assessments of areas such as ventilation systems, noise abatement, fire protection, life safety, etc., also dictate safety professional participation. In addition, the safety function has a vital role in training managers and other key employees in productive (i.e., performance-based rather than compliance) inspection techniques and hazard recognition.

Perhaps most importantly, the safety staff should play a central role in assessing the overall safety system. This assessment should include a critical and independent look at the effectiveness of organizational safety functions such as safety committees, accident investigations, assessments, corrective actions, and employee work practices. As previously noted, workplace inspections need not mimic traditional compliance inspections but instead focus on safety system effectiveness and employee (people) behavior rather than conditions (things). They should also recognize that unsafe work practices and conditions are merely symptoms of weaknesses in the overall safety system. Getting to the root causes of these safety system deficiencies is the goal.

Working smarter

When famed safety pioneer, Dan Petersen was interviewed for the March 2007 edition of *Professional Safety* he was asked what he considered his most important safety legacy. His

response was brief and to the point. He simply expressed the hope that he had contributed to an understanding that, "You've got to take safety out of the safety manager's hands" (Williamson 59). In other words, safety practitioners must learn to view themselves as safety advisors and consultants rather than the safety "doers." I used to genuinely relish owning the lead safety role and I've known many safety professionals that felt (and still feel) the same way. Having seen so many safety-led efforts fail, however, has convinced me that if you're trying to lead overall safety performance from a staff position you're just standing in the way. This observation is not indicative of a lack of respect for the safety profession. I have, after all, proudly called myself a safety professional for nearly 40 years. Furthermore, there is no doubt in my mind that safety professionals have a tremendous potential to add safety value. Smart organizations involve their safety staffs from the very beginning and include them in every company activity from building and product design to facility closure and cleanup. The main role of the safety function should, however, be to provide the best possible guidance to line managers who possess the authority and responsibility to drive the organization's safety culture. It's a fine thing to be considered the place to go for safety expertise and advice but if the safety staff is viewed as the lead for safety, it has failed its organization.

To avoid becoming part of the problem safety professionals need to get smarter – and more relevant. Many of the safety pros I know (perhaps due to their engineering rather than business backgrounds) are virtual encyclopedias when it comes to the minutia of hazards and their controls. This is terrific, but it is also far from sufficient. Safety professionals need to understand safety management, and management in general. Fortunately there is already an excellent body of knowledge on these subjects. For starters, I'd recommend reading some safety management books by the likes of Dan Petersen (e.g., *Techniques of Safety Management, Safety Management: A Human Approach*) as well as basic management texts by Deming (e.g., *Out of the Crisis*) and other recognized management experts. The business courses offered by local universities and community colleges are another great source of management insight as are the many safety management seminars sponsored by the American Society of Safety Engineers (ASSE). And don't forget the ASSE publication, *Professional Safety.* Some of the best safety management advice and insight I've seen has come from within its pages.

Conclusion

The safety traps identified in this paper are hardly new. Most have been well identified for thirty years or more; pretty much the span of my career in safety. Yet old habits, especially bad ones, die hard. I still see these same errors repeated over and over again, greatly to the deficit of safety – and organizational efficiency. Why do so many companies continue to address their perceived safety problems with punitive self-defeating personnel policies, redoubled efforts to inspect in compliance, or attempts to buy their way to safety by hiring big staffs and/or acquiring expensive prepackaged "safety programs"? The answer to this question is a complicated and long story worthy of a separate paper(s). But whatever the reason, these long identified safety mistakes are not inevitable. Managers need only recognize the imperative to manage safety like they manage any other important business priority. In the meantime, safety professionals need to get out of the way and instead use their expertise to help management do the right thing. There is nothing magic and very little new about achieving top safety performance. The good news is that by now we should have learned from our mistakes and have, therefore, no reason (or excuse) to repeat them.

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