Face to Face

The Culture of Safety

An interview with safety pioneer Dan Petersen

In late 2006, Dan Petersen sat down with long-time professional acquaintance Mike Williamsen, Ph.D., from CoreMedia. The two spent more than 20 hours speaking about Petersen's life and career, as well as his thoughts on safety's past, present and future. Excerpts from those conversations are presented here.

On Jan. 10, 2007, safety innovator and thought leader Dan Petersen passed away. During his illustrious career, he advised some of the biggest names of American industry. In addition to a long list of publications and nearly a dozen training videos, Petersen was a president of the National Safety Management Society and a vice president of ASSE. He was elected an ASSE Fellow in 1998.

Changing the Safety Culture

MW: If you were placed into an organization to change its safety program, how would you get started?

DP: Get everyone involved. Conduct a safety perception survey and make sure it includes the entire organization. An all-inclusive survey builds an atmosphere of involvement and participation. There's no better way to foster initiative and good ideas than to let people know their opinion matters and that they have at stake beyond just showing up for work every day.

MW: What will this survey do for a company?

DP: The results will tell me where to go and how to get everyone involved and thinking. Besides measuring all the strengths and weaknesses across safety categories/processes, it tells how well management philosophies have been integrated into the incident/prevention processes. All this helps organizations identify needed safety system improvements that will further strengthen accident prevention processes and drive safety culture performance.

MW: What about conducting in-depth personal interviews as well?

DP: The qualitative interview information is important, but not by itself. The quantitative survey data tells me where I need to start and presents more dimensions to the data—the thinking behind the numbers, if you will. The safety perception survey gives me excellent background as I listen to what people have to say. The sum helps chart a course to address the vulnerabilities.

MW: You received your Ed.D. at the University of Northern Colorado (Greeley) in management, yet your dissertation was centered on safety: "Human error reduction and safety management."

DP: It interested me. I studied a lot of Heinrich and the university decided my dissertation on safety was publishable.

MW: What happened after your Ed.D.?

DP: I received an educational doctorate. But I got tired of campus life, so I moved to Tucson to get a new job and got into consulting, which is what I've been doing ever since.

MW: Talk about your first consulting client.

DP: I started consulting with Union Pacific, which decided to join forces with an independent railroad called Frisco. The railroads wanted to conduct a study to measure people, proposing a methodology and an approach I disagreed with. I told them you don't just put together five questions and send it out. We went down into the basement of a hotel in Minneapolis and I remember arguing with a railroad lobbyist in front of 40 people, and the railroaders finally agreed with me—and Chuck Bailey from the University of Minnesota in Duluth also stepped up. From there, we joined forces on the extensive study of railroad safety.

MW: That's when the safety perception survey was developed at the University of Minnesota?

DP: In Duluth, Chuck Bailey and I set up a project to identify processes or categories to measure the health of an organization's safety environment. It was in the late 1970s and the U.S. rail industry became a 10-year sponsor.

MW: Discuss the research you did on the 20 fundamental safety processes—recognition for performance, discipline, accident investigation, new employee training, supervisor training and the like.

DP: Chuck and I started out by looking at the psychological unknowns of human behavior. Our interest lay in what happened when people were faced with working hard at their tasks and being overloaded with whatever was on their mind. Were there associated traps that ended up with human error? We looked at the personal value system, unconscious desires and other psychology aspects.

MW: How did you form the methodology?

DP: Chuck had ties with the railroads, which were looking to evaluate their safety. They needed some direction and we were willing to help. It made perfect sense. Chuck recognized the need to survey perceptions. From there, we asked all the railroad safety directors to come up with a list of safety-related questions they would like to ask their people. We ended up with more than 1,500 questions.

MW: How did you sort through all the questions?

DP: We had our best students and some of the faculty cull the list of questions and got it down to 74. We then ran the questions past the railroad safety directors, who basically told us to go for it. We had so much confidence with the 74 questions, we decided to look for similarities and ended up with 20 categories as a way to organize the results.

MW: You've given the survey to more than 2 million hourly workers. How did you get that many?

DP: It's actually been fairly easy. We've been conducting the same survey for a long time. What many

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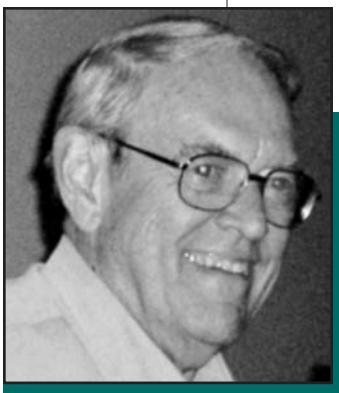

The Early Years

Dan Petersen was born in 1931, in Omaha, NE. When he married in 1951, he was 1 year from completing his bachelor's degree in general engineering and about to be stationed in Germany as a first lieutenant in the U.S. Army. Petersen's storied career as a safety innovator would begin with Wausau Insurance in 1953, where for 8 years he tracked the health of foundry and tannery workers throughout Wisconsin.

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people forget is that we don't survey a representative or random sample or anything like that—in sampling terms, we're getting the universe, or at least 90% of it. We try to make sure everyone takes the survey. It's how culture perception surveys need to be. This is as much about involvement and participation as it is about data. The numbers add up when you consider all of the industrial and energy companies in Wisconsin, Colorado and Texas who've implemented the survey. We've surveyed a lot of people.

MW: Of those who have taken the survey, what percentage do anything with the data to make themselves better?

DP: You're wasting money if the results collect dust on a shelf. I tell people that.

MW: What percentage of those just put them on the shelf?

DP: I will give the client a report with recommendations on what they should be doing. If they don't take what I recommend, that's up to them. It doesn't happen often. The survey is especially effective when they compare perceptions with some of the training or other safety initiatives they're pursuing at the time. They track changes with where they place their focus. I've had companies do the survey 6 years in a row. And every year, positive scores improved anywhere from 5% to 10%.

MW: Their survey scores improved, but what about their injury rates?

DP: Incident and injuries went way down in every instance. The survey tool is very valuable. I believe in it.

OSHA vs. the Culture of Safety

MW: Early in your career, you were in charge of tracking the foundry workers who were having lung exposure.

DP: That's right. We tracked people's lung function. That was the only thing we were worried about at that time.

MW: So you tested their pulmonary function?

DP: In those days, that is how we controlled injuries in the foundry industry.

MW: Your practical industrial safety education had more to do with exposure than prevention. Were there preventions?

DP: No. We would send workers a letter that said something like, "Get over there and get your pulmonary checked." That sums it up.

MW: And if it started going bad?

DP: We basically forced them to leave and find another job. If they wouldn't, we'd cancel [the insurance coverage].

MW: Was there anything you did when you realized their health was beginning to degrade?

DP: We'd cancel them. We wouldn't insure them any more. At the time, it seemed very simple. Fortunately, safety has come a long way since then.

MW: An employee either needed to change jobs or be at risk?

DP: Yes. This was a long time ago, in the late 1950s.

MW: Where did your career take you after your foundry and tannery work?

DP: I became the head of safety and health with Wausau in Wisconsin, but I soon realized it would be 15 more years before I could work at a higher level. I quit, and ended up at Industrial Indemnity in San Francisco, until they got bought out. I moved around until the late 1960s, which is when OSHA started.

MW: Let's talk about OSHA.

DP: Sure, and I'll be direct. I don't think the amount of time, effort and expense that's necessary to comply with OSHA standards correlates well with its mission. When you spend all your effort on OSHA compliance, the focus ends up with the condition stuff, which ensures what you're not going to have. The culture approach ensures what you will have.

When your focus is on relationships and culture—when you talk about and work on all the things that benefit people's lives and health, it's not because of OSHA. High-performing safety is derived from good relationships and a strong culture among hourly people—supervisors, managers and executives—everyone. Whenever you have a culture headed in the right direction, a booklet full of rules and regulations to ensure it's happening is secondary.

MW: You can't deny OSHA's role in setting a minimum standard and putting a stake in the ground.

DP: You're right. OSHA has made equipment and physical workplaces safer, and fatalities have been reduced, but the change in minor or lost-time injuries is insignificant. Lost days are about 50% worse than they were 25 years ago. I think OSHA has elevated safety procedure, no question. And it's done well in making the worst companies better, but I don't think OSHA's been all that effective in making the good companies better.

MW: How do your teachings fit or coincide with OSHA?

DP: My concern with OSHA is that it's looked upon as the answer when it's not. If most incidents are caused by unsafe acts—the Heinrich triangle concept—if we all agree with that, then we have our first clue that there's a problem with OSHA. Standardizing safety programs and guidelines for safety management are off target. If we concentrate on the 10% of incidents that result from unsafe conditions with more regulations, we're missing out on a huge potential for change and improvement. The research says "that ain't it."

MW: So, focusing on a company's culture is an alternative to classical OSHA safety management?

DP: Not really. It's separate. It's an additive to OSHA. That said, the top-down accountability culture approach will transform companies in ways OSHA never can. Remember, culture involves what people think about each other. It's the relationships you have between you and the guy above you and this guy "up here" and that one "down there." How much do we know about these people and what they think about you and your company and what their commitment to safety is like? How people feel about one another and what we're all doing is important. How we are interacting on our individual and group focus points. This is what transforms cultures.

MW: What does a good safety culture look like?

DP: First of all, culture has nothing to do with safety per se. Safety is not a subfunction of culture. Culture is one of the things that establishes what goes on in organizations for productivity, for everything—including safety. Culture is how we work with one another.

MW: And it's not a specific safety culture—it's an organizational culture that includes things like safety and productivity and quality?

DP: Actually, safety exists as a result of culture. Productivity exists as a result of culture. Everything happens as a result of culture, which also means the company can never reach its full potential if it doesn't pay attention to its culture.

MW: What would this overarching culture of the company look like?

DP: You've got to first look at how you measure the condition of the culture to find out where you are so you can improve safety and take the organization to where you think it needs to go. Many companies don't do the necessary legwork or the intense effort it takes to determine their baseline, then plan a change process that achieves excellence.

MW: How do we effectively measure safety? What metric are you looking for that determines the health of the culture?

DP: The safety perception survey is excellent for this. The point is to measure the opinions and perceptions of all the people at different levels of the organization. Get a pulse on what people really think and believe to be true.

The Interviewer

Mike Williamsen, Ph.D., is vice president of consulting for CoreMedia in Portland, OR. A workplace safety specialist with more than 25 years' safety and business change management experience, Williamsen served as an operations and/or safety manager for companies such as Frito-Lay Inc., General Dynamics and Teledyne. Starting in 1985, Williamsen teamed with Dan Petersen for 3 years to develop and implement a nationwide safety accountability and continuous improvement system that helped a Fortune 50 company reduce injuries more than 80% in 2 years.

It's essential to ask the same question to each member of the organization across all levels. I've been to organizations where the CEO of the company destroys the way he's thought about because his response is so vastly different from those of the hourly employees. Where there is a disconnect, it is always a concern that needs resolution.

MW: So top decision makers' actions and values can have a tremendous impact on the culture of an organization?

DP: That's right. Management sets the direction and the pace of where it thinks it should be, and how and when it is to get there. Of course, management may or may not actually end up there. There could be a gaping disconnect between what management thinks is true and what's actually going on at the front line.

Too often, I find a big difference between what people say they believe and how the organization puts the beliefs into actions and accountabilities. The question is, "Is everyone really committed to the walk as well as the talk?"

MW: So what we're doing is establishing a baseline and a standard, which is part of what you and Chuck Bailey developed with the safety perception survey?

DP: I wouldn't begin to establish a safety program or promote a safety culture initiative without first conducting a perception survey to find out where you are. It's like the blind leading the blind if you don't assess reality before you decide what you're supposed to do to improve. That's extremely important.

MW: Is there anything being overlooked in today's safety initiatives?

DP: The first thing that comes to mind is stress. We've effectively talked ourselves out of working on stress because we don't like people being stressful. Somehow, stress isn't our problem. It is like circular reasoning on this "soft" safety issue that truly exists in many workplaces.

We've come a long way in some areas, but we're missing out in others. I think about what used to build safety 20 years ago, based a lot on what Heinrich said, the 1-30-300 accident pyramid, the theory that all accidents were the direct result of unsafe actions and unsafe conditions. Because a lot of training might lack staying power or continuity, we lose focus. I'm currently in the process of identifying key safety components in an effort to help organizations stay on track better.

MW: You're working on a new training or instructional project?

DP: Or maybe an article on redundant controls. Several years ago, I attended a symposium called The Human Error in Occupational Safety. We talked about the procedures in place when we're admitted into a hospital—an excellent example of preventing human error—the way nurses have us read something out loud, read it again to make sure we're the person they're supposed to be talking to. They already know us, but their rules say they have to read our tag again to make sure they're not going to make a mistake. It's an excellent model that is probably underutilized.

MW: It sounds as if you're folding in human error controls with your culture-change philosophy.

DP: It's important to understand the influence of culture and human error, designing and modifying jobs around error reduction—examining the entire system to better understand human error. We experience more human error from "stuff" we don't take into account because we have limited ourselves to certain physical environments instead of focusing on the realities of mental human nature. We need to use measures that look at what we do and don't do as a way to follow up on our systems and controls.

MW: Have companies failed to factor in appropriate human nature and psychology with respect to safety?

DP: We also need to move away from the focus on the number of people who get hurt. We still seem to make the mistake of waiting until things get really bad and somebody gets killed before we say, "Hey, we didn't use the right measures."

MW: Measurement is essential?

DP: Absolutely. We need to do a better job of applying a process map to define all the steps and variables. We need to deter-

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mine how to eliminate errors or injuries at each step. But there are also things like leadership that matter. Understanding and developing leadership traits and abilities is also mission-critical to safety.

MW: Instead of a single focus on incident analysis or accident investigation, you recommend that we analyze the processes that are being used for potential traps in safety, then educate people so they don't step in to those traps?

DP: Yes. Instead of asking if we have problems while waiting for someone to get hurt, let's be proactive. Let's actively be looking at what's installed and assuming something can go wrong.

Safety Accountability & Stress

MW: How do companies achieve safety accountability today?

DP: That's a good question. Safety by objectives is the common approach whereby we hold people accountable by defining what it is they're supposed to do—the accountabilities of their job: Are you going to do it, and are we going to measure you by whether or not you carry out the things that have been defined? There must be follow up by (and for) supervision. That's what gets lost a lot of the time—the follow up.

MW: How about near-miss reporting?

DP: We're just starting now to understand why people screw up. If we don't pay attention to that, we lose the whole thing. We know human error reduction can be done by observing when people are in danger, which includes documenting close calls or near misses.

MW: What are some other traps built into the system that affect human error?

DP: Stress. We've succeeded in kicking out stress as a concern, which is unfortunate. The reality is that people are affected by stress on the job and from home. We also create stress in management by the kinds of decisions we make. Stress is something that needs to be taken seriously, yet we don't seem to focus much on it.

MW: You wrote a book on managing stress in the industrial workplace and your safety perception survey has 26 questions that are stress-related.

DP: One of the challenges that existed when I wrote that book was that we still paid people for stress-caused accidents. In California, we had something like 50,000 stress-related workers' comp claims.

MW: Fifty thousand stress claims?

DP: It got so bad they said there's only one thing we can do, which was to remove stress from the compensable injury list.

MW: Change the law?

DP: That's right—make it go away. Did that solve our problem? No. It drove it underground. Not one of safety's finest hours. By putting people in stressful situations, you're subjecting your organization to too much risk. Sometimes, managers can do some pretty lousy managing. This, in turn, puts people into stressful situations that, in turn, contribute to incidents.

MW: Are you talking about what happens when people get overloaded? A decision that is forced on someone puts the person at risk, or is it more about a mechanical or electrical trap?

DP: It really is all of those. Those are the three big ones, but you can get little issues that also lead into those big ones. The principles of safety management include an unsafe act, an unsafe condition, an accident and symptoms of things wrong in the management systems. Certain sets of circumstances can be predicted to produce severe injury. Some are spelled out more explicitly. Others sort of get thrown together in one big box of risk-related circumstances.

MW: Describe your 10 principles of strong safety management.

DP: Unsafe acts, unsafe conditions and accidents are all symptoms of something

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wrong in the management system. That's number one.

Number two is a certain set of circumstances that can be predicted to produce severe injuries, which can be identified and controlled—unusual or nonroutine, nonproductive activities, high-energy sources and the like.

Three is that safety should be managed like any other company function. Management should direct safety efforts by setting achievable goals, by planning, organizing and controlling to achieve them.

Four involves management procedures that establish clear accountabilities.

Five is the function of locating and defining the operational errors that enable accidents to occur. This function can be carried out in two ways: first, by asking why and searching for root causes; second, by asking whether certain known effective controls are being used.

Six addresses the causes of unsafe behavior, which need to be identified and classified—personal or mental overload, improper matching of a person's capacity to carry the load, traps, worker decisions. Each factor needs to be controlled if injuries are to be eliminated.

Seven recognizes that unsafe behavior is normal human behavior. It is the result of normal people reacting to their environment. Management's job is to change the environment that leads to unsafe behavior.

Eight includes the three major subsystems that must be dealt with in building an effective safety system—the physical, the managerial and the behavioral.

Nine states that safety should fit the culture of the organization. A square peg in a round hole never works.

Ten—there is no canned way to achieve safety. However, for a safety system to be effective, it must demand high performance from supervisors, involve middle management, have visible commitment from top management, involve hourly employees, remain flexible, and be perceived as a positive system and effort by the workforce.

MW: Talk about your work with Southern Pacific during the mid-1970s, which was the beginning of your work to establish safety accountability measures.

DP: That is where the concept of this principle began. We worked with Southern Pacific Railroad to come up with accountabilities. We observed and got to know all the various tasks and what people did all day. To make a long story short, we looked at reinforcing good safety behavior and, in so doing, figured out a way to measure and follow up on what's expected of everyone.

MW: So you looked at two organization safety cultures—"business as usual" versus a new dynamic centered on personal accountabilities?

DP: That's what it was all about. We got 80% improvement in those that used safety accountability and the others got no change whatsoever.

MW: When did you start using the survey in other industries?

DP: It was a natural progression to measure against companies outside the railroad industry. The survey data indicated weak safety management systems, no matter what the industry. Companies that got great results addressed the issues and both corrected and positively reinforced.

MW: You force people to observe what's happening in the workplace and they must both correct unsafe behaviors and reinforce safe behavior? This becomes their job?

DP: Correcting and reinforcing both the actions and the safety management systems that deliver workplace actions. I would also add stress to the necessary considerations.

The Business of Safety

MW: What do you think are the best safety books that have been written?

DP: Management books make the best safety books. I think all of them are probably a step up from safety books.

MW: Can you give an example?

DP: It's difficult to give a blanket recommendation, but *The Power of Ethical Management* comes to mind. It would turn safety on its head.

Once emotional intelligence is understood—instead of taking interest in how smart people are—it becomes more important to have empathy and cooperation. Are employees adult enough to be able to manage themselves and work well in an organization? That's emotional intelligence. It's an important metric, which is all but invisible through the lens of safety.

My point is that safety books limit us. When it comes to safety excellence, I'm interested in management titles.

MW: What's the difference between management and leadership?

DP: How to manage—both people and yourself. How to manage your organization so that you can accomplish the right things for the people out there. If you don't understand management principles, you're going to fail in safety.

MW: Where does *The One-Minute Manager* fall into the equation?

DP: Let me ask you this. Why can't we have a 1-minute safety program? Why don't we say to a supervisor, to a manager, to a CEO, "You have a job when it comes to safety. It's to take a look at people who're working safely and take 1 minute a day to communicate with them and find out what they are doing." Once you interact with these individuals this way, you're on your way to opening the door to empowerment and fostering a core value system that includes safety awareness and ownership and recognition for a job well done.

MW: So, relational leadership is key?

DP: The role of leaders and managers is to empower the people they oversee. One of the best examples of relational leadership involved my work with Union Pacific. I got to know the president, a leader who was able to get the most out of people because of the kind of person he was. He knew everyone by name, he meant what he said and he was an excellent communicator. You bottle up and pass out pieces of those attributes and you'll be able to create a company culture that's productive, safe and a great place to show up every day. Granted, some traits that make good leaders can't be taught, but it doesn't mean we shouldn't try to explain the basics and present them—respect, communication, recognition, dedication, accountability, integrity. Hire people with these basic values and I believe amazing things will happen.

MW: How do relational leadership and your views on reactive versus proactive safety work together?

DP: I think about that all the time. If you get a good leader, someone who possesses those attributes I mentioned, then you'll be able to explain very easily in my opinion that reactive safety doesn't work. You have to create an environment that is conducive to, that enables, creative solutions and dealing with a wide range of possibilities.

MW: What about parallels with quality control? When a quality defect occurs, we conduct a post-mortem to ensure it doesn't happen again. If I have 20 safety perception survey categories and an injury occurs, I need to go back and find out what failures in these fundamental areas led to the injury?

DP: You're being reactive when there's a problem, but proactive the rest of the time. That's the way a lot of the world works, but I'm not convinced it's anything better than what we've been doing for the last 25 years.

MW: How do you respond when people say you're too much about theory and not enough about practical application?

DP: There might some truth to that, but it doesn't make my ideas any less valid. Comments like that might also explain why I would've expected things to get better—to be at a place in time where we would learn how to manage safety. My biggest frustration is that too many safety programs are built around OSHA, which is a mistake. I worry about the progress we're making in safety. We're talking about the same things we were talking about 20 years ago. What does that tell us? It tells me that OSHA could be getting in the way of real innovation. I think OSHA is not what it wants to be or was meant to be.

The Future, Safety Innovation

MW: What do you expect the trend to be in the future?

DP: I would expect it to be much better—fewer accidents of any kind, way, shape or form. We'll have a better way of looking at and resolving causes.

MW: Are we going to keep doing the same things we've always done, only with better execution?

DP: We might look a little further into accountability as the key. You know, one of the things about accountability is that we just don't seem to get it across. There's a breakdown somewhere, as if we're squeamish about it for politically correct or other reasons. There is nothing wrong with holding people accountable. That's all there is to it. What's my job? What do I have to do? I'll do it. It's very simple.

MW: Your ideal?

DP: It's essential that everybody work with one another to figure out all the things that can be done to work as safely as possible. We ignore a lot of common sense, especially if we lack communication between managers, hourly people and supervisors, in all directions. It comes down to working together, communication and interpersonal relationships. This is safety leadership.

MW: What do you want your lasting impact on the world of safety to be?

DP: I'm not concerned about that. I am hoping that some people take some of this stuff and use it in some way that makes sense to them. I want us to give weight to the realities of human behaviors—take a human approach, a program that embraces the value of relationships and teambuilding at every level.

MW: So, the safety culture, people and how they interact, people working on issues together?

DP: That's what is so crucial—embracing a human approach to safety. One day, the safety manager is going to have less to do with how safe a company is because it's the people in management who are serving a constant, everyday function. People who used to have nothing to do with safety are now realizing that safety isn't about flipping a switch or reading a manual. That's the biggest change I've seen: Safety has been for the safety guy for so many years—and it still is for many organizations—but companies are finally coming around to seeing that everyone in the organization is responsible for safety.

MW: So your legacy is the importance of people, relationships and a human approach to improving safety?

DP: I hope I've added to that. You've got to take safety out of the safety manager's hands.

MW: What are a few things you would like to tell SH&E professionals to focus on or pay attention to?

DP: I guess my feeling is nobody has the answer for a company until they've been out there and gotten to the point where they understand why they have problems. What is it within the organization, what happens within the management of this organization that leaves you in the situation you're in?

The message is that we're here to listen to what the hourly people have to say, what the supervisors have to say, what management has to say and to get it together until they're all saying the same stuff. That's not easy. The CEO has to listen to what these people have said; they have to listen to what the CEO has to say, too. But let's get ourselves together so we're all contributing and feeling valued because of it.

The team dynamic is barely tapped. We need to learn from high-tech companies and entrepreneurial start-ups because I think they've been extremely successful in a more democratic and dynamic way to come up with solutions. I remember talking about these things in front of a military audience—all kinds of generals were in the room—and I was saying, "You have to change, and you have to let people have an important role and figure out better ways to open the channels of communication. Information needs to work its way upward and across—and remember to build relationships with the rank and file."

I was probably a little flip about it, but I said, "It's just as important that privates have a piece of this army as you do—they deserve it as much as a general." I probably could've been more tactful, but my point was how much impact teams can have all the way up and down an organization. I've come to the conclusion that continuous improvement boils down to relationships.

MW: Successful global companies are now very team-based.

DP: The figurative corporals, privates, frontline worker bees like their job and have hope for future advancement and want to be a part of making things better. It's innate. I don't know why we can't get this across to people. We've got to tap into their initiative and empower them. It can have a huge impact on safety and productivity and everything else.

MW: My experience with companies that "turn around" has been that in an authentically involved culture, performance improves significantly in all areas, including safety.

DP: Proctor & Gamble is a great example. I realized early on that all you need is solid people who champion common sense and can communicate it. Basic leadership stuff. They're good because they don't have egos and they enjoy listening to anyone willing to speak up. They'll listen to people within the company. They pick up on what needs to be fixed, what needs to be changed. Solutions and problem solving are constant and don't apply only to safety. Continuous improvement is bigger than safety.

Undervaluing Human Nature

MW: Besides teambuilding and communication, what else appears to be undervalued in large corporations?

DP: I believe that you can affect the stress level on employees both hourly and salaried. It's part of leadership's responsibility to deal with it. Ignoring it is a mistake. And it's something in safety we ought to be paying more attention to, learning more about relationships.

MW: What about psychology?

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DP: Psychology is integral to understanding safety, but sometimes our assumptions are way off. We assume people are against doing things safely because we haven't built any safety into them. We have a way of saying that everybody is inherently ready to do things the wrong way.

People don't want to get hurt on the job. They have no intention of killing themselves. Too many behavior specialists approach it as if everybody wants to kill themselves, therefore we are here to save the day. We can train them so that they won't kill themselves tomorrow—and it's our job to train everybody because you and your organization are unable to do it.

I see companies hiring training firms to explain the stuff that should be coming directly from inside on a daily basis. If the message isn't being delivered to the rank and file by someone who oversees them, management is failing the company. It seems odd to bring in people to train people on how not to kill yourself. "Won't that be wonderful for you? You can sit in a hard chair and we'll give you all the rules." Don't get me wrong, processes are important, but the real answers are found in accountability, respect and leadership, and having everyone inside the company giving and receiving the same message regularly, consistently, repeatedly, correctly.

MW: What's the biggest mistake safety consulting/training companies make?

DP: I think they get too stubborn and aren't willing to hear new ideas from the companies they're supposedly serving.

And there's too much observation stuff going on, which is overrated in terms of benefit. You might end up with 2,000 people who may have gotten hurt twice and you might have 2,000 people who simply don't want to participate and, therefore, don't.

Safety change requires strong commitment and involvement from all levels. You have to have involved management and employees. You have to have a lot of employee involvement. You also need involvement by CEOs, plant managers, managers, supervisors and people throughout the organization. You need buy-in by all on their own and on other's accountabilities.

MW: And the accountabilities at each level are different?

DP: There are roles and responsibilities at all levels of the organization. These roles are things that have to be defined, then measured as to whether or not they have happened. It's a basic management tenet. It all boils down to solid management stuff.

Culture is the real answer. It is not the behavioral part of individuals, it's having the culture build in the organization so that people will all be a part of working together from all levels. It all fits together because it's what defines the culture.

MW: Have you witnessed safety management mistakes?

DP: We all have. I was once part of a company where the president said to me, "We decided we need to transform the department" and proceeded to bring in four more safety people above me. They needed me to train them on safety so they could consult with the executive team. It may sound like sour grapes, but the reality is that I spent 6 months going in early every week, rehashing what I already knew. Six months later, the president said, "I want some safety improvement, so I'm going to give bonuses for having a safe operation and we will use accident records." Dumb, but that's what we did. It's a classic example of delegating safety. It probably wasn't the first time it's happened, nor will it be the last.

MW: The goal was reducing the number of injuries?

DP: Yes. The president said, "I've got a new incentive. Pay is going to be tied to injuries"—meaning the more incidents, the less you get paid. That's the way he saw it and the new safety people let it happen. That was the only thing that mattered because that's what was going to be rewarded. Just make sure nobody got hurt, which, of course, leads to hidden issues.

MW: Live and die by the numbers?

DP: Doesn't do a thing. In fact, it could make things worse. And that's the way he ran it. Shortly after, two people were killed on the line by a contractor.

MW: What happened to the president?

DP: Nothing. He didn't like it that somebody got killed. It's a horrible story, but a good example of what not to do. They eventually figured it out and were probably embarrassed, pointing fingers at each other because they were doing everything that you're not supposed to do.

I think Frito-Lay is excellent from the standpoint of distilling what kinds of behavior are important and necessary, then being held accountable for them. Results are sustainable. Supervisors and middle managers have to engage in certain actions on a regular basis—it's their job. Accountability isn't about whether or not you've had accidents. Being accountable has to do with the actions you take—carrying out the activities you have been hired to do, trained to do.

MW: Simple stuff.

DP: That's part of the point. It should be simple or it'll never take hold.

MW: To get to a point where zero incidents occur, I'd have to have a system of accountability. I'd have to have hourly and salaried people working together on continuous improvements teams, focused whenever there was an actual or potential error, to drill down and eliminate the cause?

DP: And you'd have to have upper management engaged with the hourly personnel on an ongoing, day-to-day basis. Upper management who are visible in the facility or wherever, rather than limited appearances at management meetings. These kinds of things make a difference.

MW: How do you get the data to find out where the issues are, rather than just saying "the solution is . . . "?

DP: You either can do it through surveys and get it quick, and/or listen to what your hourly workers and officers, and supervisors have to say. The important part is that consultants shouldn't be saying, "you need us." The answers and solutions are more valuable if they come from within. Sure, use the survey to get focused, but the real problem solving will have much greater staying power if it comes internally. Don't focus all the activity on the hourly person. You're going to fail if you ignore the role of management and their number-one mission to support the employee.

MW: What is a safety consultant's role?

DP: The job is to explain to or sell management on the value of the people at the bottom of the organization. The biggest thing a consultant can emphasize is to build the culture, and to build the relationships between all different levels. The consultant's role then, if he wants to add value, is to focus on the relationships that exist between CEO, hourly workers, supervisors, in all kinds of ways. Foster a way to build relationships where everybody needs each other. If you can't buy that thinking, you're never going to come up with a long-term, sustainable solution.

MW: What are the traits of a safety professional who's likely to get the job done?

DP: I think the important thing for the safety person, in any organization, is that he listens more than he talks. Get your information from the people in the organization who know what's going on—hourly people who know and care about what's good and what's not so good in the organization.

MW: So aside from listening?

DP: Communicate, which is part of listening. Communicate with people in management, telling them exactly what is going on and being thought about. Always be ready to go to bat for the workers at all levels of the organization.

I remember one company that had a system where the president level would meet with hourly groups on a regular basis and promised to listen to and act on what the people would have to say.

MW: This roundtable concept works?

DP: Very well—as long as you've got executives who will go to these things, shut their mouths, listen and follow up. It takes a special kind of person to do this, to have that kind of personality. Successful organizations do this today.

MW: If there's a single motivating factor that keeps you inspired, what is it?

DP: Aside from preventing injuries, I'm compelled to explain why safety that revolves around OSHA isn't enough. Good safety is about what people think about and how they work with other people on a regular basis to build excellence.