

Safety Improvers

Working together to reach and maintain zero incidents and accidents



WHITE PAPER NO. 2

by

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Safety Alerts as a Valuable Resource for Teaching Safe Behaviours

*Helping People See For Themselves How Their
Behaviours Can Cause Accidents*

1.0 Introduction

In this white paper, the term *safety alert* refers to the note, presentation or video sent to everyone in an organisation, to share the lessons learned from recent incidents so that the chance of the same incident happening again can be minimised.

Safety alerts have the potential to be valuable learning tools to help people choose the best safety behaviours. However, in many organisations that potential is not being fulfilled, for two main reasons.

1. Some organisations do not distribute the safety alerts effectively – some people do not even see them. Some organisations send them out by email, or by paper copy to be placed on a notice board. Sometimes people are instructed to logon to a web page to see the safety alert. Guess what? Many people do not even know a safety alert has been issued, and if they do, they end up just scanning them, or do not bother to read them at all. Even if people do read the safety alerts properly, there is no certainty that they have understood the lessons. I am sure you'll agree that it is poor practice not to ensure that people take-in the lessons that could help avoid an accident.
2. Many organisations follow the good practice of orally delivering the lessons in safety alerts, by holding a short team briefing, a safety meeting or toolbox talk. The quality of these oral sessions can vary. If the lessons are just read out without any discussion, do you agree that that is not as effective as it could be? If there is some discussion of the lessons and how they can be applied at a specific worksite, that is much more effective.

There is an even more effective way of extracting safety value from safety alerts.

In this White Paper, I'll share a technique I have used successfully over many years, that increases the chance of the valuable safety lessons being learned and applied. To explain this technique we have to first consider briefly the best way to get people to learn.

2.0 The Best Way For People To Learn

When we read a book, manual, or safety alert casually, we can pick up a few lessons. Our understanding is greatly increased if we stop to question what we are reading and think about what it means for us personally. Similarly, in a lecture, seminar, or training course, understanding is increased if participants have to do some kind of exercise, such as a discussion in a group, or filling in a section of a workbook. Of course, for teaching people how to conduct a technical task, the exercises would be hands-on.

Have you noticed how we get bored quickly in many training presentations? The reason for this is that in most areas of life and work we already *know* (from years of experience) most

of what we have to know. For example, in a safety leadership course I ask people what they think makes a brilliant leader. Within five minutes the flip chart has about 18 traits of a brilliant leader. Similarly in a presentation skills course, I ask people what they have to do to make a brilliant speech. They come up with at least twenty-five things they should do. So why spend an hour or so in a training course boring people by telling them what they already know?

What people do not know enough of, is what they really have to do to *apply the knowledge they already have*.

What does this mean for safety? Lecturing or telling people to behave safely does not work.

People already know they should always risk assess thoroughly, wear the right PPE, follow the procedures, stop any task that seems unsafe, and report every incident as soon as possible. People already know they should not take short cuts, not put unreasonable pressure on people, and not fool around with equipment.

However, there are aspects of our human nature that *prevent people from doing what they know they should do*. White Paper No. 1 goes into detail on these aspects of human nature are, understood as five behavioural traps. People want to know how to overcome the barriers that inhibit them doing what they know they should do. This is why safety alerts are a valuable resource in helping people see how certain behaviours can result in accidents, and what they must do to overcome the traps that 'make' them behave unsafely.

Using safety alerts in a certain way gets through to people. They see for themselves without being told. If a manager or safety adviser tells people how to behave safely, that may have some minimal effect. Remember, adults do not like being told their behaviours may be unsafe – it is a very personal matter.

However, if a person realises for themselves what they should do, that is more powerful. How can you go against your own wisdom? In educational jargon, this means that the lessons are more *effectively internalised*. No one is telling them, they are telling themselves based on their training, experience and common sense. That is why the learning takes place.

3.0 Using Safety Alerts to Generate Discussion about the Best Safety Behaviours

Here is a suggested method for using safety alerts that increases the chance of lessons being internalised and acted upon:

- Take a safety alert and adapt it by taking out most of the technical causes.
- Then analyse that incident by identifying the behaviours that contributed to the error, or by asking why certain things happened.
- Then, in a workshop, toolbox talk, or a safety meeting, present the safety alert using a slide or handout, and ask people what they think happened, and why. As

participants recognise the behaviours you can point them out on the slide or a flip chart. You will be amazed at the extent and depth of discussion if you give people the time to consider themselves what happened and why.

Next you will find three examples that can be used as templates for this kind of analysis, to point out the behaviours that have contributed to accidents. Notice how in these examples, the analysis exposes that some question about the accident have not been answered in the alert.

Take a look at Analysis 1.1 below.

Accident Behaviour Analysis 1.1 (Lifeboats)
**With respect to the colleagues who have lost their lives, and their families*

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An Assistant Electrician (AE) and Assistant Mechanic (AM) were inside a lifeboat performing weekly lifeboat preventative maintenance, while a Motorman was positioned on standby outside. When the work was thought to be **completed**, the hang off **pendants were removed**, with the AE still on board the lifeboat. The AM re-entered the lifeboat to address **an unfinished task**. He **asked the AE to function the lifeboat's engine throttle**. The AE **instead pulled the lifeboat's release lever** and the lifeboat fell 125 feet to the water. Both employees perished in the fall.

Diminishing the Risk!
Develop your awareness of the "NON-JOB" syndrome. The job was completed and they were just finishing off a task. It was not a "real job". Guard drops after a huge task completed or when the task seems minor.

Lack of Awareness? Did they know the pendants were removed? If they did, why not get them reinstated?

Assumption!
Did the AE know the difference? Check every time!

Doubt or lack of knowledge? Ask!

Or

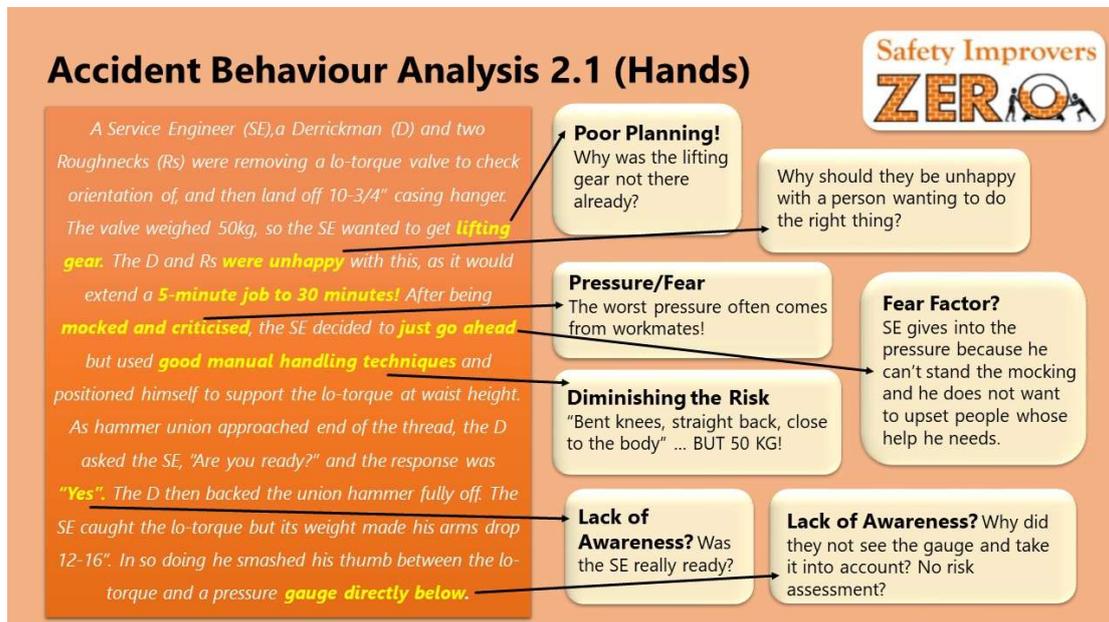
Loss of concentration – for a fraction of a second! Take five seconds and ask, *What am I doing here?* Orientate yourself.

Notice the behavioural traps: (i) wrongly diminishing the risk, (ii) lack of awareness, and (iii) assuming. You will expect to have some participants ask some relevant questions:

- Did the AE know the difference between the throttle and the release mechanism?
- Did both the AE and AM know the pendants were removed?
- If so, why did they not ask for the pendants to be reinstated?
- What did the risk assessment look like?

It does not matter that we cannot know the answers to these questions. The very fact they are asked tells people what should have happened – and what they should do in future.

Take a look at Analysis 2.1 below. This incident involves workmates putting unreasonable pressure on each other, and wrong manual handling.



Notice again how one can point to the behaviours, such as lack of awareness, the fear factor and wrongly diminishing the risk. Again, engaged and alert participants might ask a range of questions:

- Why were D and R unhappy about getting the right tool (lifting gear) for the job?
- Did the risk assessment not identify the pressure gauge directly below the valve?
- If the risk assessment stated that lifting gear was required, why was it not there?
- Should they have been mocking and belittling their workmate?
- Why did the SE give in to the mocking and take the weight of a 50kg valve?
- If someone confirms that they are ready, what other checks should we do to be double sure they really are ready?
- Was the SE really using "good manual handling" techniques?

Notice a very important and useful teaching point: to hold these behavioural discussions, the participants do not need to know the technicalities of the job.

Take a look at Analysis 3.1 below, which gives the example of a shipping incident. I do not want to be over-critical about the accident investigation and, of course, a safety alert cannot contain everything in the investigators' report. However, look at all the "why" questions.

Accident Behaviour Analysis 3.1 (Collision)



Vessel A dragged its anchor in heavy weather and collided with vessels B and C. All three vessels sustained shell plate damage.

The investigation identified that:

- **Insufficient anchor cable** had been deployed for the tidal range and environmental conditions
- Anchor drag was not immediately identified – anchor position **monitoring was inadequate**.
- A's bridge watchkeeper **did not alert** Vessel Traffic Services or nearby vessels.
- Class conditions for engine readiness with only one anchor **not followed** – A's engine not on immediate readiness
- **Lack of company guidance** meant that there was an inconsistent approach to engine readiness on board sister vessels in the same fleet.

Why insufficient anchor cable?

Why was monitoring inadequate?

Did he not alert VTS and other vessels?

Why were they not followed?

Why was there lack of guidance?

From this safety alert, participants should learn – as all safety professionals know – that an accident is not solely down to the operators at the “coal face”. The insufficient anchor cable and the lack of guidance seem to be an organisational failure. However, participants will probably come up with some sensible practical observations:

- Knowing the weather was going to be bad could have prompted the Captain to make an alternative arrangement.
- Improve the monitoring of the anchor positioning.
- Improve knowledge of the tidal and environmental conditions.
- The bridge watch keeper should have alerted everyone (did he or she have enough experience?)
- Is there confusion about the anchor policy and keeping engines running?

Again, note that technical knowledge of shipping and navigation is not necessary to learn about what to do to prevent similar incidents. Also, do not worry about not coming to firm conclusions and not being able to answer questions. The very fact of raising issues and asking questions sows the seed in participants' minds about what they should be asking and doing, and how their own and others' behaviours impact their safety performance.

The next four summary points should put your mind at ease when facilitating these safety alert discussions.

4.0 In Summary

1. This technique is simple and low-cost. All it needs is a little time to think beyond the technical, and to analyse the incidents from a behavioural perspective. It also requires making time for the discussions to take place.
2. Facilitators of the discussions do not need to be psychologists. This means that safety advisers/officers can do more coaching. Also, why not get supervisors to do the coaching? They will be reading out the safety alert anyway, so the safety team could provide the analysis and the supervisor could facilitate the discussion.
3. Do not worry about persuading people about the "right answer", and do not worry about coming to definite conclusions. The discussion is good enough for the seeds of thought to be sown. Even if there is disagreement that is okay, it means that people are thinking.
4. Keep doing this kind of discussion session over and over again. Perhaps do one a week at pre-job (toolbox) talks. In a safety meeting, why not do three? And why not prepare a half-day workshop where you use five? The result of this will be that people begin to realise that one or more of the same five behavioural traps are at work in almost every incident. The context and the equipment may be different, but the causes of accidents are mostly the same, whatever the industry.

For more information, have a look at the contents of the e-manual: [*10 Pillars of Organisational Safety Performance: How Solid Is Yours?*](#) The ten pillars described in the e-manual will assist you in:

- Seeing through complexity and making better recommendations.
- Evaluating safety proposals to ensure that it contributes to building and maintaining safety pillars.
- Gaining more safety improvements for the amount of time and money spent.
- Quickly judging which of the safety pillars are missing, and those that need repair.

As always, your comments on this white paper are most welcome – please email me at bill.robb@safetyimprovers.com.