Leadership, and ‘Human at Fault’ Thinking

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Not too many people will dispute that human behaviour and in particular, human actions are commonly implicated in accident causation.

The key word here is - implicated. It is astonishing how quickly and easily we can travel from ‘implicated’ to ‘responsible’ and ultimately to human error being a ‘root cause’ of accidents. It often happens in the blink of an eye, through several specific cognitive processes; mostly associated with the Western view of the world and involuntary effects such as the fundamental attribution error. Not surprisingly, this internal bias is often manifested in accident investigations where we often find people to be responsible for accidents, ‘just as we originally thought’.

In describing this internal bias, just culture and human errors as consequences of deeper cognitive failures, Professor James Reason rightfully points to ‘*illusion of free will*' (Reason 2008). This deep and often erroneous belief in humans as free agents is often a core issue affecting our judgement, ability to understand causation of accidents and create a culture of safety and resilience in organisations. Believing that we are capable of guiding our own fate and exercise consistent correct actions towards achieving certain goals, despite an array of environmental, sociological and systemic influences around us is the key barrier to our ability to see beyond human error.

As one senior leader put it to this author, “…we give workers systems, processes and good tools. We also tell them that it is ok to stop the job if something is unsafe, there is absolutely no excuse for doing the wrong thing and having an accident”.

If only safety and risk management was that simple. What we often believe is under complete and direct control of people involved in the operational execution of work and the actual reality those people face are two very different things. In real world, work execution is much more complicated. Incompatible and conflicting goals, shifting priorities, work pressures, poor leadership and their unconscious messages are just some of many additional factors critically influencing operational execution of work.

Sadly, despite making progress in safety and risk across industries, the lack of quality leadership and understanding of human factors continues to dominate many boardrooms and executive levels.

This further drives the tendency to allocate blame to those at the sharp end and allocate punishment for human errors instead of self-reflecting when looking for accident causes. One of the basic trademarks of good leadership is the ability to think along the lines '*what could I have done differently to prevent this from happening* and what do I need to do right now'. Not surprisingly, this type of critical thinking remains as elusive as it is uncomfortable. It is unfortunately far easier and emotionally satisfying to stop at human error and discharge the accountability of senior decision makers by sending good and competent people out of organisations, often for nothing more than being human. It may sound harsh but this is a cruel fact of life in many industries today.

Despite overwhelming opposing evidence from modern psychology, neurology and the study of human errors; the illusion of free will and tendency to find blame is so deeply ingrained in human decision making it can be said that it has almost been normalised in many aspects of our lives. This is particularly visible in the legal system where the need for social justice often takes precedence over latest scientific research. It is also strongly represented in behaviour of various regulatory authorities and supported by media driven blame in the reporting of major accidents and catastrophes. This is particularly well illustrated in the recent movie 'Sully', depicting the events surrounding US Airways flight 1549. In this event the conscious and unconscious thinking from investigators and bureaucratic figures was to immediately default to illusion of free will thinking and analyse human actions in hindsight and from the same perspective as if the human was a machine and had the luxury of time, ability and opportunity to rationalise all possible scenarios before supposedly acting 'erroneously'. The movie has a happy ending for the pilot and his first officer, however many other professionals across various different industries are not afforded the same wisdom and continue to suffer as the result of poor leadership and this archaic thinking.

It is simply staggering that despite so many scientific breakthroughs related to the power of unconscious thinking, especially in terms of speed, reliability and accuracy of unconscious and heuristic decision making; we are still not adequately understanding, sharing, promoting and implementing knowledge of human factors in practice, on a mass scale. And let's face it; if internally embedded safety professionals, especially those in very senior positions, don't unlearn the ways of the past and learn how to think differently and promote this knowledge with senior leadership and management in organisations, how can we expect a change?

As safety professionals, we need to acknowledge that our efforts in Occupational Health and Safety are still mechanistic and focused on forcing people into predetermined operational and procedural envelope under the cover of internal or external compliance. Some great examples aside, in many cases what starts as a compliance requirement often transpires in blind compliance which creates a

culture where people are discouraged to think for themselves, reluctant to engage and contribute and are disempowered to make the right decisions and challenge work methods. Where this culture exists a culture of safety and true continuous improvement cannot flourish and operational as well as safety performance usually stagnates. Sure, leadership may be lacking in many regards but there is no escaping the fact that safety professionals have a lot to answer for when it comes to this state of affairs, including the never ending tendency to write 'yet another procedure', introduce another 'blanket rule' or ban yet another 'dangerous' tool.

Are we sure that we are promoting right things, or are we suppressing the natural human ability of our workers to be safe and productive? Rather than police, suppress and blame, should we instead teach, mentor, empower, engage and coach?

People are not machines which need to be programmed or controlled but rather the opposite. People are solution and agents of successful recovery, as proven time and time again in many real-life examples involving accidents and disasters. From the perspective of risk management in modern complex industries, the human ability to recover 'out of control' situations is far more profound than the inherited human propensity to err, however the non-tangible nature of safety is such that the effect of human errors tend to be publicised much more readily than occurrences of the human ability to recover from seemingly impossible problems. No doubt human behaviour can certainly be a hazard, however our continuous improvement in areas of safety and risk must be in further promotion of the human ability to be a solution so that we can harness that still largely untapped human potential. The benefits can be tremendous and the change is within our grasp, however, for this to occur an entirely different method of thinking is required in the way we see people and their actions, allocation of blame and connection of human actions at the sharp end to behaviour and practices of senior leaders. Instead of forcing people under mechanistic compliance and blaming or punishing for human errors, we need to enable creativity, foster collaboration with workers at the sharp end and develop flexible, error tolerant systems capable of absorbing specific and identified types of human errors. Flexibility and error tolerance of organisational systems and processes is an integral and critical part of operational discipline and culture of safety. It is an absolutely essential element for achieving and sustaining a culture of resilience, especially in complex industries such as chemical, nuclear, aviation and others.

To further clarify, having the systems and rules is not bad, actually it is essential. However, those rules and prescribed requirements need to be balanced, meaningful, and reasonable, as well as cater for human fallibility. They must be developed by people involved in the execution of work. Above all they need to be flexible and able to be continuously modified as the team skills are enhanced or reduced and new error promoting conditions are discovered. For this culture of

flexibility to exist, the culture of safety leadership needs to be very mature; senior leadership needs to be knowledgeable and abreast of the latest thinking in safety and risk.

Reversing and modifying the way we think about human errors, violations and situational decision making will be a long and onerous process. It is difficult to change and influence views of senior organisational decision makers if the overall regulatory environment is not driving the change. The author of this paper recently attended a regulatory information session focused on safety improvements. Amongst the usual array of statistical information, the presentation by the inspectorate delivered the somewhat peculiar view reiterating one of the biggest safety fallacies of all time, that people are causes for over 85% of all accidents. To hear such confirmation of human at fault culture from the regulator is very surprising to say the least, and this confirms the size of our challenges and issues in viewing people as a problem to control.

By looking deeply into the conscious and unconscious 'human at fault thinking', especially at senior organisational levels, a careful observer can also clearly see the correlation and influence of this thinking on some common organisational approaches in trying to improve safety performance. Some examples that come to mind are the ever present programs and messages proclaiming safety as everyone's responsibility and a range of pledges, commitments, slogans, value and reward based initiatives or behaviourally based safety programs. Most of them are based around the premise that people are 'at fault' and need to be 'fixed' or corrected in some way, either by making them 'responsible', by modifying their values or by observing their workplace behaviours in order to modify it towards a 'safer' way of working. There is little, if any empirical evidence that any of those strategies produce any meaningful and sustainable improvements in safety performance. On the contrary, some of them are actually very counterproductive in obtaining workers engagement, establishing a just culture and increasing human reliability. The reasons for this are not so much in the way those initiatives are intended but rather in the way they are practically implemented. Experience teaches us that in practice, each of these initiatives and messages has a clearly communicated, intentional meaning but also a hidden, subliminal message or meta meaning, which is far more powerful. Let's examine some of those.

SAFETY IS EVERYONE'S RESPONSIBILITY

This is absolutely correct, safety is indeed everyone's responsibility and on the surface there should be no issues with such statements and programs. However, in practice, slogans such as this are often used to shift the responsibility for accidents away from the senior management and point out to workers that their behaviour needs to be more 'responsible', therefore their behaviour is actually

a problem which needs to be corrected. So, when accidents occur, leadership's reluctance to self-reflect, hindsight bias, emotional convenience, basic fundamental attribution error and illusions of free will, often combine to create false logic that someone has to be 'responsible' and this is frequently the person at the sharp end who made the error. This 'responsibility' quickly grows into 'accountability' and blame and punishment is assigned to the wrongdoer.

But, is this really well placed? The science of human error confirms two critical things.

Firstly, human errors are part of 'human design', they are impossible to eliminate. It is how we learn and develop skills and knowledge and also how we are able to simplify complex processes and recover from sometimes seemingly hopeless situations. Secondly, both, human errors as well as our extraordinary ability to recover from out of control situations come from the same cognitive mechanism. One cannot exist without the other.

When accidents occur, their consequences and severity of 'rule breaching' quickly blurs the lines and common human errors involving unintentional actions or actions involving the right intent but wrong execution, all too easy become intentional violations. Senior leadership should be constantly aware of the key differences between human errors and intentional violations, as even those can be induced by various external factors such as culture or leadership and are often blameless. Allocating blame and punishment for common human errors implicated in accidents does very little to promote safe behaviour as it creates fear and fear is never the right way of engaging adults in leadership and behavioural change. What we actually practice in organisations has much stronger implications on worker's behaviour than what we openly communicating and promoting, especially in terms of 'safety responsibilities'. The power meta meaning is not to be underestimated as it acts as a critical barrier to collaboration and causes damage to relationships and organisational safety culture.

In terms of actual responsibility for safety, all legislative jurisdictions prescribe the largest part of safety responsibilities to – senior leadership and management. Workers are mostly entrusted with complying with their employer's lawful safety instructions. It seems strange, but if the law holds those with decision making authority and resources responsible, it does not make much sense to continuously try and transfer this responsibility to those at the sharp end, yet this is precisely what occurs in many organisations under the mistaken belief that putting systems and processes in place discharges senior decision maker's due diligence and the safety is now 'up to workers'. Nothing can be further from the truth and be so damaging to organisations as systems and processes which are not implemented in practice, or a culture where accountability for safety is blurred and misguidedly delegated to workers or support functions.

Having a policy in place clearly defining line management accountability for safety, key performance indicators and programs aimed at observing leadership behaviours would provide far better results in any organisation than strategies of delegating responsibility to workers and observing their behaviour. Safety related behaviour of workers is far more dependent on consistent and aligned leadership practices, (waking the talk) than any other internal or external factor. Introducing slogans or programs which declare safety as a line management responsibility and driving this accountability would yield far better results in creating and sustaining operational discipline and culture of safety in operations and safe operations create safe organisations.

PLEDGES AND COMMITMENTS

The simple meta meaning here is that workers can work safely but they just don't have enough 'commitment', therefore by pledging and signing various declarations through road shows and public displays, their commitment to safety will increase and transpire in 'safer' actions and their 'safety values' will be improved. In a way, this methodology again passes the message of the 'unsafe people'. Of course, we know that no one goes to work to get injured and people are not unsafe but to the contrary, they are naturally predisposed to make safe choices through their sense of self-preservation and ability to calculate risks. Just the self-preservation alone is more than enough 'commitment' for most people to stay safe. The assumption that people lack commitment to safety and therefore injure themselves and cause accidents is simply a fallacy. It is not the lack of commitment which causes errors and violations in the workplace but rather an array of other factors such as person – task mismatch, incompatible goals, work pressures, mixed messages, poor leadership, inadequate systems of work and error promoting conditions.

The commitment of workers towards safety depends far more on leadership practices and demonstrated organisational commitment, specifically in terms of trust, level of collaboration and engagement with the workers, as well as an existence of just, leaning and flexible cultures. Pledges and declarations of commitment do not work; they only contribute to an increased trend of juvenilisation of the workforce which has a profound and long term negative effects towards the very goal they are trying to achieve. If we want people to be mature and make right choices, treating them with mistrust, contempt and in a juvenile way will only achieve opposite effects. People respond far more positively to mature treatment such as engagement, collaboration, trust and respect.

CARDINAL RULES AND LIFE PRESERVING CHOICES

Just like many other safety initiatives, rightly or wrongly, processes involving minimum behavioural expectations have spread like a wildfire and became a permanent feature in many occupational settings. In many industries today, if the organisation does not have one of those, it is almost taken as the organisation is not serious about safety and is 'lacking commitment'; such is the power of 'keeping up with joneses' in safety.

The hidden meaning here is that the organisation has done everything correctly and it has such strong commitment to safety that now has a system aimed at dealing with the members of the workforce (bad apples) who are not sharing that 'commitment' and are routine or opportunistic violators. Usually these systems are marketed as being applicable to everyone; including management however their main intent is rooted in 'people at fault' thinking and they are predominantly aimed at people at the work execution level.

Practical application of these systems implies that the breaking of those rules often carries severe disciplinary actions, often involving termination of employment. Implementation of these systems is often an easy way of demonstrating perceived organisational commitment however often with profound negative effects. This is especially the case when these systems are used prematurely and selectively or when they are used to apply punitive actions for human errors by bundling them together, or mistaking them for intentional violations. Very few organisations reach the maturity stage in their development where application of these processes is appropriate and consistent with just culture models, especially in terms of having well developed front line and senior leadership capable of implementing these systems appropriately.

In practice, the enforcement of cardinal rules and similar 'choices' often discounts the influence of leadership behaviours and practices, work pressures, incompatible goals, fatigue, culture and host of other things, and creates focus on people, with ever present 'human error' being identified as a 'root cause' of accidents.

Most people really enjoy being productive and respond in various ways to productive obstacles and barriers such as unworkable procedures or inappropriate tools and equipment. When presented with difficult choices, they often create workarounds to cater for the shortcomings and still achieve goals which give them satisfaction. Contrary to some behaviourally based theories, rewards of completing the job provoke much stronger pleasurable emotions than taking the dangerous thrill seeking shortcuts. In the experience of this author, the vast majority of safety violations are

condition compensating violations (or situational violations as Reason calls them) rather than optimising violations involving thrill seeking and risk trading for convenience or even system induced violations. Most violations occur through well intended although erroneous actions to get the job done, especially when faced with competing priorities and mixed messages on what is important and valued from the local leadership. When such practices are locally condoned, sub cultures are created and at the same time, senior management is completely unaware of them until something goes wrong. Although technically violating cardinal or lifesaving rules, severe punitive actions for those cases are extremely counterproductive and often terminal for the existence of any meaningful culture of safety, trust or collaboration, trust here being of the outmost importance.

To illustrate, if the organisation has a rule where no person can enter an area such as mechanical workshop, without wearing gloves, even if the person is not doing any manual activity, it is unlikely that the environment is the one of trust and confidence where workers are empowered to make choices and decisions based on their competence. Where organisations demand blind compliance, irrespective of the views and concerns of those who work with risks and treat competent adults as children, it is impossible to expect that people will feel empowered to use their initiative, challenge the status quo, drive continuous improvement and make the ‘right choices’. When faced with dilemmas such as working on pedestal grinders for example, they will mostly make those choices which are enabling them to continue their employment which means they will be too scared to take their gloves off, even though the risk involved in keeping them on is significantly higher. When the incident occurs, the focus will be again on worker’s behaviour rather than the culture and conditions in which people are operating.

Organisations cannot have it both ways, either people can be trusted to make the right choices as responsible adults or they can’t. Bipolar expectations are unrealistic, unachievable and highly damaging, especially if the reason for mandatory compliance has nothing to do with hand protection as in this particular example where all previous injury data used for decision making were crush injuries and gloves would not have changed the outcome.

Dehumanisation and juvenilisation of the workforce is a trademark of an inhibited safety culture where things such as lifesaving rules and choices are premature and counterproductive.

BEHAVIOURALLY BASED SAFETY (BBS) APPROACHES

There are many variants of the old BBS being applied in various industries; however, the basic meta meaning of all those programs supports common belief from senior management that people at the sharp end are the problem and their behaviour requires modification. Alignment of BBS with common views and perceptions in this area is also the main reason why BBS has been so profitable for consultancies over the years; however it often failed to provide substantial and sustainable organisational benefits.

At its core is the subconscious and implicit that people are not engaged, careless, disconnected and inherently ‘unsafe’. The premise is that ‘If we could just get them to care more, they would work much safer. Bradley’s model, often used in DuPont’s based BBS approaches clearly supports this thinking as it associates the ‘unsafe’ natural instinct of people with the lowest point on its evolutionary scale (DuPont 2016).

This is simply a fallacy. People are naturally careful and calculated risk takers with a fundamentally strong natural sense of self-preservation and the ability to simplify very complex processes and mechanisms to be able to cope and make correct decisions. This is the story of many successful recoveries. Instead of seeing people as unsafe and forcing them into a specified, rigid framework, we need to foster human variability, individual qualities and talents as well as unique human ability to adapt to unexpected changes. This also needs to be supported by a flexible operating and decision making organisational hierarchy.

Some of more recent ‘value based’ variants of behavioural safety initiatives are built on the premise that the safety problem resides within people’s values and that by changing them, people can be enticed to choose safer actions and ‘be safer’. We are led to believe that some people’ values are so deficient; they simply do not care for their own safety or safety of others.

This is simply not the case and another way of selling the same old snake oil. Individual risk perceptions, occurrence of human errors and poor personal choices implicated in accidents are neither value driven nor they are moral issues. Those are issues of inherent human fallibility combined with a number of individual cognitive, sociological, environmental, leadership and organisational system failures. Instead of endlessly trying to ‘fix’ people at the operational execution level, we should invest in better recruitment, training and development, engagement and collaboration with the workforce. Above all, we must develop leaders who really understand leadership and human factors and can create organisational culture where new people feel

compelled to follow established ways of doing things, not because someone from management is watching, but because their own peers are setting the standards of how work is being done and what takes to get accepted and belong to specific group operating within specific culture – a culture of safety.

For as long as we continue to entertain theories of careless and uncaring workers with poor values making poor choices and ignore our own leadership issues, we will continue the self-fulfilling prophecy of repeating our own mistakes, giving the meaning to the old saying, there are no new types of accidents, only people with short memories.

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