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Safety Leadership

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CONSTRAINING YOUR PEOPLE OR EMPOWERING THEM?

Bill Gates recently said that in this century, leaders will be those who empower others. It is about nurturing and enhancing, agrees Tom Peters. Safety leadership, then, is about empowering others. It is very different from safety management. You manage things, you lead people. Peter Drucker once said that so much of what we call management consists in making it difficult for people to work. Managing things can get in the way of leading people, just as it can get in the way of those people actually doing the work you hired them to do. Safety management often does make it more difficult for people to work.

Safety management, as opposed to safety leadership, can typically tell people how not to do things, or what not to do, or when not to do it. It is about constraint and control. About stopping people from doing things which are unsafe. But recognise the assumption beneath this. It assumes that you, the leader, know precisely what "unsafe" actually means. But do you? Good safety leadership is not about knowing everything and directing others how to work safely. It is not about making it impossible for others to operate in an unsafe manner based on your own ideas of what their work consists of. Instead, good safety leadership is about acknowledging that the work that your people do has evolved to cope with the inevitable hazards, complexities, gaps, trade-offs and dilemmas which your organisation (and the nature of their work) helps create.

Good safety leadership is about putting in place the conditions for your people to do things safely, more than about putting in place the constraints that prevent your people from doing things which are unsafe.

-Leo Praesen

When you look honestly at the work that your people are doing, you will quickly discover that they are trying to reconcile multiple goals simultaneously. These goals can conflict because of the expectations that you, and your organisation, have put on them. For example, people will need to meet production targets but also comply with regulatory and statutory demands for procedures, checklists and paperwork. Over time, people in your organisation learn to cope with the complexities and often, contradictory goals, of their work. In the details of how they do this, there is an enormous amount of data, wisdom even, about how people get work done inside of your organisation. It is their expertise that holds together the patchwork of goal conflicts, technologies, tools, pressures, paperwork requirements and other expectations. Such expertise is critical for the success of your organisation.

Safe organisations are those whose leaders defer to expertise; whose leaders defer to those who know intimately the messy details of what it means to get the job done. Deference to expertise means that you, as a leader, engage those who are practiced at recognising risks and anomalies in the operational processes in your organisation. So-called high- reliability organisations, for example, have been acclaimed for their sensitivity to operations and deference to expertise. They are attentive to their operational front-end, to the sharp end where the "real" work gets done [1], where your workers are in direct contact

with the organisation's safety-critical processes [2, 3]. Such organisations send "power to the projects" as John Green, a HSE Director in the construction industry recently called it. High-reliability organisations indeed push decision making down and around, creating a recognisable "pattern of decisions 'migrating' to expertise" [1]. You, the leader, might not know how safety is created and risk is controlled in the messy details of everyday work. But you have people who do. Do you want to make it impossible for those people to operate in an unsafe manner– based on your imperfect knowledge of what it takes to get their job done? Or do you want to nurture, empower them, enhance their capacities to do things safely by putting in place the conditions of possibility that make it so?

Leadership cannot be about getting your people to do less. About limiting your people, about making it impossible for them to do things. It really should be the opposite. As John Quincy Adams said, if your actions inspire others to dream more, learn more, do more and become more, you are a leader.

TAKE EXPERTISE SERIOUSLY

Not deferring to expertise comes at your own peril, and at that of your organisation. Not deferring to expertise is often constructed as a major safety shortcoming. Let's look at some examples from overseas, which resonate with what we have experienced in Australia (e.g. Montara). Prior to the Texas City refinery explosion in 2005, for example, BP had eliminated several thousand US jobs and



outsourced refining technology work. Many experienced engineers left [4]. With the appointment of Sean O'Keefe (Deputy Director of the White House Office of Management and Budget) to lead NASA, the new Bush administration signalled that the focus should be on management and finances [5], continuing a trend that had been set years before. NASA had vastly reduced its in-house safety-related technical expertise in the 1990's. NASA's Apollo-era research and development culture once prized deference to the technical expertise of its working engineers [6, 7]. This had become overridden

by bureaucratic accountability-managing upwards with an allegiance to hierarchy, procedure, and following the chain of command [8, 9].

Contributing to the Columbia accident was that "managers failed to avail themselves of the wide range of expertise and opinion necessary." Their management techniques "kept at bay both engineering concerns and dissenting views, and ultimately helped create 'blind spots' that prevented them from seeing the danger the foam strike posed" [5]. In the wake of the Columbia accident, NASA was told it needed "to restore deference to technical experts, empower engineers to get resources they need, and allow safety concerns to be freely aired" [5]. The two Space Shuttle accidents– Challenger in 1986 and Columbia in 2003–have led to calls for organisations to take engineering and operational expertise more seriously [5, 8-12]. This has become well-established in research on high-reliability organisations and resilience [1, 3, 13-17]. You, in your safety leadership, can take steps to do just that, right now, in your own organisation.

LEADERSHIP, SAFETY CULTURE AND HUMILITY

Perhaps the most important attribute of safety leadership is humility. It is to acknowledge that you don't know everything about how people in your organisation create safety and risk. But you can, and must, show that you care. That you want to learn. That you want to understand. Research from the Norwegian Oil industry has recently shown a positive link between you showing such interest in what your people do, and their safety performance [18]. It does not take much imagination to understand why or how. If a leader is intently interested in what people do to make the business work, if that leader is a listener rather than just a talker, people will feel that they, and their views and experiences are taken seriously. They will feel that they are doing things wrongly, or non-compliantly, such appreciation erodes very quickly.

So how can you be responsible for a culture of safety? Is that part of your safety leadership? Humility is a good starting point here too. It is attractive to see the culture in your organisation as something that you can easily control. As a possession, as something that your organisation has. If you see it that way, you can take away that culture, and replace it with another one. You can change that culture, you can insert new parts, take away old ones. You can impose a culture from the top down–which is perhaps your role as safety leader. The

problem is, there is little research in serious science on culture that supports this view (called the functionalist view). Instead, culture is something that emerges from the interactions of all the people in your organisation. They cocreate that culture every day, as do you and those immediately around you. You all do, all your actions do. Culture is the result of all of those actions and views and beliefs and intentions interacting with each other, it arises from them. This is called the interpretevist view. In this view, a culture is not something your organisation has, but something that your organisation does, or something that your people do. You can influence it, for sure, but hardly control it.

The importance of humility for safety leadership cannot be overstated. Humility should not only govern how much you assume you know about how safety and risk are created in your organisation every day. It should also govern what you are willing to hear and learn about your organisation. A strong safety culture is one in which you, as leader, are ready and willing to hear bad news. Where you do not deny the ugly or inconvenient truths about what is going on, and where you do not shoot the messengers.

As a safety leader, you might want to tone down your calls for control, coercion and constraint. Instead, aspire to become a leader who is ready to say "I don't know, but I have people who do, let's go ask them or look at what they do." Aspire to become a leader who is willing to say, "That is bad news. But I am glad you brought it to my attention." Align systems not along what you already believe you know, but along ways to learn, to remain open and inquisitive. Become a leader who nurtures, enhances, enables and empowers.

REFERENCES

1. Weick, K.E. and K.M. Sutcliffe, Managing the unexpected: Resilient performance in an age of uncertainty. 2nd ed2007, San Francisco: Jossey-Bass. xii, 194 p.

2. Cook, R.I. and D.D. Woods, Operating at the sharp end: The complexity of human error, in Human error in medicine, M.S. Bogner, Editor 1994, Lawrence Erlbaum Associates: Hillsdale, NJ. p. 255-310.

3. Dekker, S.W.A. and D.D. Woods, The High Reliability Organization Perspective, in Human Factors in Aviation, E. Salas, Editor 2009, Wiley: New York. p. 123-146.

4. Baker, J.A., The report of the BP U.S. refineries independent safety review panel, 2007, Baker Panel: Washington, DC.

5. CAIB, Report Volume 1, August 2003, 2003, Columbia Accident Investigation Board: Washington, DC.

6. Murray, C.A. and C.B. Cox, Apollo, the race to the moon1989, New York: Simon and Schuster. 506 p., 16 p. of plates.

7. Mindell, D.A., Digital Apollo: Human and machine in spaceflight2008, Cambridge, MA: The MIT Press. 359 p.

8. Vaughan, D., The Challenger launch decision: Risky technology, culture, and deviance at NASA1996, Chicago: University of Chicago Press. xv, 575 p.

9. Feynman, R.P., "What do you care what other people think?": Further adventures of a curious character1988, New York: Norton.

10. Mahler, J.G., Organizational learning at NASA: The Challenger and Columbia accidents2009, Washington, DC: Georgetown University Press.

11. Woods, D.D., Creating foresight: How resilience engineering can transform NASA's approach to risky decision making2003, Washington, D. C.: US Senate Testimony for the Committee on Commerce, Science and Transportation, John McCain, chair.

12. Starbuck, W.H. and M. Farjoun, Organization at the limit: Lessons from the Columbia disaster 2005, Malden, MA: Blackwell Pub. xix, 387 p.

13. Sutcliffe, K. and T. Vogus, Organizing for resilience, in Positive Organizational Scholarship, K.S. Cameron, I.E. Dutton, and R.E. Quinn, Editors. 2003, Berrett-Koehler: San Francisco. p. 94-110.

14. Weick, K.E., K.M. Sutcliffe, and D. Obstfeld, Organizing for high reliability: Processes of collective mindfulness. Research in Organizational Behavior, 1999. 21: p. 81-124.

15. Woods, D.D., Essential characteristics of resilience, in Resilience Engineering: Concepts and Precepts, E. Hollnagel, D.D. Woods, and N.G. Leveson, Editors. 2006, Ashgate Publishing Co.: Aldershot. p. 21-34.

16. Hollnagel, E., C.P. Nemeth, and S.W.A. Dekker, Resilience Engineering: Remaining sensitive to the possibility of failure. Ashgate studies in resilience engineering 2008, Aldershot, UK: Ashgate Publishing Co.

17. Huber, S., et al., Learning from organizational incidents: Resilience engineering for high-risk process environments. Process Safety Progress, 2009. 28(1): p. 90-95.

18. Dahl, O. and E. Olsen, Safety compliance on offshore platforms: A multi-sample survey on the role of perceived leadership involvement and work climate. Safety Science, 2013. 54(1): p. 17-26