
European Industrial Gases Association Winter Seminar 2021 – Behavioural Safety

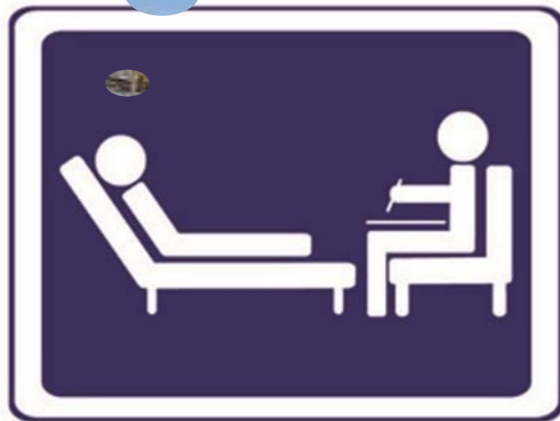
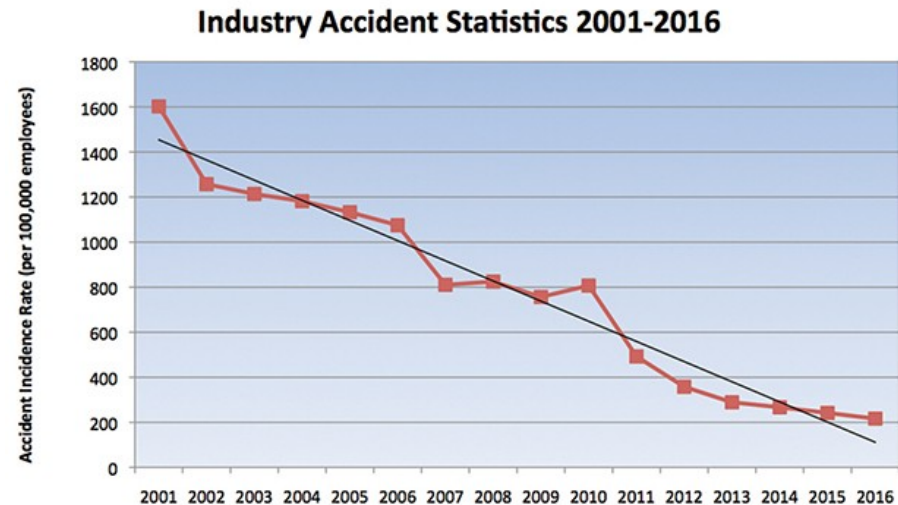
THE MANAGER'S SAFETY BEHAVIOUR

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How do we think about safety?



When we think about safety, we usually think about accidents - (low probability) events with adverse outcomes.



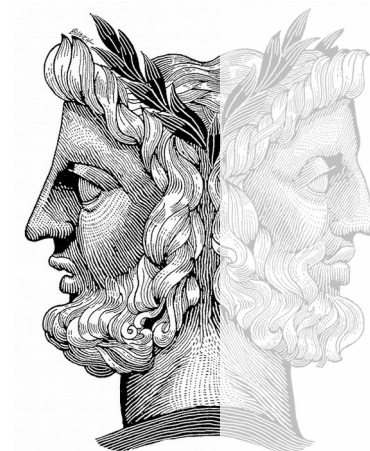
A system is therefore safe if as little as possible goes wrong.

What You Look For Is What You Find

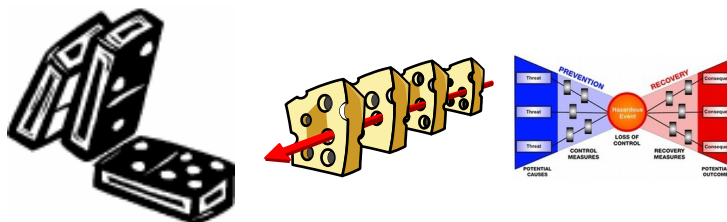


When we look back, we tend to notice accidents and incidents - events that conflict with our intentions and expectations.

These events “prove” that our understanding was incomplete or incorrect. We therefore have to improve our understanding.



There are many ways to explain why something went wrong.



But they are generally too simple.

Managing the absence of safety

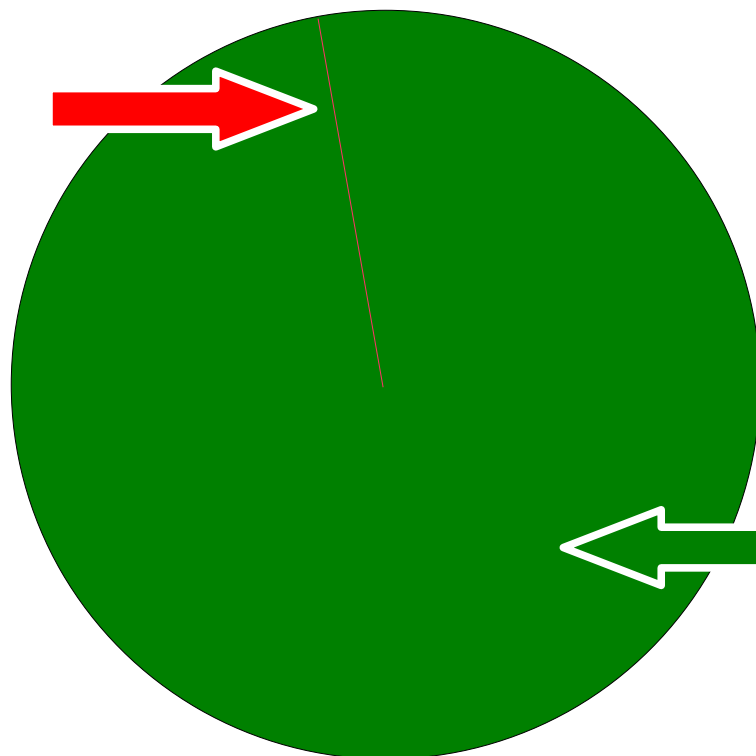


But why only look at what went wrong?

1 event out of n
goes wrong

WHY?

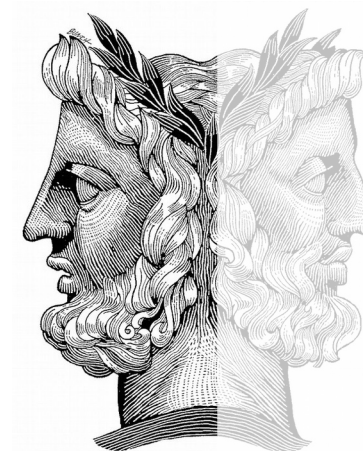
Prevent it
from
happening
again.



$n-1$ events out
of n go well

WHY?

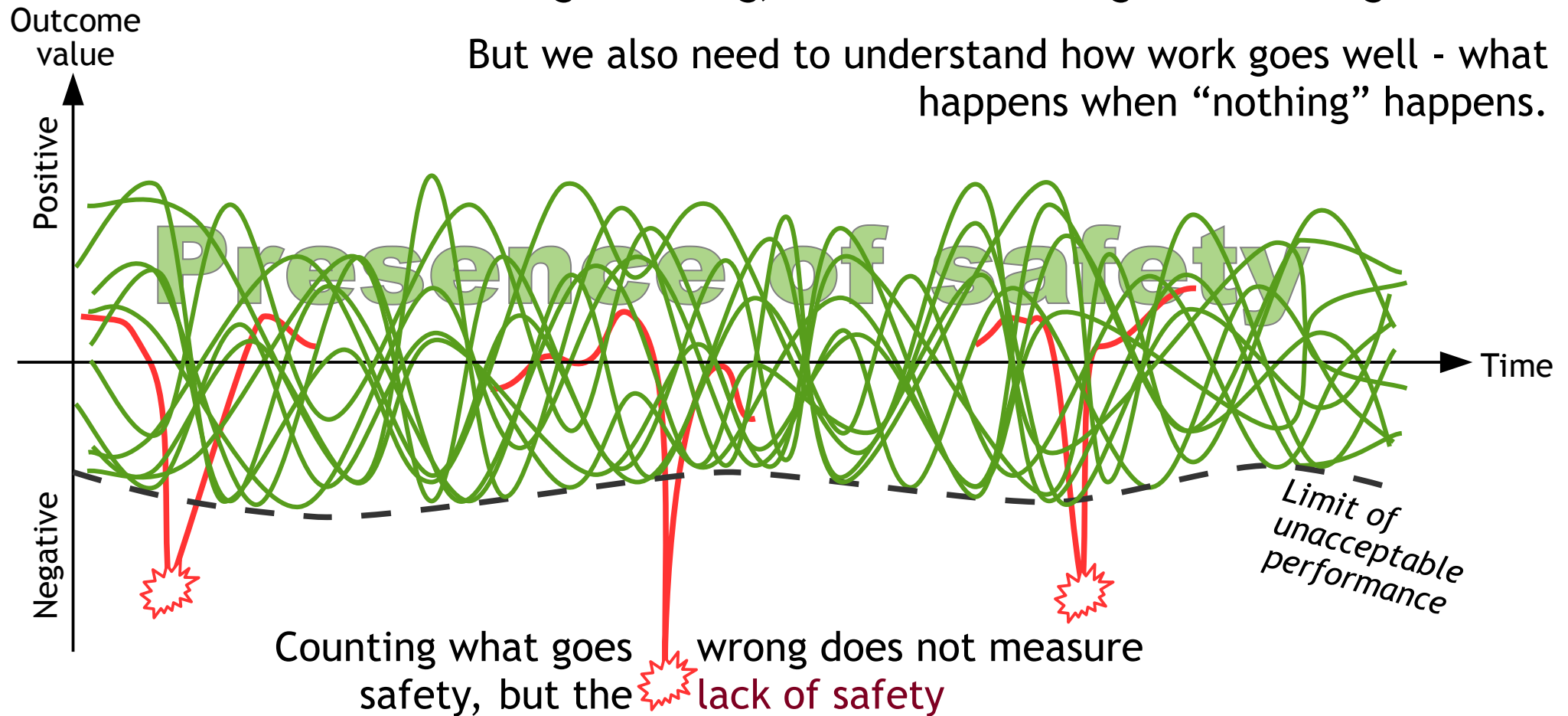
Make sure that
they happen
again!



Managing the presence of safety!

The result of Safety-I is that we know something about what goes wrong, but almost nothing about what goes well!

But we also need to understand how work goes well - what happens when “nothing” happens.



Safety should not focus on accidents

Safety is defined and measured more by its **absence** than by its presence.

Reason, J. (2000). Safety paradoxes and safety culture. *Injury Control & Safety Promotion*, 7(1), 3-14.



Reliability is a dynamic **non-event** ... it is an ongoing condition in which problems are momentarily under control due to compensating changes ...

Weick, K. E. 1987. Organizational culture as a source of high reliability. *California Management Review* 29 (2), 112-128.

*Safety is **invisible**: people often don't know how many mistakes they could have made but didn't ...*



*Safety is **invisible**: reliable outcomes are constant, which means there is nothing to pay attention to.*

Life is full of “dynamic non-events”

Every day, from morning to night,



practically everything we do

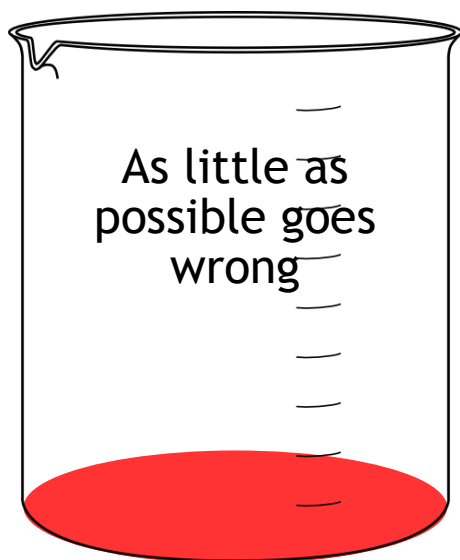


works just as it should ...

... and we take it for granted

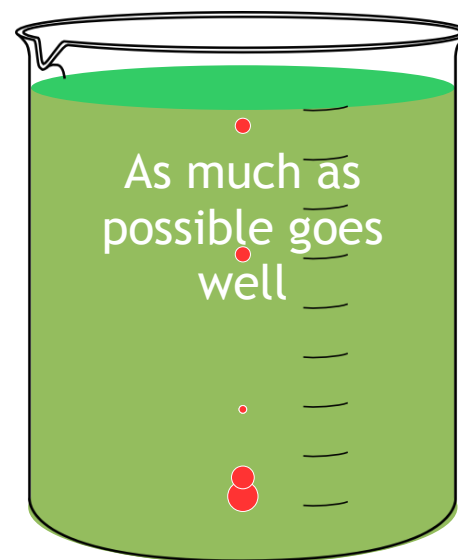
Two ways of looking at safety

SAFETY-I



Prevent, eliminate, constrain.
Safety, quality, etc. are different and require different measures and methods.

SAFETY-II



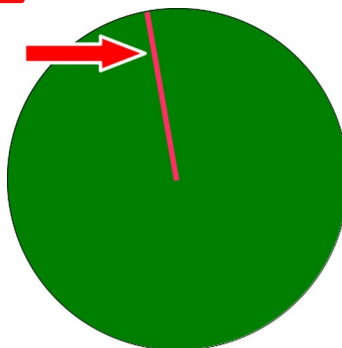
Support, augment, facilitate. Safety, quality, etc. are unified and require matching measures and methods.

What are the consequences of either view for behavioural safety?

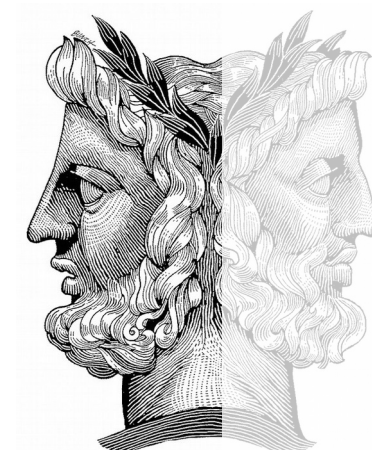
Choosing what to look at and manage

Focus on what goes wrong

Selection based on severity.
Cases are infrequent or rare.
Cases have few similarities.
Difficult to verify lessons.
Management by prevention.

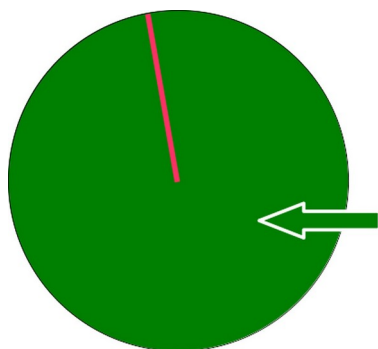


Looking back



Focus on what goes well

Selection based on frequency.
Cases are easily found.
Cases have many similarities.
Easy to verify lessons.
Management by facilitation.



The manager's safety behaviour

Managers usually look at the safety behaviour of others.

But the manager's own safety behaviour (and beliefs) has consequences for what is looked at, and for how it is managed.

A Safety-I perspective is reactive and looks at how work should NOT be done.

Changing behaviour only to prevent that things fail does not contribute to things going well. It is a cost.

A Safety-II perspective is proactive and looks at how work SHOULD be done.

Changing behaviour to increase the likelihood that things go well also reduces the likelihood that they fail. It is an investment rather than a cost.

Thank you for your attention

