Getting Past “That Will Never Happen (Again)” in SIF Prevention

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Agenda

- "It" won't happen at my organization… *or can/will it?*
- We are getting better every year… *or are we?*
- It's too bad there isn't a model we can use to get after SIF Prevention… *or is there?*
- Our policies/procedures/systems are "world class"… *but bad things keep happening! Why?*

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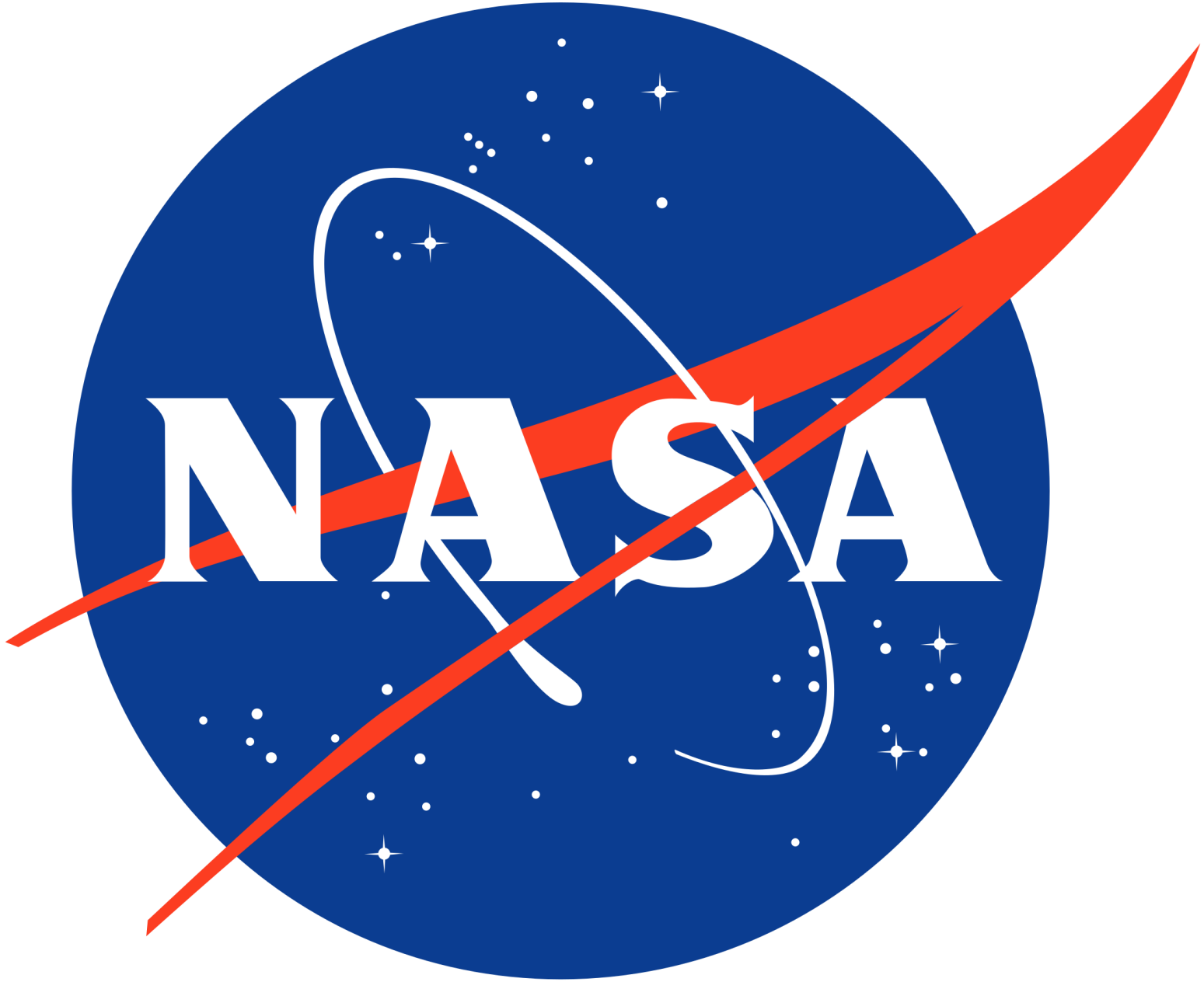
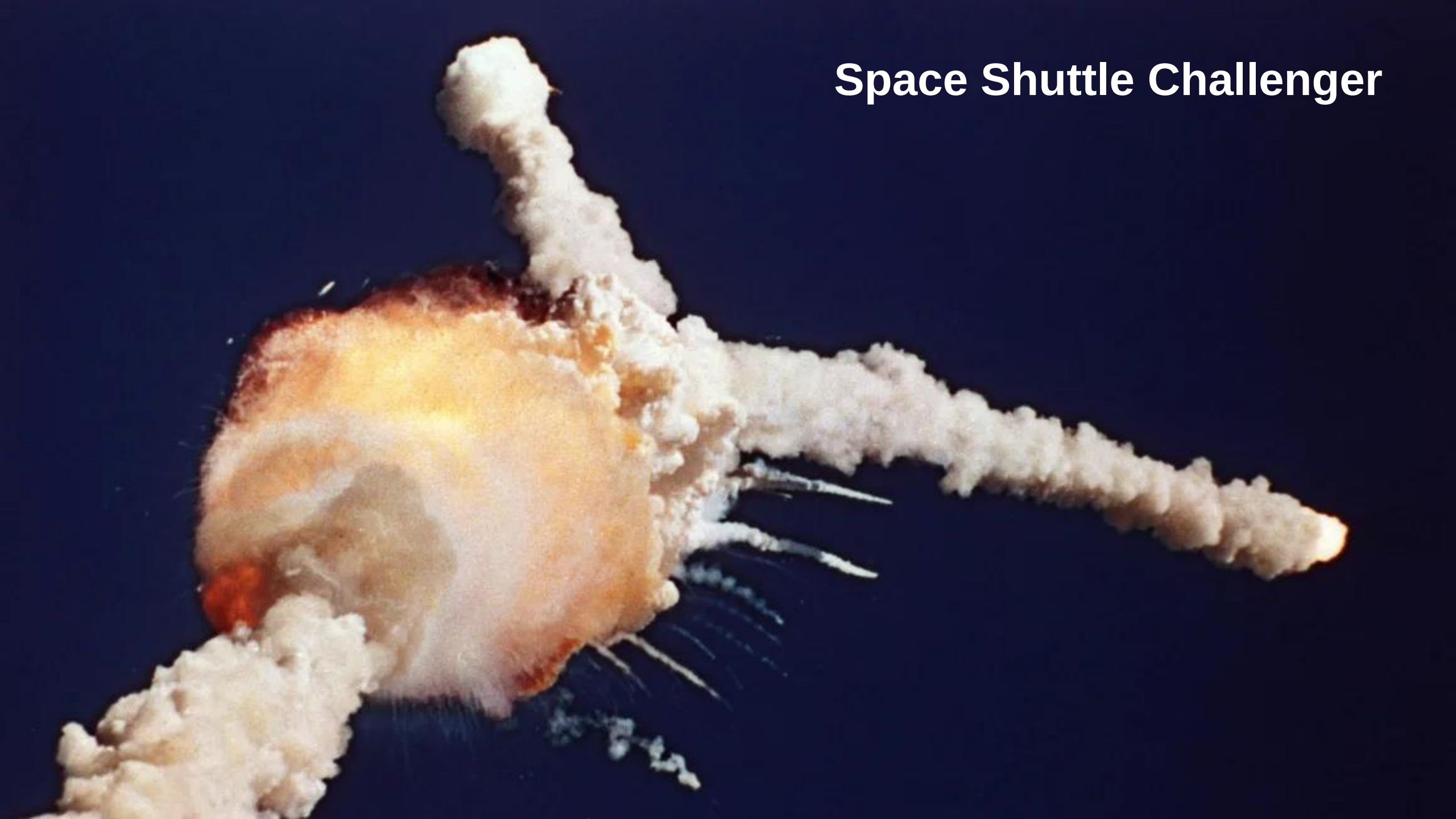
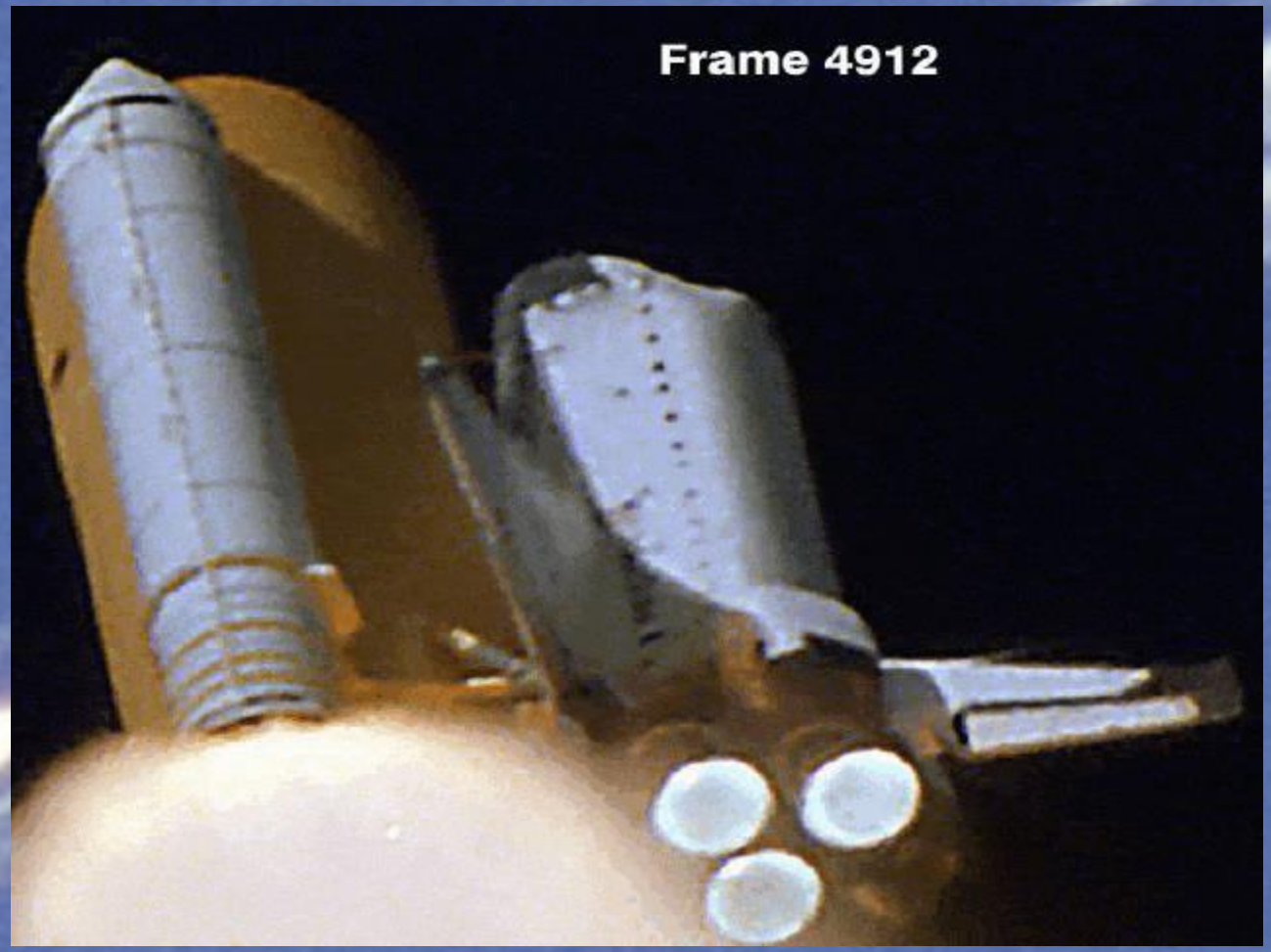
When you think of organizations with World Class Safety (private, governmental, agencies, etc.), who comes to mind?

ⓘ Start presenting to display the poll results on this slide.




Space Shuttle Challenger

Space Shuttle Columbia



#SafetyInAction

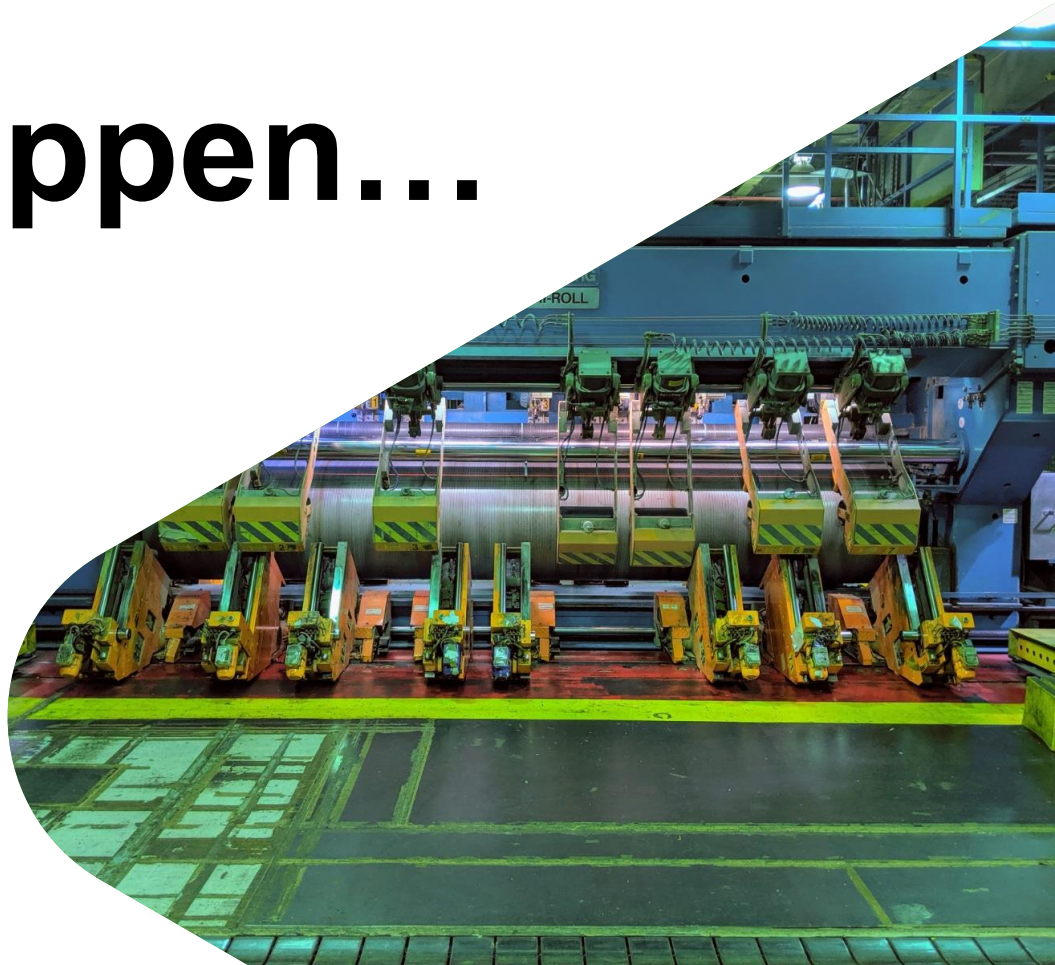
NASA’s Investigation Report

“For both accidents [Challenger and Columbia] there were moments when management definitions of risk might have been reversed were it not for the many missing signals, **an absence of trend analysis**, **imagery data not obtained**, concerns not voiced**, information overlooked or dropped from briefings**.”

“When something sounds, smells, looks, feels different from yesterday at the “pointy end” of an operation, front-line workers are the first to know because they also know how work actually gets done — not how you hope, plan, or paid for it to get done”. – NASA, 2020

That Will NEVER Happen…

HERE… ON MY WATCH… AGAIN…



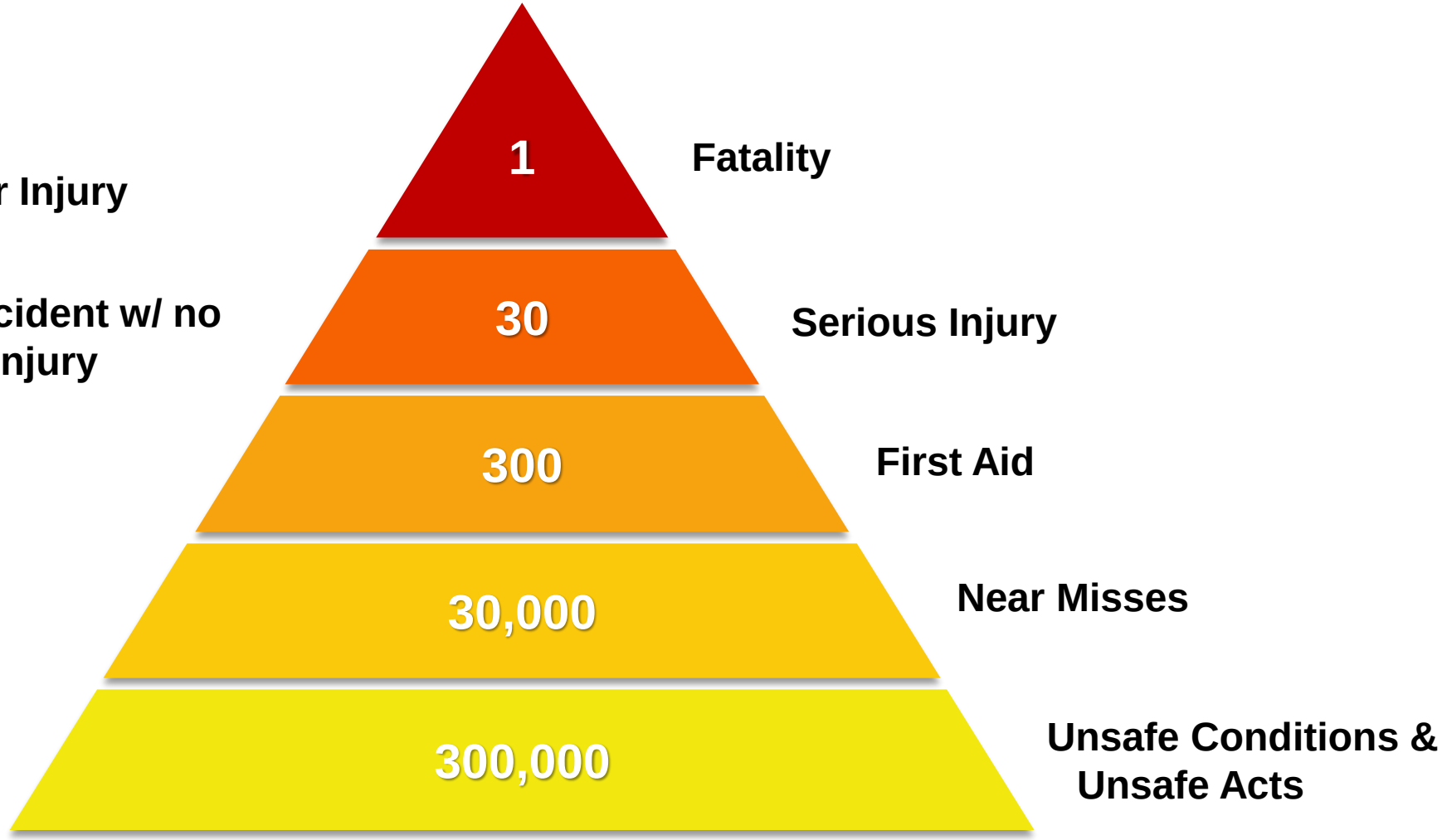
Mid 2010’s

18 Months Later…

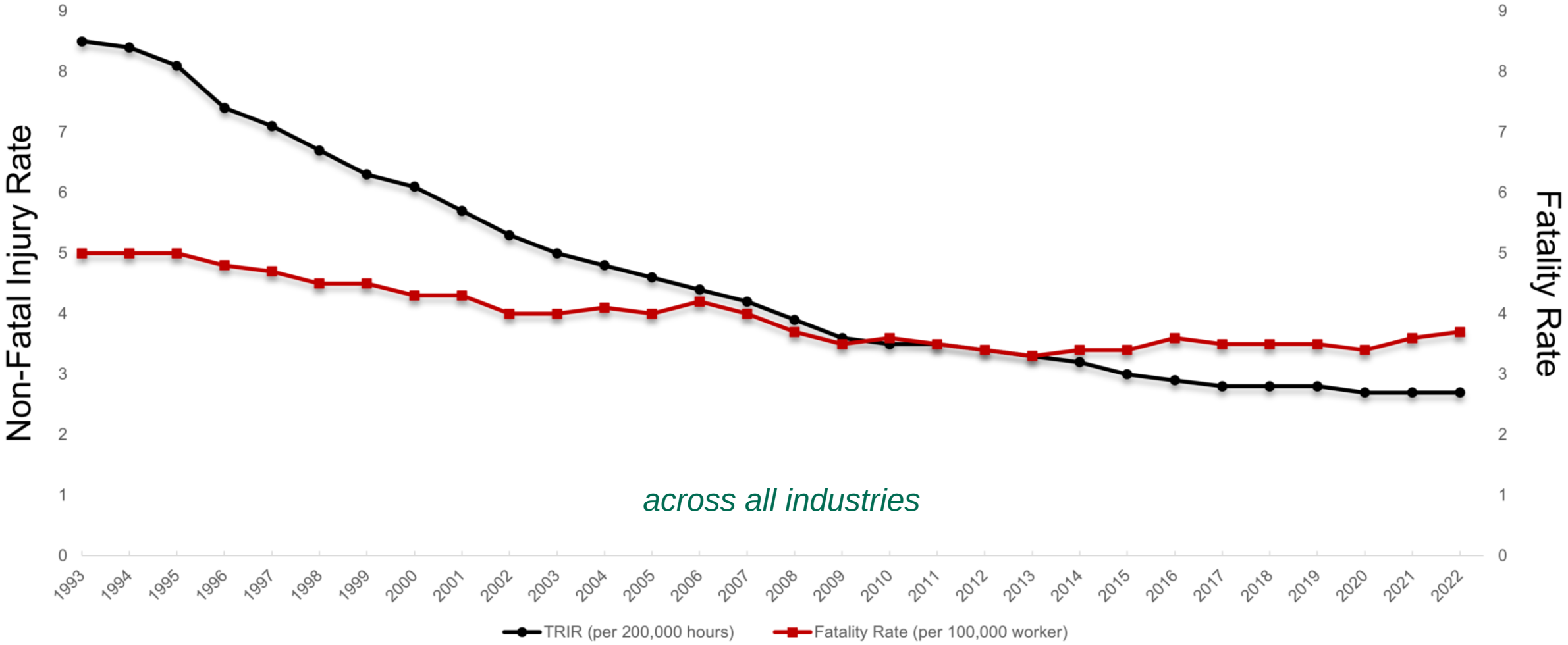
One Killed, One Injured at Local Paper Mill

So what are we MISSING?

Heinrich's Triangle



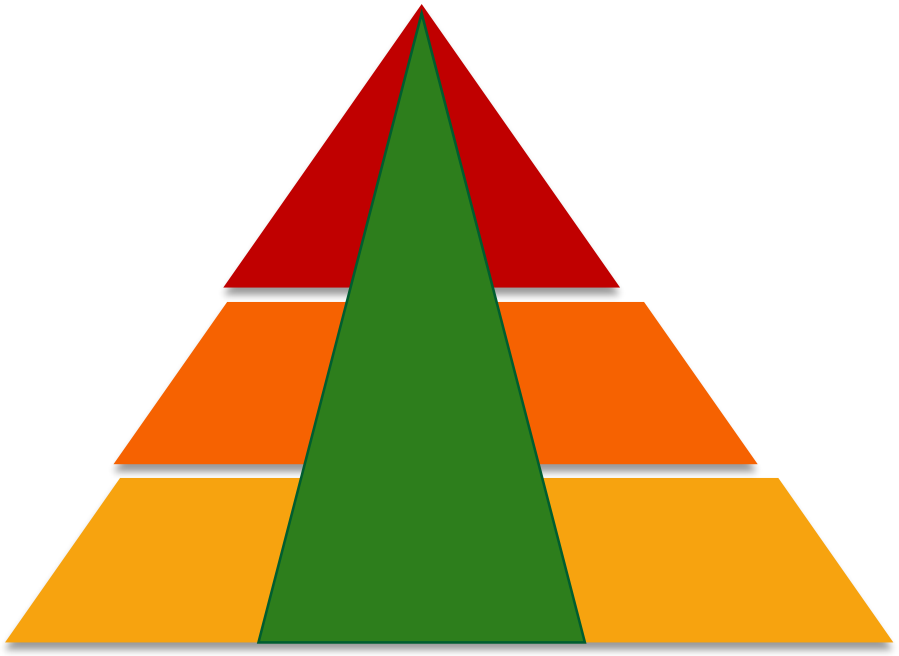
The SIF Challenge



across all industries

Source: U.S. Bureau of Labor Statistics

A New Paradigm



25%

Approximately 25% of incidents have SIF Potential

So what can we DO?

DEKRA SIF Prevention System

But WAIT

THAT'S NOT THE WHOLE STORY…

One Killed, One Injured at Local Paper Mill

DEKRA SIF Prevention System

NASA’s COLUMBIA Investigation Report

“The NASA organizational culture had as much to do with this accident as the foam.”

NASA had “the assumption that prior success could be taken as evidence of continued success”

NASA had “organizational issues that inhibited candid communication”

NASA had “institutionally siloed management practices”

“People’s actions are influenced by the organizations in which they work, shaping their choices in directions that even they may not realize.”

BP's DEEPWATER HORIZON

"…these failures (to contain, control, mitigate, plan, and clean-up) appear to be deeply rooted in a multi-decade history of organizational malfunction and shortsightedness."

"It has been observed that BP's system 'forgot to be afraid.'"

"Analysis of the available evidence indicates that when given the opportunity to save time and money – and make money – tradeoffs were made for the certain thing – production – because there were perceived to be no downsides associated with the uncertain thing – failure caused by the lack of sufficient protection. Thus, as a result of a cascade of deeply flawed failure and signal analysis, decision-making, communication, and organizational - managerial processes, safety was compromised to the point that the blowout occurred with catastrophic effects."

Source:
Center for Catastrophic Risk Management

Summary

- Heinrich’s Triangle is descriptive, not predictive
- Fatality rates remain flat
- Get your systems right, but…
- Understand that leadership & culture ensures that your systems are applied, EFFECTIVELY
- We’ve got to be better. **Holistic** is THE approach

Thank You for Attending

SIF Prevention

Culture Assessment

Leadership Development

Holistic Assessment

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In Memoriam Brian Allen & Larry Shiner