Management Flaws and Their Impact on Safety

By Thomas A. Smith

Introduction

> *"People can maintain an unshakeable faith in any proposition, however absurd, when they are sustained by a community of like-minded believers."* Daniel Kahneman

Since the 1970's business has increased its knowledge of how to manage quality, finance, sales, marketing, production and maintenance. As a result these management disciplines have been transformed. For them meeting specifications by maintaining the status quo is no longer "good enough." Now their objective is to manage for continual improvement to satisfy the needs of customers. Inexplicably the primary objectives of safety management remain compliance and fixing the worker.

To be relevant in today's economy safety management must join the transformation of other management disciplines. To do so its objectives must be changed from striving to meet specifications and controlling behaviors to continual improvement of its effect on the system. It must adopt a new management philosophy. It starts with understanding the importance of how to identify if a safety problem belongs to the worker or to the system.[1]

To do this we must stop thinking fast and start thinking deeply about safety. Doing so will reveal ideas managers now hold to be valid but are flawed. The aim of this article is to expose management flaws and how they prevent managing for continual improvement of safety.

Flaws of Management

> *"A problem in business is anything that inconveniences people downstream, either people in the next process or ultimate customers. The problem is the people that created the problem are not directly inconvenienced by it."* Masaaki Imai

Safety management must change because in its present form it performs a service but it cannot deliver continual improvement. Because of how it has been managed for the last 100 years deep down inside most managers believe it is obvious how safety should be managed. It is simply a matter of using common sense and holding people accountable for their own actions.

It's been said the obvious is not that which needs no proof but what people do not want to prove. Managers apply safety methods for reasons they believe are obvious so they don't have to prove them. In fact many of the self-evident proofs about safety are wrong and produce serious consequences. Not for the managers but for workers who get injured. Managers avoid improving safety because they believe when there is an absence of a negative it's obvious you have a strong positive. Employee accidents are rare events compared to problems managers face daily in production. So by taking corrective action on each accident it's obvious to them they are improving safety. To counteract this blind-faith you have to deny the obvious to discover what is correct. What follows are some seriously flawed ideas that prevent the transformation of safety away from quantity management which relies on command and control to quality management which seeks continual improvement.

Flaw number 1: It is OK for management to pursue objectives counter to those they publicly proclaim.

Companies issue Safety Policy Statements declaring employees are its greatest asset and their personal safety management's Number 1 concern. Most will also declare their desire for *continuous* improvement of safety. [2] Once the statement is released top management immediately shifts its attention to other things.

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[1] In the 1970's American managers held a common view that most defects were the fault of the workers. It took a major effort by quality gurus and outside competition to dislodge this thinking from manager's heads.

[2] The word *continuous* shows management's use of imprecise language. No organization practices continuous improvement. If they did they would never get any work done.

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In fact most safety departments now report to Human Resources not top management. The reason is management views safety as a requirement not an objective. So the safety department has the responsibility for safety but no power in the organization. When top management shares the responsibility of safety but does not delegate the power to go with it then no one is responsible for safety. Unfortunately this is the rule rather than the exception for how companies manage safety programs. It's one thing to say safety is a top priority of management. It's quite another to make it a reality. [3]

Flaw number 2: Managers believe improving the parts of a system separately improves the performance of the whole.

This flaw exists because generally people do not know what systems are therefore they don't study systems. Many believe a system is the sum of its parts. It is not. A system is two or more things that work together to accomplish an aim. The outcomes of a system are the product of the interactions between the parts. All parts of any work system are interdependent. That means each department and individual in a system depend on someone else to get the job done. Therefore the performance of the system depends not on each department operating at 100% for its own benefit but on how well everything in the system works together to benefit the whole.

Managers have been taught and now believe to optimize an organization each department must maximize itself. This leads to internal competition between departments which eliminates voluntary cooperation and prevents teamwork. Departments are instructed to act as like an owner or profit center so they compete for budget, time and praise from management. In this world Management believes internal competition is a good way to motivate people to do a better job, make more sales, or avoid accidents, etc. If you believe this improving safety of the system becomes optional. Activities such as safety training or safety meetings are a net loss to production and finance. Parts can't be made if workers are in a safety meeting. Middle managers are forced to choose between production and safety daily and production wins.

Flaw number 3: Management believes all problems are disciplinary in nature.

Management is divided into different disciplines. Each one has a different point of view and works to solve problems from its perspective. For example if accidents increase top management sees a "safety problem." It then pressures the safety department to fix it.

But if you keep points of view separate you cannot improve the whole. An increase in accidents is no more the safety departments doing than a downturn in sales can be attributed exclusively to the sales department. Outcomes of the system including quality, productivity and safety can only be understood by examining all of the parts simultaneously. For this to happen all management disciplines must cooperate and work together to improve not just quality but safety outcomes. This requires systems thinking and synthesis which is absent in command and control which requires the system to be broken into parts and managed separately.

Flaw Number 4: Management's pre-occupation on single-events

Managers believe "good management" requires every problem be investigated and a *root cause* determined. Of course the hidden agenda is to find the guilty party and make them pay. This is why fire-

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[3] The following quote from the article, "Years of Internal BP Probes Warned That Neglect Could Lead to Accidents" by Abrahm Lustgarten and Ryan Knutson ProPublica, June 7, 2010, says it all:
"A series of internal investigations over the past decade warned senior BP managers that the company repeatedly disregarded safety and environmental rules and risked a serious accident if it did not change its ways.

The confidential inquiries, which have not previously been made public, focused on a rash of problems at BP's Alaska oil-drilling unit that undermined the company's publicly proclaimed commitment to safe operations. They described instances in which management flouted safety by neglecting aging equipment, pressured or harassed employees not to report problems, and cut short or delayed inspections in order to reduce production costs. Executives were not held accountable for the failures, and some were promoted despite them."

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fighting routines prevail. Every business has more problems than money and resources to fix them. Managers who spend their time investigating accidents will never run out of work which means they will never have time to work on the system that caused them. This is totally wrong because it is anti-systemic. Managers become good at firefighting but never have the time nor inclination to learn how to prevent them.

Single-event thinking seeks to derive the behavior of the whole by examining the behavior of its parts. Systems thinking is holistic and attempts to understand the parts from the behavior of the whole. Single-event thinking drives managements' infatuation with root cause analysis which calls for separating the parts from the whole and assumes cause and effect are directly connected.[4] But when you separate the parts of a system they lose their essential characteristics. This prevents you from learning anything useful about the system. At that point you are looking at the problem from the same point of view from which it was formulated. This is an inadequate method for improving the system. Any corrective action you develop is merely *tampering* which is overreaction to normal variation. Of course we have to put out fires but we must take time in the present to plan how to prevent fires in the future.

Flaw Number 5: Managers believe safety is relatively simple to understand therefore simple to manage.

Top management views safety as a mature discipline. There is nothing new to learn so it can be *managed* by fiat on autopilot. Management assumes accident prevention is a simple problem and can be handled easily. It merely delegates safety down the chain of command. Ultimately workers are held accountable for safety. This seems rational and logical because management believes workers' unsafe actions cause most accidents. They are just holding people accountable for their actions, reminding them to use common sense and comply with the company safety rules and regulations. They ask, "What could be simpler, easy to understand or more effective than doing this?" as if the question contains the answer.

Managers are always looking for simple solutions to complex problems or *Instant Pudding*. The fact is preventing injuries is not a simple problem. Like defects in quality accidents are built into the system. Workers do not design the system with its common causes that exist hour after hour, day after day. They don't control the pace of production, the budget for safety, the flow of work, the culture, etc. It turns out because of the variation, complexity and interaction of common causes, even simple systems are too complex for one person to understand. We have a lot to learn when it comes to managing the improvement of safety in any system.

Flaw number 6: Managers believe they must "motivate" workers to be safe.

We've known for over fifty years that close supervision designed to enforce company rules, regulations and policies are the drivers of worker's dissatisfaction.[5] Even though the other management disciplines are seeking to give workers more autonomy a recent Gallup polls show up to 70% of workers are actively disengaged from their jobs.

Ironically safety programs rely almost exclusively on the top de-motivators.[6] Mangers believe they must somehow motivate workers to behave safely as though they are void of self-preservation. The quality circle debacle in the U.S during the 1970's and 80's proved a strategy to first to change worker's behavior when the problems are in the system is a fool's errand. It's disconcerting that safety prescribes the exact methods identified that cause workers' dissatisfaction and disengagement. Management treats workers like children then expects them to behave as adults. Safety has ignored the research refuting the pop psychology of *behaviorism* and the fact people are very highly motivated not to be injured on the job.

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[4] Root cause and "root canal" are strangely similar terms in that both produce some pain for a participant.

[5] For anyone who doubts this you should read or re-read Frederick Herzberg's seminal HBR article; "*One More Time: How Do You Motivate Employees*."

[6] To confirm this just take the time to read the job descriptions of Safety Management positions on the internet. The job requirements focus almost exclusively on enforcing OSHA regulations or implementing behavior based safety programs.

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This is just another example of management applying a simple solution to a complex problem - that is wrong.

The Final Flaw

> *"The specific problems we face cannot be solved using the same patterns of thought that were used to create them."* Albert Einstein

Dr. Russell L. Ackoff said that when he recited Einstein's quote above every person in the audience agreed with it. Then when he asked if anyone knew what it meant not one person could explain what it meant. It's easy to agree with something if you don't know what it means. This is not a criticism of management. What else can they do? Management has its rewards but it also has a price and that price is time. Like any price we are always looking to reduce it. Managers are always seeking ways to conserve their time. They know safety management hasn't changed much in the last 75 years. You could take a safety program developed in the 1950's and with little editing use it today. Hence top management delegates safety to others. They don't know safety can and should be managed differently.

By doing this management is committing an error of omission which is not doing something that should be done. Errors of omission allow management to ask the wrong questions. But the right answer to a wrong question yields little or nothing of value. Dr. Ackoff said, "When you are doing the wrong thing and make a mistake and then correct it you make things even wronger." This is exactly what's happened in safety management.

For years safety professionals have been asking, "*What must we do to prevent workers from injuring themselves on-the-job?"* It is the wrong question. As a matter of fact management studying unsafe actions as though they are a cause is treating *noise* as though it is a signal. Unsafe actions are certainly associated with accidents but they are not a cause. This is the same a studying a defect in quality and not doing anything about the system that caused the defect. Asking wrong questions about safety doesn't inconvenience managers but it causes major problems for people who work in the system. The more appropriate question is, "*What are we doing to ensure our system does not cause any harm to people who work in it?"*

This reveals the final most serious management flaw. We should not be arguing the merits of how to improve safety by either first, working on the system vs. compliance and the behaviors of workers, on the basis of a false factual premise. Since H.W. Heinrich declared that the unsafe acts of workers cause most industrial accidents safety management has adopted the premise that people are *the* problem. As they finally did for quality, management should recognize that improving safety by emphasizing compliance; motivating workers and single-event solutions is a false premise and cannot deliver continual improvement. To continually improve safety we must duplicate the transformation of quality management started in the 1970's. We must focus on studying and improving the system because that's where most causes of accidents exist.

Conclusion

Unless the safety management paradigm is transformed to manage for quality and continual improvement top management has no reason to reapportion time to safety. It has nothing new to offer. Safety management must replace its dependence on quantity management, single-event thinking and command and control with quality management theory and systems thinking. Only then will safety be able to explain to top management why the answer to the question, "*What causes of the majority of accidents*?" is not the workers but common causes in *the system*. When this happens safety will be invited back to the boardroom where it belongs.

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