

The Complacency Dilemma

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Is complacency the problem, or is the issue more complex than that?

There seems to be an upward trend in several industries to list "complacency" as a contributory cause on accident investigation reports. Many perception surveys now ask workers if they have become complacent when doing repetitious jobs and if complacency is considered an undesirable characteristic of a safety culture. Although this attention to complacency is deserved, the standard solutions to improve it fall short of success in almost all instances. Complacency is a state of mind, which is not necessarily the only influence on safety choices or behaviors.

When was the last time you were complacent about wearing seatbelts? When did you just stop paying attention to them because they didn't seem that important or you were distracted by other things? The answer is probably never. You either have formed the habit of using seatbelts or you have not. If you have formed the habit, you automatically buckle the belt, regardless of your complacency, sense of vulnerability or other distractions or priorities. If you have not formed the habit, you may buckle up only when you are concentrating on the need for such precautions (or not at all).

About half of the accidents we review that are attributed to complacency involve risks that can be avoided with simple precautions. Most simple precautions can become habitual with practice and reinforcement. Once they become habitual, they are all but exempt from complacency, distraction or other common problems. Just as many children are taught and reminded to look both ways before crossing the street, workers can be taught and reminded to take the precautions that most often impact accidents and near misses in their particular site or industry.

Root-cause analysis actually is a contributing cause to the complacency dilemma. Most organizations have not realized that root-cause analysis is geared toward machines and circuits rather than human beings. Human behavior almost always is more complex than the model of contributory and root cause describes. When workers get tired or distracted and are injured, their condition tends to be described as complacent, and that condition tends to get listed as a contributory or root cause of the accident. Such simple, linear thinking usually is inaccurate and ineffective at preventing future accidents.

Root-cause methodology also is flawed. The idea that five is the magic number down a causal chain has been disproved again and again. That you have reached a root cause when you run out of data and cannot answer the next-level "why" question equally is erroneous. The more appropriate question to ask is, "When workers become complacent, what precautions do they most often fail to take?" The answer to this question will reveal the habits that need more focus and to be reinforced in the safety culture.

A behavioral Pareto analysis of accidents and near misses can be a real eye opener. The key to such an analysis is to determine not what caused the accident, but the behavior that could have prevented or lessened the severity of the accident. If the preventive behavior is complex and highly cognitive, then forming habits might not be the answer. However, if the preventive behavior is simple and rote, forming

habits around these behaviors can be the solution.

Habitual behaviors continue to occur regularly in spite of complacency or other mental states. If these habitual behaviors impact the majority of accidents, then habits solve the safety problem. Remember the stages we went through to get drivers to use seatbelts in cars? We raised awareness, sold people on the wisdom of seatbelt use, punished them for not wearing it and put devices in all cars that noisily reminded us until we buckled up. In the end, we did not change the mindset nearly as much as the habit. Most drivers use seatbelts because they are in the habit of using them, not because of some elaborate strategy to overcome complacency.

Admittedly, not all complacency results in risks that can be addressed by forming habits. We want workers buckling seatbelts, using the right tools and equipment and using good body mechanics automatically without reliance on conscious thought. We don't want workers at nuclear power plants refueling nuclear reactors that way.

Certain tasks require great planning and meticulous, conscious thought to carry out safely. Such tasks should not be addressed with cultural habit forming. However, in our experience, these complex tasks compose half or less of all risks attributed to complacency in most industries. In a few organizations, such tasks are negligible or non-existent.

Some of our clients have observed how nuclear power plants operate and tried to use them as a model. The main attraction was to strictly define procedures and reduce decision-making in the workplace that often results in human error, leading to accidents. If your business is not labor-intensive, this approach may work. However, most organizations require frequent interventions, often calling for the laborers to make workplace decisions. Such decisions are difficult to control through rigid guidelines or procedures. In such cases, worker competence and judgment becomes more critical than written procedures, and the forming of basic safe work habits has a significant impact on such decisions. Overall safety performance is impacted by common practice, and common practice is impacted by worker safety habits.

In the end, safety solutions can be divided into conditional and behavioral. The behaviors can be divided into two categories as well: simple, repetitive behaviors and complex, cognitive behaviors. Root-cause analysis has great value in the conditional part of safety. Machines and circuits malfunction for a reason, which must be traced to its source to keep it from recurring. Human beings are more complex. When people "malfunction," we need to decide whether better habits or better thinking is needed. Forgetting that habits are part of the issue makes safety seem much more complicated than it has to be.

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