HOW LEADERS UNDERMINE THEIR OWN SAFETY PROGRAMS

Effective safety leadership strategically plans to coordinate all efforts.

A Fortune 50 company once discovered a problem with the way accident investigations were being conducted. Their directors of safety put together a training program to address the problem. It involved a half-day session for safety professionals and first-line supervisors. A schedule was devised to roll out the training to every division and location as soon as possible. The leadership team approved the plan and it was put into action. An operational issue came up and one of the leaders scheduled a visit of the managers involved to attend in the middle of the night. The VP of EHS was excited at the prospect of the CEO really giving priority to safety and launching a new safety initiative that had just been approved. The CEO did promote safety but failed to mention the new initiative.

When the VP pointed out the omission, the CEO said that his omission in the one address would not compromise the importance of the new program. The disappointed VP mentioned that intelligent managers around the world would take what the CEO chose to discuss in such an important and unprecedented address as more important than anything he chose to omit. The CEO did not take the criticism well and the VP was reassigned to a regional position.

The manager of a complex of four petrochemical production units was concerned with the lagging indicators of his safety performance. He decided to get more personally involved in safety. One of his several chosen activities was to call anyone who was involved in an accident and anyone who turned in a near-miss report into his office for a personal visit. He thought this would demonstrate his concern for safety and possibly help him discover things he could do to improve. He felt successful when the number of accidents and near misses began to diminish and then disappear.

He got a wake-up call when a near fatality happened and the investigation uncovered the fact that the risk involved was common, well known and repeatedly happening. After further talks with his safety professionals and workers involved, he discovered that his efforts had driven reporting underground. What he considered a demonstration of his caring about safety was perceived by workers as being called on the carpet for reporting. Their response was to quit doing what got them into trouble.

A refining company hired a brilliant engineer who had just finished his PhD and quickly promoted him through the ranks and ultimately to manage a refinery. He assessed the state of his workforce and noticed that he had several
senior engineers who were only a few years away from retirement age. He determined that he could quickly recoup the costs of forcing these engineers into early retirement and hire new graduates for a fraction of what the older ones were being paid. He reasoned that fresh blood would bring fresh ideas and innovate the processes and site culture. He was admonished to use the retiring engineers to mentor the new ones or to keep a few of them to train the new ones and serve as subject-matter experts and advisors. The manager ultimately decided against these steps.

Shortly after making the changes in personnel, the refinery had a fire, then an explosion, then another of each. The new engineers tried to solve the problems, but the problems not only persisted but got progressively worse. The company replaced the young manager with another brilliant recent graduate from a prestigious engineering university and considered the problem solved. It was not!

A service providing company lost an important contract because their safety record was less than stellar. The stockholders angrily demanded the directors take action to correct the problem. Without formulating a strategy to address the underlying issues, each director took to the field criticizing perceived problems and suggesting solutions. None of the directors had any background in safety, nor had they really studied the data to understand underlying causes of their accidents. The net result was that everyone in the field was given different feedback and went in different directions in their safety efforts. The net result was that safety performance got worse instead of better.

These and dozens of other cases I observed suggest to me that, regardless of good intentions, leaders often sabotage their own safety efforts. In every one of these cases the leaders lacked an overarching strategy for safety. They had programs and activities and assumed these would solve their safety challenges. Such approaches fail to create the unity of effort needed for success. They also often miss the mark of addressing underlying influences on their safety culture’s performance.

Leaders often have a limited understanding of workplace realities and naively assume that giving the right marching orders will solve the problem. Effective safety leadership strategically plans to coordinate efforts, so the right hand does not undo what the left hand is accomplishing. EHS

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