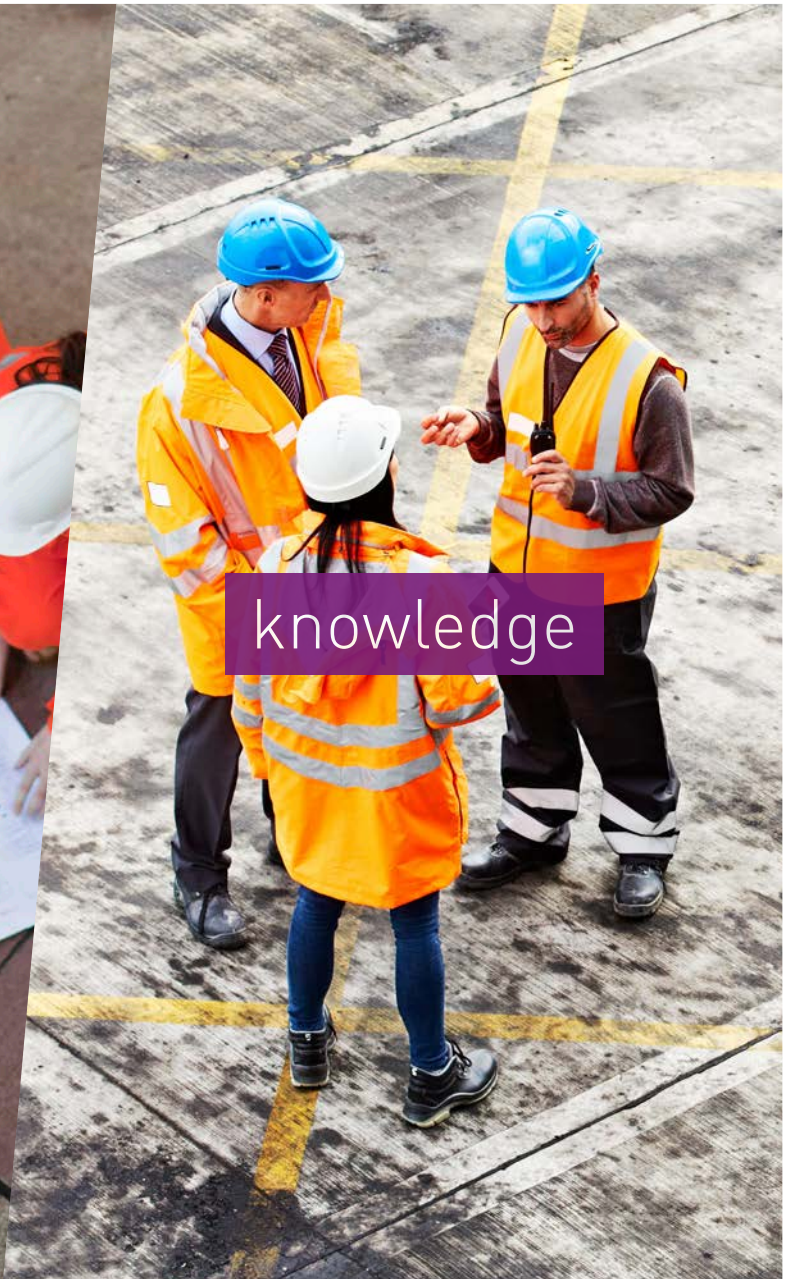


# Safety Leadership in Practice: A Guide for managers



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## Acknowledgements

Safety Committee

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# Safety Leadership in Practice: A Guide for Managers

## Revision history

VERSION	DATE	AMENDMENTS
1.0	October 2019	First release
1.1	February 2020	Minor edits applied

# Contents

<b>Scope</b>	<b>5</b>
<b>Foreword</b>	<b>6</b>
<b>Structure of the document</b>	<b>7</b>
<b>1. Safety Leadership: get the culture you want</b>	<b>9</b>
<b>2. Underpinning knowledge</b>	<b>12</b>
<b>3. Things you can do</b>	<b>16</b>
<b>4. Getting into action</b>	<b>38</b>
<b>References and further reading</b>	<b>40</b>

# Scope

This guide has been developed to be used in conjunction with IOGP Report 452 – *Shaping safety culture through leadership*. This report is designed to support senior and/or middle management and supervisors in applying the Safety Leadership Characteristics described in Report 452 and creating a workplace culture that values safety.

# Foreword

Knowledge doesn't stand still. IOGP published Report 452 - *Shaping safety culture through safety leadership* in October 2013, but in the years since then, our industry has gained a huge amount of experience and insight into how workplace cultures are formed. This document aims to make that insight and experience available to you.

We know, for instance, that rules alone don't drive behaviour, and that even the best trained, most diligent, and well-motivated people can make mistakes. All of us thrive when we work in an environment we can trust, with tasks and systems that are designed to reduce the potential for error. This is enabled by the culture of the organisation.

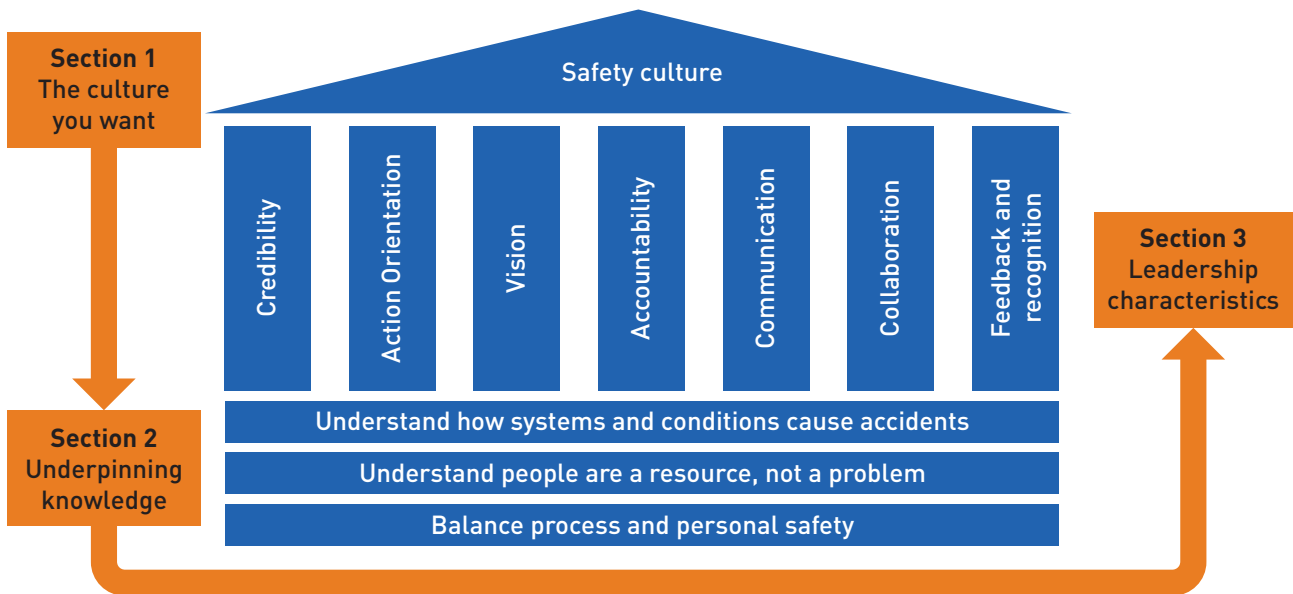
For an organisation to be successful, leaders work to shape the culture by the priorities that they set and their engagement with the workforce. We hope that, with this guide, leaders can develop ideas for practical action to shape the culture and success of their organisation.

If you're reading this, the chances are you are already a good leader. How do we know? Because you want to learn, and that's why you're here.

This guide has been developed to provide leaders across an organisation, senior leaders, mid-level managers and frontline supervisors, with advice to be more effective in their role as Leaders in Safety. Much of what we talk about is the style of leadership you adopt, but we will also touch on some new approaches that will help. We hope that, whatever level of influence you have in your organisation, some of the tips in this document will help you become a great safety leader.

# Structure of the document

The document is based on this simple model:



- **Section 1** – *Safety culture* describes what safety culture is and how your leadership shapes it.
- **Section 2** – *Underpinning knowledge* describes some fundamental things you should know about how incidents happen, the role of people and the necessity of balancing high-frequency occupational safety with the rare but potentially catastrophic process safety events.
- **Section 3** – *Leadership characteristics* discusses the visible traits, behaviours, and actions a leader displays to the organisation, and how to develop them.

Throughout the document we will use a number of icons:



### Translate Jargon

This icon will show when there is a commonly used term or jargon that describes what is being talked about in the text. You don't need to remember it, but it may help you if you hear people using the term.



### Worked example

Case studies that demonstrate what's being discussed.



### Key points

Brings out a small number of key points that will be particularly useful to you in this section.



### 452 Says...

Reminders of key points from Report 452 – *Shaping safety culture through safety leadership*.



### Start here

It doesn't matter where you start, just start. This icon shows one impactful thing that you can do to make a difference, for each leadership characteristic.



### Ask the expert

Includes insights from industry recognised experts in the topic.



# 1. Safety Leadership: get the culture you want

There have been many attempts to define organisational culture; Report 452, using Deal and Kennedy's<sup>1</sup> popular definition, defines culture as "the way things get done around here".

Report 452 goes on to tell us that culture is a "complex process, which is influenced by a number of factors". It's true that the culture of any organisation is a complex and unpredictable mixture of leadership, employee involvement and motivation, workforce and national values, beliefs, assumptions, business pressures, and practices, to name a few.

This might give us the impression that culture is an immovable object, something which is the outcome of so many complex variables that it's almost impossible to influence. However, research has revealed that leadership has an especially high influence on workplace cultures.<sup>[2]</sup>

This means that how we lead has a significant impact, and potential to give us the culture that we want. Unfortunately, it also means that some of the things we do as leaders can unwittingly lead to a culture that we don't want. In other words, we get the culture we deserve.

452  
says...

...that a strong Safety Culture consists of:

- **An informed culture** – the organisation collects and analyses relevant data to stay informed of its safety performance.
- **A reporting culture** – people are confident they can report safety concerns without fear of blame.
- **A learning culture** – the organisation learns from its mistakes and makes changes to unsafe conditions.
- **A flexible culture** – the organisation is able to reconfigure the chain of command if faced by a dynamic and demanding task environment.
- **A just culture** – people understand the boundary between behaviours considered acceptable and unacceptable. Unacceptable behaviours are dealt with in a consistent, just and fair manner.



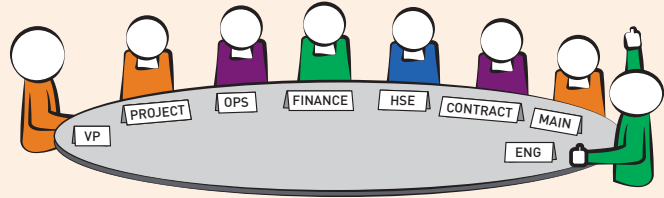
**Safety Leadership:** How leaders support and influence people to enable strong organisational safety. Leadership is not about the attributes of individuals; it is about their actions.

<sup>1</sup> Deal TE and Kennedy AA. *Corporate Cultures: The Rites and Rituals of Corporate Life*. Reading, MA: Addison-Wesley, 1982.



### Scenario: The leadership meeting

It's the monthly leadership team meeting, and all the heads of department are gathered around the table. The vice-president is there, as are managers from operations, finance, maintenance, wells, engineering, contractor management, HSE, and projects. The VP is looking at some graphs, shaking his head and frowning.



“We have to do something about our safety culture,” he says. “It seems like our people are taking risks, making mistakes, and simply not doing what they are supposed to. We have to do something before we have a bad accident. What on earth can we do?”

There is silence. At the end of the table the engineering manager cautiously raises her hand.

“I wonder,” she says, “if it’s something we are doing?”

That’s a very good question...

How do you want things to get done in your organisation? We can't read your mind, but you might want:

- People to feel accountable for their role, and be motivated to fulfil it to the best of their ability
- People to be open about little problems, and take ownership to fix them before they worsen
- People to be eager to learn from good practice, near-misses and incidents from anywhere

We also expect that the culture you **don't** want is one where people are:

- Unwilling to speak up about problems
- Demotivated and disenchanted
- Unwilling to learn

Applying and modelling the seven safety characteristics can give you the safety culture you and your organisation want.

Finally, remember that while the examples in this document are often focused on middle levels of leadership, the advice is relevant to all levels in the hierarchy. Senior leadership or board members, even though they may be more distant from operational issues, have a significant effect on the safety culture of an organisation.<sup>[3]</sup>



### Remember:

- Leaders are in the best position to positively influence their organisation's safety culture.
- Understanding the 'foundations' of the safety culture model is essential
- The pillars above show characteristics to adopt and model

452  
says...

...that there are 7 leadership characteristics that can influence Safety Culture

- **Credibility** – what leaders say is consistent with what they do
- **Action orientation** – leaders act to address unsafe conditions.
- **Vision** – leaders paint a picture for safety excellence within the organisation.
- **Accountability** – leaders ensure employees take accountability for safety-critical activities.
- **Communication** – the way leaders communicate about safety creates and maintains the Safety Culture of the organisation.
- **Collaboration** – leaders who encourage active employee participation in resolving safety issues promote employee ownership of those issues.
- **Feedback and recognition** – recognition that is soon, certain and positive encourages safe behaviour.



### Who says what's 'good' or 'bad' in leadership?

Good and bad can often be very subjective, but there has been a great deal of research over the years into which leadership practices are effective, and which have unintended consequences. For example, Flin and Yule<sup>4</sup> note three different styles of leadership:

- Transactional: seek to have compliance from followers, set goals, get agreement on what is to be accomplished, monitor performance, and administer reinforcement
- Transformational: provide followers with a sense of purpose, shared goals, mutual understanding, and a bright future, questioning traditional assumptions, and encouraging others to approach problems from many different angles. Transformational leaders take into account the level of maturity, capabilities, and needs of people as unique individuals.
- 'Laissez-faire': no active leadership effort

Whilst transactional leadership is a readily recognisable approach in the oil and gas industry, Flynn and Yule's research shows how transformational approaches of motivating, coaching and rewarding behaviour, have supported rule compliance and 'speak-up' about safety by employees.

The third approach ('laissez faire') is not advisable in a major hazard industry like ours.


<sup>4</sup> Flin R and Yule S. "Leadership for Safety: Industrial Experience". *Quality and Safety in Health Care* 13 (Supp. 2). p. 1145-1151.

## 2. Underpinning knowledge

### Understand how systems and conditions cause accidents

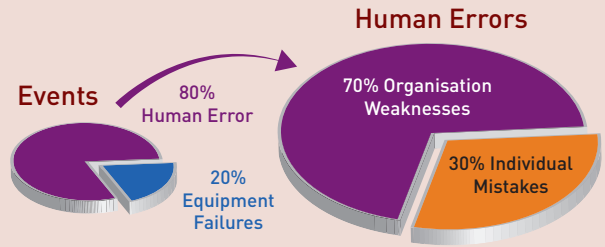
We often hear statistics like “80% of accidents are caused by human action”<sup>2</sup> in newspapers, presentations, and training courses. It makes us think that incidents are caused by people, but is that true? What causes people to do what they do?

When we look at the detail of these incidents we find that there are many contributing factors in the workplace. Problematic tasks, unclear procedures, difficult equipment, workload, resourcing, and training – these difficulties often lead to mistakes and workarounds, which eventually become incidents. What’s more, all of these are conditions that leaders have the potential to influence. Leaders can make decisions to change and improve systems and make procedures and tasks resistant to error, especially if they have the support of the workforce.




**What the experts say about “80% human error”**

When the 80 percent human error is broken down further, it reveals that the majority of errors associated with events come from latent organisational weaknesses (mostly the result of human and organisation actions in the past) whereas about 20 percent are caused by the individual worker who last touched the equipment or process.



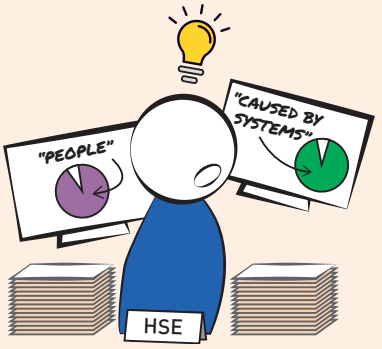
**Human Errors**

70% Organisation Weaknesses  
30% Individual Mistakes



**Case study: the curious HSE manager**

The HSE manager is looking at the 350 historical incidents that had been tagged as potentially rule-breaking. Of these, 90% are due to issues with systems, including unclear procedures (24%), capability and resources (30%), and mistakes due to labelling, alarms, or tool issues (21%). That means that only a very small proportion of all incidents resulted from intentional rule-breaking. The HSE manager notices that this experience matches that of other companies and of other industrial sectors; for example, 95% of incidents in the construction industry were found to be system-related, with only 5% intentional rule-breaking. The HSE manager realises that if the workforce and leadership work together, they could tackle some of the big issues underlie many of their incidents.



<sup>2</sup> Perrow C. Normal Accidents - Living with High-Risk Technologies. New York: Basic Books, 1984. p.183, 187

Work As Imagined (WAI) versus Work As Done (WAD) is a key concept for leaders to understand. We tend to put a lot of effort into imagining and designing how work will be done – risk assessments, HAZOPS, and procedures all describe how we imagine the work will go.

Work As Done is how the work really happens on the day, in the circumstances that exist at the time. No matter how good we are at imagining how the work will happen, **the workforce always has to do the last part of the design of any task**. They are the ones faced with the slightly different layout, or an awkward to use tool, or the rain-soaked work surface. They will always have to make adaptations in order to make the imagined work happen. Sometimes these adaptations are real improvements and tips that others can benefit from; other times they may introduce new hazards or potentials for error or misjudgment.

A leader who is in regular contact with the workforce, helps them to work through difficulties and encourages speak up about how work actually happens, stands a chance of maintaining some influence over these necessary adaptations.

---

## Understand your people are a resource, not a problem <sup>[4,5]</sup>

Although we might assume that it's somebody's fault when something goes wrong, investigations into incidents more often find mistakes and judgements made with the best information available at the time.

How do we find out about these system issues before they become accidents? That's where safety leadership plays an essential role. Evidence shows that when there is higher trust and respect between leaders and workforce both injuries and spills reduce. That's because when the workforce genuinely believes that leaders care what they think, people are encouraged to speak up about what makes work difficult for them in the day-to-day work.



### What the Experts Say: Tom Krause and Kristen Bell<sup>2</sup>

The insight that leaders need to understand is this: Incidents are caused by a network of factors including design, safety systems, leadership, culture, and behaviour. The role of behaviour in incident causation is important, but it is only one piece, and usually a small one at that. Focusing only on behaviour as if it is the whole story is a serious mistake. It can alienate employees, drive accurate data underground, and leave other risk factors unchecked.

We know that these difficulties are where the mistakes and work-arounds, that eventually become incidents, could be.

When the leaders and workforce collaborate to get rid of these difficulties, they can prevent incidents. It's the people closest to the job who can help identify those problems and provide solutions.

That can mean that we have to change our perspective on the role of people in incidents so that we believe that: <sup>[6]</sup>

- People interact with each other, plants, and process as part of a complex system. Human beings are essential in maintaining our barriers and safeguards. They can, and often do, “save the day”.

- We understand and accept that people will make mistakes, but these are typically due to underlying conditions and systems. People's actions are rarely malicious and usually make sense to them at the time. Since human error will never be eliminated entirely, we try to make sure that our most critical tasks and barriers are resistant to error.
- Understanding how mistakes happen can help us prevent or cope with them. We use what we learn to design plants, tools, and activities to reduce mistakes and better manage risk.

Finally, we know that leaders help shape the conditions that influence what people do. It matters how leaders respond when things go wrong. This document will demonstrate how leaders can educate others about **human factors** roles in incidents.<sup>[7]</sup>

If you are a leader worried about safety, your people are not the problem; they are an incredible resource of real skills and local knowledge.

---

## Balance process and personal safety

There's always a lot to do on an operation or project. Although oil and gas people are dedicated and good at prioritising, it's easy to get focused on the immediate problems, and neglect the longer term issues that will cause future difficulties.<sup>[8,9]</sup>

We sometimes focus resources and attention on lower severity, high frequency events that we see often in our business, including less severe injuries and occupational incidents. We all strive for nobody getting hurt, but at the same time we want to make sure that we guard against the low frequency, high consequence events like major accidents and process safety events.

We used to think that looking after the lower severity incidents would automatically take care of the high severity incidents (the triangle theory). Evidence against this view is beginning to accumulate<sup>11</sup>, because of the realisation that many latent conditions that lead to major accidents and fatalities are not seen in near miss reporting.

The lack of near-miss/lower severity events might lead you to believe you have a low risk, until the day disaster happens. Instead, you may need alternative, leading sources of information, including verifying that you have the right barriers/defences, precautions and activities to protect against these incidents.

There are many examples in our industry's history where companies have believed that they have good control over personal safety, and serious process safety incidents emerge. For these reasons, a leader has to maintain a balanced focus on both process and personal safety, and always be looking for the system causes that lead to both.



**Human Factors:** 'Human Factors' are simply those things that can influence what people do. They may include factors relating to the job people do (e.g., time available or control panel design) personnel factors (e.g., fatigue, capability) and organisational factors (roles, manning levels). This list of factors is often referred to as "Performance Shaping Factors".



### What the Experts Say: Todd Conklin, PhD <sup>[10]</sup>

- What you look for is what you will find.
- It is good to use multiple tools to get the big picture.
- The goal is to learn (not to determine the root cause).
- You need to see mistakes as opportunities to learn, not opportunities to punish.
- You must also investigate and learn from 'successes'.
- Look separately at mechanistic failures (machine failures are linear) and holistic failures (interface of people, machines, etc.). You need both to tell the whole story.
- Ask "how" instead of "why".

### 3. Things you can do

Great leaders develop a number of key characteristics that affect safety, as reported in IOGP 452 - *Safety culture through safety leadership*. The objective of this section is to define these characteristics, and explain how you as a leader can develop each one and translate them into visible actions. The table below contains a practical overview of “key actions” for a specific characteristic.

**Table 1:** Elements of the safety culture and actions by safety characteristic.

	<b>What safety culture elements do they support?</b>	<b>Actions promoting a positive safety culture</b>	<b>Actions harmful to a positive safety culture</b>
Credibility	Informed culture Flexible culture Just culture	Make yourself available in the field Develop healthy, trusting relationships Be honest and open with information Be visibly committed Be visibly courageous Serve your people Manage uncertainty and create a learning environment Respond constructively to bad news	Concealing negative information about safety performance Compromising operational safety limits to protect production or scheduling Creating an environment of fear or blame
Action Orientation	Learning culture Just culture	Act to support risk barriers Act on facility integrity – focus efforts on elimination or engineering controls Take action to learn	Not following up on problems with management systems or actions Not ensuring adequate management of operating scenarios and risk controls Overreliance on administrative controls – not using a ‘Hierarchy of Controls’ Not making technical expertise available
Vision	Informed culture Flexible culture	Provide a clear company vision Communicate the vision with words and actions Turn the vision into improvement plans Monitor progress Avoid focusing solely on outputs	Not engaging the workforce when developing the strategy Having a false sense of success when verification processes show satisfactory results
Accountability	Flexible culture Just culture	Help people understand their roles and responsibilities Help people to be able to deliver those responsibilities Help people feel ownership for their roles and responsibilities Understand the context when accountabilities aren’t met Manage safety aspects of organisational changes	Not understanding the risk associated with assets under your control Seeing human error as a cause of trouble Not building the capabilities of investigators and creating expertise Not developing a workforce understanding of risk consequences
Collaboration	Informed culture Reporting culture Learning culture	Engage managers Work for and with the team Develop key relationships and mutual collaboration	Not encouraging the team to discuss safety concerns Not talking or developing relationships with unions Not involving workforce in safety programs, new safety initiatives, projects, or improvement actions



	<b>What safety culture elements do they support?</b>	<b>Actions promoting a positive safety culture</b>	<b>Actions harmful to a positive safety culture</b>
Communication	Informed culture Reporting culture	Active listening Be assertive with peers and other leaders Consider the hierarchy of effectiveness for communication Adapt leadership style to be more effective in communications Promote 'speak-up' and reporting	Responding badly to a safety event Not supporting the resolution of raised safety issues Not suggesting safety improvements to senior managers of the organisation
Feedback and Recognition	Learning culture Just culture	Show genuine care Recognise good performance Coach others in safety Get feedback on your own performance in building culture	Not giving regular feedback and coaching on individual and team safety performance Appealing to individual responsibility and inappropriate use of disciplinary actions Not being fully transparent about process safety incidents

### 3.1. Credibility

#### Why does Credibility matter?

Credibility is a valuable resource. When you have credibility, you receive the trust, goodwill, support and collaboration of people in your organisation to make the improvements that you want. Credible leaders are trusted by the workforce, are believed to be genuinely committed to their safety, are consistent between what they say and do and value the views and expertise of the workforce.

As a leader, your credibility grows when you:

- Influence through interaction in the field and safety meetings
- Develop healthy, trusting workplace relationships
- Are honest and open with information
- Are visibly committed and courageous
- Serve your people
- Manage uncertainty and create an environment to learn



**...that to build credibility** leaders begin developing trust by acting in ways that provide benefits to their employees<sup>1</sup>

#### What can you do?

##### Make yourself available in the field

Credible leaders visit work sites regularly, and participate in risk assessments, inductions, toolbox talks, HSE audits, and safety meetings. These experiences give you a better understanding of the difficulties people on site face, and allow you to share your influence with the workforce. You can check that messages have been correctly understood, and give workers an opportunity to share feedback directly.



### ...by making yourself available in the field

This is a good way to start “credibility”. It allows people to get to know you, and for you to understand the work. Understanding what workers face and helping them with their problems builds trust and gets ahead of incidents.

## Develop healthy, trusting workplace relationships <sup>[11]</sup>

When people trust you to listen to their concerns and respond in the right way, they are more likely to tell you about problems and respect your wishes. Building trust between a leader and a team takes time and commitment, and there is no ‘right’ way. That said, research shows that trust grows from:

- Genuinely caring for the safety and welfare of the team
- Valuing the expertise and experience of your workforce
- Engaging people in opportunities to grow, and increase the value they feel they bring
- Giving everyone an opportunity to be heard.
- Not rushing to judge others when things go wrong
- Promoting collaboration between leaders, employees and contractors
- Helping to resolve conflict



### Key points:

- Trust comes from people believing you genuinely care for them and respect their knowledge and experience
- It matters how leaders respond when things go wrong. Take the opportunity to learn
- Leaders commit to safety, and take visible action that supports safe operation
- Leaders listen to workers’ concerns and collaborate with them to find solutions.

## Be honest and open with information <sup>[12]</sup>

Credibility depends in large part on honesty. Honesty about your own performance/behaviour is critical to being taken seriously and trusted by a team. Leaders need to acknowledge their mistakes as well as their successes. Leaders should be careful not to commit to actions that they are unable to complete.

## Be visibly committed

A leader represents and promotes the safety of their team. Teams are highly sensitive to leaders saying one thing, but doing another. A team will notice if the leadership’s behaviour and actions do not live up to the leadership’s statements on valuing safety. It’s good when leaders visibly commit to safety standards; but they need to build a track record of taking action that furthers those goals.

## Be visibly courageous <sup>[13]</sup>

Leaders sometimes have to be courageous in making difficult decisions, or with having challenging conversations with those more senior to them. Teams appreciate this clear commitment to doing the right thing in difficult situations. Leaders who are open about the difficult things they have done to support safety generate fellowship and encourage others to take safety action. Leaders who talk about their own decisions to stop work, or reject business opportunities because of safety concerns, reinforce support of management to front line workers making decisions about stopping work.

## Serve your people

Even though people work for you, according to the hierarchy of the organisation, if you strive to serve the people who work for you, higher performance and good engagement will follow. Aim to continuously improve your operation or project in a safe, controlled way, in response to frontline feedback and suggestions. Ask people what they need from you to remove obstacles and enable improved safety.

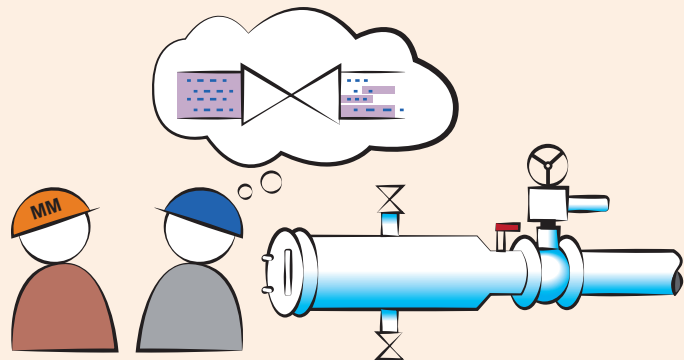
## Manage uncertainty and create an environment to learn

Accept that activities in our industry are often dynamic and uncertain. Create an environment in which people feel comfortable sharing what they've learned, mistakes they've made, as well as proposing ideas for improvement.



### Case Study: The Credible Maintenance Manager

The maintenance manager is on site, talking to an operator about working safely on a pig receiver. The operator tells the maintenance manager that they have a real problem with valves passing hydrocarbons, so that it's becoming increasingly difficult to vent the receiver



to remove the pig. The operator says there are passing valves all over site, and they are causing real problems with isolations. There's no point putting them into the maintenance system, because they keep getting a low priority and nothing gets fixed, so the operators just do the best they can.

#### To be a credible leader

- What might you say to the operator?
- What courageous decisions or actions might you have to take?



Think about these questions, then see the next page for the Maintenance Manager's debrief.



## Debrief: The Credible Maintenance Manager

### To be a credible leader, what might you say to operators?

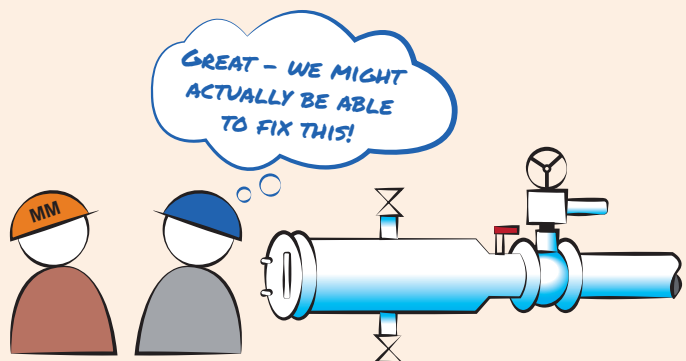
You may have considered:

- Thanking them for speaking up about this
- Asking more about the problems they have, and how they have to work around them
- Accepting there is an issue with your maintenance prioritisation on this problem
- Asking operators to work with you to identify problem valves and tasks that involve them
- Engaging a team to investigate any systematic quality issue with the valves at the plant

### To be a credible leader, what courageous decisions or actions might you have to take?

You may have considered:

- Halting operations with passing valves and not restarting unless the risk can be safely reduced
- Stopping other work to shift to this priority
- Engaging senior leaders in the need to halt tasks, or shutdown to allow corrective work
- Looking at how maintenance issues raised by the workforce are prioritised
- Talking to the workforce about your decisions and actions



## 3.2. Action orientation

### Why does Action Orientation matter? <sup>[13]</sup>

No management system, learning, or knowledge can make a difference in an operation until it is turned into real-world action. Leaders take action to solve real-world problems. This also encourages teams to take action themselves.

As a leader you can be action oriented by:

- Setting standards and ensuring barrier/safeguard performance
- Ensuring facility Integrity
- Encouraging report, analysis and learning from events taking appropriate risk actions
- Understanding “work as done” <sup>[14]</sup>
- Following-up on the implementation of actions

452  
says...

...that to be 'action oriented', a leader goes beyond monitoring compliance with rules and regulations.

A leader encourages suggestions, motivates their staff, and engages with the workforce to solve safety issues. Leaders must be proactive rather than reactive in addressing issues and give timely meaningful responses to safety concerns, demonstrating a sense of personal urgency and energy to achieve results.

## What can you do? <sup>[15]</sup>

### Act to support risk barriers/safeguards <sup>[16,17]</sup>

Clearly identify 'owners' of actions related to the establishment and/or maintenance of barriers. A leader should periodically verify and monitor that these actions are being completed and are effective. If actions are ineffective, ensure that any corrective actions taken are visible to the workforce.

### Act on facility Integrity <sup>[18]</sup>

Leaders take action on the integrity of plants and equipment. Facility inspections should be systematic and include reporting, discussion, identification of gaps or flaws, and implementation and testing of corrective actions.

### Take action to learn <sup>[19, 20]</sup>

Leaders should take a personal interest in helping their organisation to learn when things go wrong. They can do this by:

- Responding in a way that encourages people to be open when events occur
- Seeking to take sustainable action to embed a learning, not just rely on sharing information about the incident
- Paying special attention to High Potential Events
- Use the **Hierarchy of Controls** to take action that is more sustainable
- Keeping the workforce informed of corrective actions and plans
- Following up on actions that embed learning, to make sure it is having the effect you expect

START

...by avoiding immediately assigning blame when something goes wrong. Try to understand the full context of the event to prevent the same thing happening to others



**Hierarchy of controls:** An industry concept that sets out an ideal order in which to consider controls that reduce risk. These are considered in order of the most reliable and sustainable to the least. It is particularly relevant to human factors, where the most reliable approach is to eliminate a hazardous or error-prone task, rather than rely on human controls.

- Elimination (of hazard or task)
- Substitution (with a less hazardous material or process)
- Engineering controls (design of process and equipment)
- Administrative controls (such as control of work procedures, signs, etc.)
- Personal protective clothes and equipment

Leaders should encourage learning from a wider range of sources. This may include:

- Pulling in the experience of other companies and industries
- Understanding the good practice that prevents incidents
- Providing systems that help personnel (employees and contractors) find learning that is relevant to them so that they can take action



### Case Study: The Action Oriented Operations Manager

The Operations Manager (OM) gets a call from a site supervisor. It's bad news - they've found a leak from a pipe supplying highly toxic product to a tank. The supervisor thinks it's been leaking for a period of some months, but the leak detection equipment was not working and nobody raised the issue.

It's been a long, frustrating day, and this is the last thing the Operations Manager needs.

*What might the Operations Manager say to the site supervisor? What would be helpful?*



### Debrief: The Action Oriented Operations Manager

It matters how leaders respond when things go wrong. The Operations Manager (OM) might have several possible reactions:

- 1) The OM might ask **who** is accountable and why people were not careful. The supervisor interprets this as the OM seeking to place blame. This response can get in the way of looking deeper at the underlying, less visible, contributing factors.
- 2) The OM might ask for the leak to be fixed and cleaned up, so that the plant can get back to normal. This might mean that the same thing will happen again because nothing is learned.
- 3) The OM might ask if anybody was affected by the toxic material, and what we need to do to understand how the leak occurred, to prevent something like it happening again. This leads to learning about the workplace context that led to the event.

The OM responds with approach (3). The supervisor says that one of the team did get toxic material on their skin, and is on their way to the site medic. He suggests some operators that really understand the problems with the system to be part of any investigation. This issue with the leak detection is not confined to that location so it would be great to get this sorted out. The investigation goes on to reveal some design inconsistencies, modifications, and operational issues that led to the pipe failure.

*Spend some time thinking about the questions you would ask if you received a phone call like this. Having thought through your response will make it easier for you when something unexpected happens.*



## 3.3. Vision

### Why does Vision matter?

Leaders create a sense of purpose for a team with a shared vision. They establish a destination for a team to reach over the longer term, even when it is not obvious how that destination might be reached.

A leader can:

- Provide a clear vision
- Communicate the vision by word and action
- Turn vision into improvement plans
- Monitor progress
- Avoid sole focus on outputs



...that the vision is the foundation on which a strategy is built - a leader needs to be able to “visualise” what excellent safety performance looks like and communicate this vision in a compelling way.

### What can you do? <sup>[21, 22]</sup>

#### Provide a clear vision

A robust workplace safety culture begins at the top. Senior leaders adopt the company policy on safety and help employees visualise what excellent safety performance looks like.

Thought should be given to the unintended consequences of any vision or goal. In particular, vision statements that target “zero” injuries or incidents can lead to:

- Reduced reporting of incidents or conditions that influence them
- Reluctance to be treated for first-aid injuries because of the risk of them being reclassified as something more serious
- Effort diverted into minimising the classification of any injury and finding alternative (but meaningless) duties for injured parties
- Loss of motivation when an incident happens which means the target can't be met

Instead, visions should focus on positive outcomes that promote collaboration, such as

- Everybody goes home safe
- We work together to keep each other safe



..by talking about your vision for everybody to go home unharmed

#### Communicate the vision by word and action

Leaders have to communicate and inspire the vision in a compelling way. People at all levels need to know that their actions will be supported by their organisation. Make the high-level vision meaningful for your operations or project.

## Turn vision into improvement plans

Leaders establish their own expectations and set their own safety performance goal to be consistent with the overall vision.

Once a safety goal has been identified, consider the gap between where your organisation is now and where it wants to be. Improvement requires a thorough and honest evaluation of current shortcomings. This is where support from upper management and open communication between different levels of the organisation is essential. At this stage it is useful to create an **improvement plan**, which may include the following elements:

- the gaps you are trying to close
- actions you will take to close them
- how you will measure progress

## Monitor progress <sup>[24]</sup>

Leaders should specify how to measure progress.

This may include data collection and analysis, evaluating the results of activities aimed at enhancing safety performance. Do not let yourself be carried away by a sense of success, even when verification processes yield positive results.

A combination of lagging and leading indicators should be used to create safety performance metrics. Use data to make decisions about your plan, whether you are on track or need to do more.

## Avoid sole focus on outputs <sup>[23]</sup>

A sole focus on numbers and outcomes can cause problems. Lagging indicators cannot tell you if you are doing the right things to be safe – they may just tell you that you've been lucky so far. It can also lead to dysfunctional behaviours, such as discouraging reporting. Quantitative targets can sometimes be achieved by sacrificing quality. Monitor the quality and the effectiveness of actions. Consider the balance of both quantitative and qualitative measures of your performance: if you rely on numbers, have a quality mechanism to help you understand how the trends are achieved.



**Goal** (Aspiration): An ambitious commitment to address a single challenge. Goals can be qualitative or quantitative.

**Target** (Action): A specific, measurable and time-bound outcome that directly contributes to achievement of a goal.

**Indicator or metric**: A way of measuring progress towards a target generally based on available or established data and related to specific targets (the terms indicator and metric are used interchangeably here)

- Lagging indicators (retrospective) are the traditional safety metrics used to indicate outcomes of our efforts - injury frequency and severity, number of releases, fires, near misses, etc. The major drawback to only using lagging indicators is that they don't tell you how well your company is doing at preventing incidents and accidents by managing the defences or barriers.
- Leading indicators (predictive) are measures used to prevent or mitigate an incident. Leading indicators are focused on future safety performance and continuous improvement. These indicators are proactive and report what the company is doing on a regular basis to prevent accidents.





### What the Experts Say: James Reason <sup>[25]</sup>

The 'upper echelons of the organisation' have the greatest potential to cause 'latent' failures; that is, failures that may be 'removed' from the incident, but are endemic in how work is managed and organised.



### Case Study: The Visionary Finance Manager

The Finance Manager (FM) is visiting one of the sites to recognise its "zero days away from work" performance. It has achieved several years without a Lost Work Day Case. On the day of the visit, the Finance Manager overhears the HSE team talking about an incident that has happened that day - a site supervisor has slipped and sprained their ankle. The FM stops and asks the team if the injured supervisor is going to be alright. They tell the FM that they don't know yet, but that they have found some alternative desk work for the supervisor to do. That will make sure that the incident doesn't result in lost work days, and their zero performance is intact.



#### What would you do?

- How can you rephrase a "zero" target to avoid this kind of behaviour?
- What other indicators might you look for to tell you if there are problems being hidden by this "zero" vision?



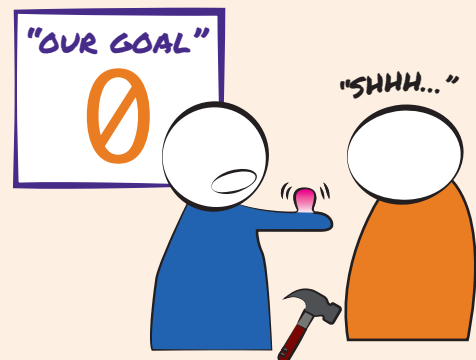
### Debrief: The Visionary Finance Manager

The Finance Manager talks about the intent of the "zero lost days" target. He explains to the HSE team that it means that we care about each other's safety, we want everybody to go home unharmed, and we are all committed to doing that.

He asks about first aid treatments and the team tell him that they have very few, but they are worried that people have stopped reporting them. They have discovered some "secret" first-aid treatment kits in the changing rooms.

He talks to some scaffolders on site and they tell him that nobody wants to be the person who breaks the zero target, even accidentally.

At the next leadership team meeting the Finance Manager raises the question of whether their 'zero' target is being misinterpreted, is leading to a lot of effort in recategorising incidents and discouraging people from speaking up.



## 3.4. Accountability

### Why does accountability matter? [26]

As well as taking personal accountability for safety critical activities and process and personal safety management, leaders help others understand their accountabilities. In terms of leadership in safety, “being accountable” means that leaders take responsibility for activities being conducted in a safe manner.

Leaders build accountability by:

- Helping people **know** what they are responsible for
- Helping people to be **able** to deliver those responsibilities, through capability, tools and resources
- Helping people **feel** ownership for their roles and responsibilities
- Seeking to understand the full context when accountabilities aren’t met
- Considering the potential consequences of organisational change on safety



...that leaders ensure employees take accountability for safety-critical activities [1]

### What can you do? [27]

#### Help people understand their roles and responsibilities

Define and clearly communicate the roles, responsibilities, and levels of authority to fulfil key safety duties. Talk about your personal explanations as a leader, both formal and informal. Demonstrate accountability, assuming individual responsibility for Safety and Environment and openly value safety over any other business objective such as costs, deadlines, or productivity.

#### Help people to be able to deliver those responsibilities [28, 29, 30, 31]

Make sure that people have the necessary level of capability, as well as the necessary tools or processes, that help them to fulfill their responsibilities. We know that many of the issues with tasks, tools and processes, that prevent responsibilities being delivered, only come to light when the workforce trust leadership to respond in a helpful way when problems are discussed. If leaders react to problems badly, they are likely to reduce the ability to detect problems that prevent people from delivering their accountabilities.



**Accountability:** The word “accountability” is often interpreted in different ways. In fact it does not have a specific translation in some languages. It is sometimes translated as “responsibility”. However, in Report 453, accountability is more than that. The meaning that Report 453 wishes to convey with “accountability” is :

- Having both the responsibility for delivering a result and the capability to do those things necessary to achieve the result.

Or simply, “The ownership and the ability to make things happen”.



... by assessing the consequences of organisation change on people's understanding and ability to deliver accountability

### Help people feel ownership for their roles and responsibilities

Employees who feel real ownership for their accountabilities frequently have higher job satisfaction, conformance, and performance.

These things can all increase a sense of ownership for accountability:

- Good relationship with the line manager
- When leaders talk honestly about what they value, and role-model accountability
- Level of trust and support between worker and leader
- Meaningful work that people feel they have ownership and some control over
- Having a sense of how their work relates to organisational goals and vision

If employees feel over-controlled, untrusted, unsupported, or penned in by overly-restrictive rules, felt accountability usually reduces.

### Understand the context when responsibilities aren't met <sup>[32]</sup>

In the event that responsibilities haven't been met, the role of the leader is to fully understand the reasons. As with any other incident or event, understanding the context of a person's actions or decisions helps us to learn how to prevent others getting in the same situation. In the case of a responsibility not being met, a leader might seek to understand the factors identified above and then ask themselves:

- Were the responsibilities understood?
- Did people have the capability and/or resources to deliver them?
- Did people feel accountable?

As discussed previously, when a leader responds with interest and an appetite to learn if things go wrong, they will benefit from better information and increased participation in the work of developing their organisation's safety culture.

### Consider potential unintended consequences of organisational change <sup>[33]</sup>

Changes to organisational structure and accountabilities are a normal part of business life. They can sometimes have unanticipated consequences for safety. When considering these types of changes, ensure risk assessment covers:

- How changes in resources (human, time, information, skills, location, etc.) could affect people's ability to fulfil duties.
- Take into account that overload can lead to work being more difficult or prone to error.
- Verify how the change affects responding to operational problems, deviations, incidents and emergencies.

Where critical work is externally subcontracted, ensure that:

- Your own company retains appropriate technical skill to provide oversight or ensure that work is carried out to the necessary standard.
- There are contingency plans to minimise risks in the event that the contractor loses the capacity to deliver requirements.



### Case Study: The accountable Engineering Manager

The Engineering Manager is on the phone to the control room to ask about a modification in the shutdown. Normally, she would have walked to the control room, but recently the entire engineering department has been moved 50 miles away to the head office.

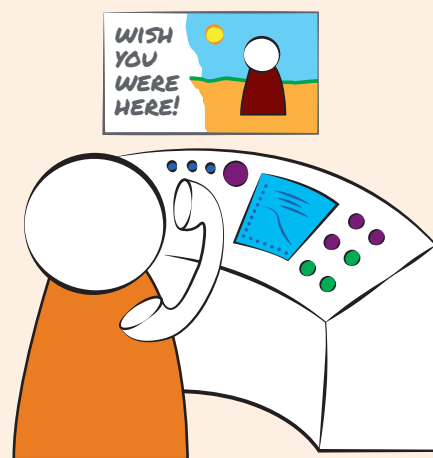
The control room operator (CRO) says he's glad the EM has called, because they are trying to restart the Liquefied Natural Gas plant, but it is behaving weirdly. Normally, control room personnel would have called an engineer in to discuss the problem, but they've been trying to resolve the issue themselves.

The CRO says that the heat exchangers have become very cold, because the hot oil that heats them had accidentally been shut off. They were just about to restart the hot oil and warm up the exchangers.

The Engineering Manager is alarmed, and tells the CRO not to restart the hot oil. Pumping hot oil into the very cold exchanger could cause it to crack, like pouring boiling water into an ice-cold glass. She says to keep everything on recycle and she will drive right over and help.

After safely warming and restarting the plant the EM reflects on some of the organisation changes that might have led to the situation.

*What things might she consider?*

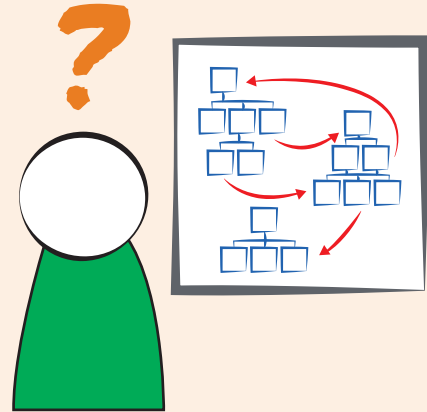




### Debrief: The accountable Engineering Manager

The Engineering Manager considers the following:

- There has been a lot of reorganisation, which resulted in separate reporting structures for engineering and operational staff. In addition, some staff had been moved into new roles. The reorganisation was not managed effectively, causing confusion about who was responsible for important safety roles. People aren't clear for which roles they are accountable.
- Employees who had moved into new roles were expected to make decisions without being given sufficient time to get up to speed with their new roles. Also, the engineering resources team have been moved a long way from the operation they support. Operators were no longer able to get engineers involved in the day-to-day operations. People may not have the capability and resources to deliver their accountabilities



## 3.5. Collaboration

### Why is collaboration important? <sup>[34]</sup>

Leaders who encourage active employee participation in resolving safety issues gain the trust and respect of the workforce, and increased employee ownership and engagement in those issues.

Leaders build collaboration by:

- Manager engagement
- Work for the team, and with the team
- Develop key relationships and mutual collaboration



...that leaders who encourage teamwork, and who ask for, and act upon, others' input in resolving safety issues, create a greater sense of ownership. <sup>[1]</sup>

### What can do you?

#### Manager engagement

When leaders show enthusiasm and dedication for safety, people will adopt these characteristics to collaborate with others in safety. When there is active engagement of teams from different areas of an organisation, the workforce is less likely to regard safe working practices as an obstacle or a waste of time.

#### Work for the team and with the team

Workers practical knowledge of how work actually gets done provides them with invaluable insights into how to improve safety. Leaders should work for their team, fostering their motivation

and encouraging them to work safely. Involving workers in the improvement of tasks, tools and processes engages and motivates people, which helps to increase participation in reporting. Ask for and listen to people's input, and show that others' views are valued. Encourage the team to discuss safety concerns openly, and respect everybody's input. A leader should be open to new ideas and input on decisions. Incorporate advice from the team into the decision-making process. Allow employees to voice their opinions, concerns and ideas without fear of punishment or reprimand. Help teams to make sense of problems, seeking any help and data necessary, even if it comes from other areas.



... by picking an improvement topic to collaborate with the workforce on.

### Develop key relationships and mutual collaboration

Visibly engage with stakeholders in safety issues. Create new ways of working together, including any processes and structures needed. Work with contractors and suppliers to understand what their challenges are, and any good practice they have that you could learn from.



What the Experts Say: James Reason, "Managing the risk of organisational accidents" <sup>[25]</sup>

"Any safety information system depends crucially on the willing participation of the workforce, the people in direct contact with the hazard."



### Remember:

- Leaders should work for their team, fostering their motivation and encouraging them to work safely. Your team doesn't work for you; you work for your team.
- Leaders should be open to new ideas, including others in decision making and showing more trust.
- Leaders should ensure the meaningful participation and decision making of operations and maintenance workers and other employees in all analyses required.
- In a contract environment, leaders can help clients and contractors align on how to manage HSE. This may include a focus on significant risks, systematic verification and monitoring of barriers/controls effectiveness, and assurance mechanisms through the life cycle.



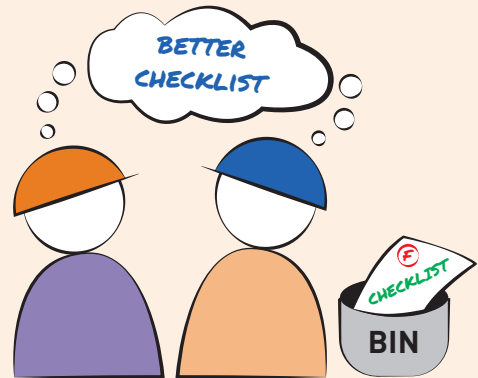
### Case Study: The collaborating contract supervisor

In one of his routine audits, the contract supervisor realizes that an operator has not followed a checklist. At first he is angry, because everyone has been trained and should know that it is essential to follow the procedure to be safe.

The procedure was developed by managers who had some previous experience in the field, but had not conducted real operations for some time. The procedure was published and managers warned that workers would be punished if it wasn't followed.

The supervisor thinks that some disciplinary action against this operator may be necessary

What could he do to understand the situation and prevent a problem in the future?



### Debrief: The collaborating contract supervisor

The supervisor talks to the operator who tells him that it is not possible to fully follow the checklist because it does not match the current conditions of the job. The supervisor reviews the checklist and agrees with the operator.

The supervisor speaks to some of the operator's colleagues and finds that they had given suggestions during the development of the procedure, but they had not really been listened to. When the procedure was published the management warnings of punishment had discouraged people from speaking up about the problems. Nobody really uses the checklist.

The contract supervisor asks for the operator's help in making the procedure better. They organize a workshop where managers, supervisors and operators rewrite the procedure together, all actively participating. The contract supervisor realizes that this could be a new era where everyone participates in a collaborative way, so that rules and procedures are practical and helpful, and people follow them because they feel ownership of the content.

## 3.6. Communication

### Why communication is important

How leaders communicate about work-related issues shapes the organisational safety culture.

Leaders can improve communication by:

- Actively listening
- Being assertive with peers
- Considering the hierarchy of effectiveness of communication
- Adapting your leadership style for effective communication
- Promote speaking-up and reporting



...that the way leaders communicate about safety creates and maintains the Safety Culture of the organisation.<sup>[1]</sup>

### What can you do?

#### Active listening

Take the time to listen to the workforce. How well leaders listen has a major impact on job effectiveness, and on the quality of the relationships with others. Becoming a better listener will help you improve safety, as well as the ability to influence, persuade and negotiate. Moreover, leaders can avoid conflicts and misunderstandings. Simple techniques such as asking open questions and paraphrasing what we hear can help active listening.

#### Be assertive with, peers and other leaders

In any organisation, there are competing priorities and opinions. If you think something is important to the safety of your operation you need to make sure you are heard by others. Being more assertive doesn't mean you will always have it your own way, but it can help you achieve a compromise by respecting the views of others as well as your own. Be open, specific, and honest about what you think and feel.

#### Consider the hierarchy of effectiveness for communication

The **hierarchy of effectiveness for communication** (see Figure 1) can help you pick the most effective form of communication for your purpose. Remember that the most effective communication is two-way; telling people what you want them to hear, but also listening to their responses, opinions and ideas.



...by seeing how well imagined plans, documents, and management systems are actually operating in the field



**Hierarchy of effectiveness for communications:** More effective ways of communication derive from personal engagement in the workplace, which are more influential but labour-intensive. Less effective interventions reach more people, but it is more difficult to ensure coverage, quality of communication and lasting effect on retention of key messages or behavioural changes.



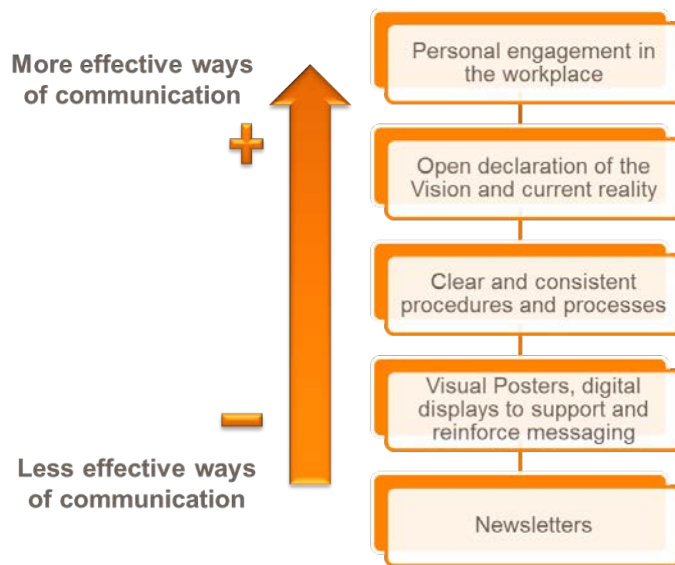


Figure 1: Key Hierarchy of effectiveness for communication <sup>[35]</sup>

### Adapt the leadership style to be more effective in communications

The most effective form of communication is a two-way exchange of information between people. Varying communication styles helps a leader engage and get the support of people, and reduces conflict. The objective is to understand and influence behavior.

When seeking to engage a team there are a few simple steps that will help the conversation:

- **Engage:** Seek to understand the other person’s context, put yourself in their shoes, be curious, listen
- **Influence:** share mistakes, show people that they have been understood, show your own vulnerability, and show that you care
- **Inspire:** share your experiences, what you feel, what you value, and be honest and transparent
- **Challenge:** get commitment from the team for the desired behaviour or values, and continue to listen for what obstacles may emerge

### Promote speaking-up and reporting <sup>[36]</sup>

Leaders should encourage the workforce to raise safety issues and encourage a two-way communication. They should regularly meet the workforce and discuss safety with them; regularly communicate company safety objectives to employees and contractors; and help each individual in the organisation understand their important contribution.



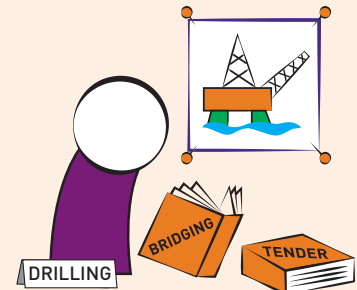
#### Remember:

- Great leaders communicate consistently and continuously. Effective communication builds relationships and gets results.
- Leaders should promote ‘speak-up’, and open and transparent employee reporting. How leaders respond when things go wrong has an important influence on transparency.



### Case Study: The effectively communicating drilling manager

The new Drilling Manager is reviewing a bridging document that has been agreed between the Operator and Drilling Contractor, for a well that is currently being drilled. It contains a single set of procedures for the rig. It covers everything she can think of: drilling, shut-ins, well-killing, staffing, responsibilities, audits, training, incident reporting, material stocks, operational limits, evaluation, and emergency plans. It all looks very impressive. She wonders how she can test whether it's actually making a difference on the rig?



If this was your company, whom might you talk to to evaluate whether the bridging document is helping to keep the rig safe?



### Debrief: The effectively communicating drilling manager

The drilling manager decides to talk to all parties involved, including a visit to the rig. As a result of her visit, she learns:

- The company's drilling team are worried that HSE requirements in the original 'invitation to tender' were too vague, allowing a loose interpretation of your company standards.
- The Contract Manager says that some of the listed procedures are available, but others are only in draft format. A lack of resources meant safety aspects of bids weren't fully evaluated. However, the final contract did include a proper set of HSE requirements. He admits that the contract award decision was based mostly on cost, although drilling safety performance was considered.
- According to the Company rep on the rig, the Drilling Contractor is not meeting the contract HSE requirements in operation, and this situation is being ignored. The rep doesn't have enough time to make all his reports to the corporation and enforce the requirements.



The drilling manager is very concerned by what she hears. She calls an immediate halt to operations, and meets with the leadership of the drilling contractor. Everyone agrees that there needs to be better support for the rig to meet the HSE requirements of the bridging document, and managers on the rig need to be more active in verifying and improving compliance.

## 3.7. Feedback and Recognition

### Why is feedback and recognition important?

Leaders give feedback on progress in safety improvement and recognise employees' involvement and ownership. This is rewarding for all parties and motivates continued effort. Leaders also look for feedback from the work force on their own contribution.

Leaders can do this by:

- Showing genuine care
- Recognise good performance
- Coach people to develop them in safety
- Get feedback on your own performance in building culture



...that providing feedback and recognition for individuals and teams is a powerful tool for encouraging safety and building a stronger Safety Culture.

### Show genuine care <sup>[37, 35]</sup>

Showing care means that leaders personally demonstrate their genuine concern for the wellbeing of the team. Leaders encourage employees to speak-up about safety issues or concerns about Work as Imagined versus Work As Done. They show care by listening to the workforce and helping to fix their problems.

### Recognise good performance <sup>[38]</sup>

Reinforcing good performance, and those who contribute to it, helps to increase motivation, confidence, and personal growth. Visible recognition and appreciation turns those rewarded into role models for others.

Team engagement and participation are most effectively driven by personal thanks or public recognition. Material and cash incentives can feel impersonal. Preferences differ - some people like to be recognised in public, others do not - so knowing what your team responds to is important.

When recognising, encourage proactive safe behaviours. Reward those that anticipate safety opportunities in the long term, as well as those who perform heroic rescues. Recognise people who have shared what they've learned and mistakes they've made, as well as proposing ideas. Describe how the person or team contributed to performance. Try and show appreciation as soon as possible after praiseworthy actions, so that recognition is directly linked to the actions.



#### Key points:

Work in psychology shows us what makes for effective recognition and reward. In particular we know that

- **Positive** is more powerful than negative
- **Immediate** is more powerful than future
- **Certain** is more powerful than uncertain

So recognition that is positive, immediate, and certain (PIC) is the most powerful. People remember and are very motivated by it.

Simple recognition shouldn't be underestimated. An operator who stops a job may be very proud and motivated when a manager gives him a letter recognising his impact.

## Coach to develop others in safety

Coaching is about developing people to their full potential. Nobody is born with all the skills to be a good leader. Both coaches and those being coached benefit from coaching conversations. As well as giving the benefit of their experience, those coaching can practice how they communicate with others, and hear directly from junior members of their organisation. Those receiving coaching benefit from experience and practice speaking-up with more senior leaders.

Define a motivation campaign that reinforces positive and proactive behaviours and encourages people to surface and talk about unsafe conditions and problems.



... by talking to people about what is working for them and what is not

## Get feedback on your own performance in building culture <sup>[39, 40]</sup>

Leaders track and measure performance against objectives and use data to make changes in plans and coach improvement. Leaders also seek out evidence of their own impact on the organisation and its culture. Here are three established ways of doing that:

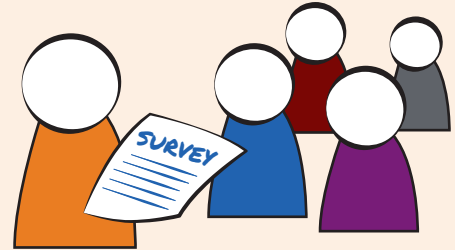
- **“Trust” questions in regular employee satisfaction surveys:** The easiest and most effective way <sup>[42]</sup> to measure your impact. Positive responses to questions like “do you trust your leader?”, “does your manager value your opinion?”, “does your leadership team listen to and address your problems?” are all indicators of a positive, collaborative safety culture. Track how responses to these questions change over time. Increases in positive responses should correlate to reduced personal and process safety incidents.
- **360 surveys:** Often routine for leaders, these surveys can give feedback to an individual from employees, colleagues and line managers, which will give an insight into the impact they have on others.
- **Culture surveys:** Typically involving a dedicated survey against a series of different elements of culture, followed up with employee workshops to understand the issues behind survey results that are lower than wanted. They produce huge amounts of information but can be labour intensive and hard to determine actions for change. Since we know that leadership shapes culture, it helps to read cultural surveys as an indication of leadership, not the people being surveyed. Although regularly used by many companies, some large operators have stopped using culture surveys, favouring the more dynamic “trust question” approach above.



### Case Study: Weren't you listening?

The Site Superintendent is going over the cultural survey data with a work party. He's wondering why the team got a low score on "Valuing Procedures". He says that the team has to start valuing procedures as they are an important way of keeping safe. The team nod, but look unhappy about something.

How might the Site Superintendent approach this differently?



### Debrief: Weren't you listening?

The site superintendent asks if there any issues with the procedures.

The team tell him that the procedures are complicated, out of date, and difficult to get off the computer. They say they have been telling management this for years, and ask whether it was really necessary to have to fill in a survey for that message to finally get through?

## 4. Getting into action

Let's see what our imaginary leadership team have learned.

### Scenario: The next leadership meeting

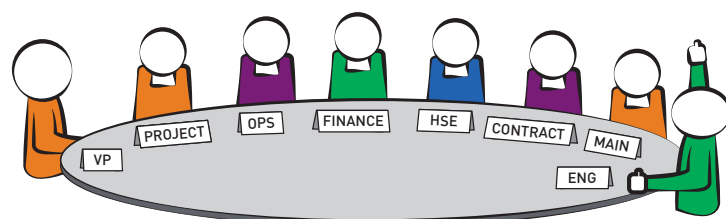
It's the next monthly leadership team meeting, and all the heads of department are gathered around the table again. The Vice President asks his team what they have learned in the last month.

- The curious HSE manager has learnt that only a small portion of their incidents are due to intentional rulebreaking. The majority of incidents are due to mistakes and conditions that people are making the best of.
- The credible maintenance manager talks about the importance of being available in the field, helping people with the problems that they have doing work.
- The action orientated operations manager talks about how he had responded when something went wrong, not tried to apportion blame prematurely, and tried to understand the full context of the event to prevent the same thing happening to others.
- The visionary finance manager learned about downside of 'zero' targets and the importance of explaining how it means we care about each other's safety, and wants everybody to go home unharmed.
- The accountable engineering manager describes the consequences of an organisation change that meant that people were unclear about what they were accountable for, and didn't have the capability and resources to deliver their accountability.
- The collaborating contract supervisor talks about the benefit of having collaboration between leaders and workforce so that rules and procedures are practical and helpful, and people follow them because they feel ownership of the content.
- The effectively communicating drilling manager explains how she discovered that the carefully designed bridging document wasn't working in practice, by talking with people in the operation.
- The listening site superintendent learned that listening to the workforce about the problems they face can do more for culture than a survey.

"So it really is something we are doing, and we could make a difference," says the Vice President.

The Engineering manager raises a hand. "I wonder," she says, "if we should start talking about some of our findings with the rest of our senior leaders, supervisors, and foremen?"

Now that's a very good idea...



## This is the end. So what message would we leave you with?

- You can learn leadership skills
- Be systematic about developing all the leaders in your organisation
- It doesn't matter where you start, but start

## You can learn leadership skills

Being a leader is not a function of personality, charisma or intangible attributes. Inspiring a vision and shaping a culture is an outcome of behaviours and skills that can be learned and practiced like anything else. Those characteristics are listed in this document and may take time to develop.

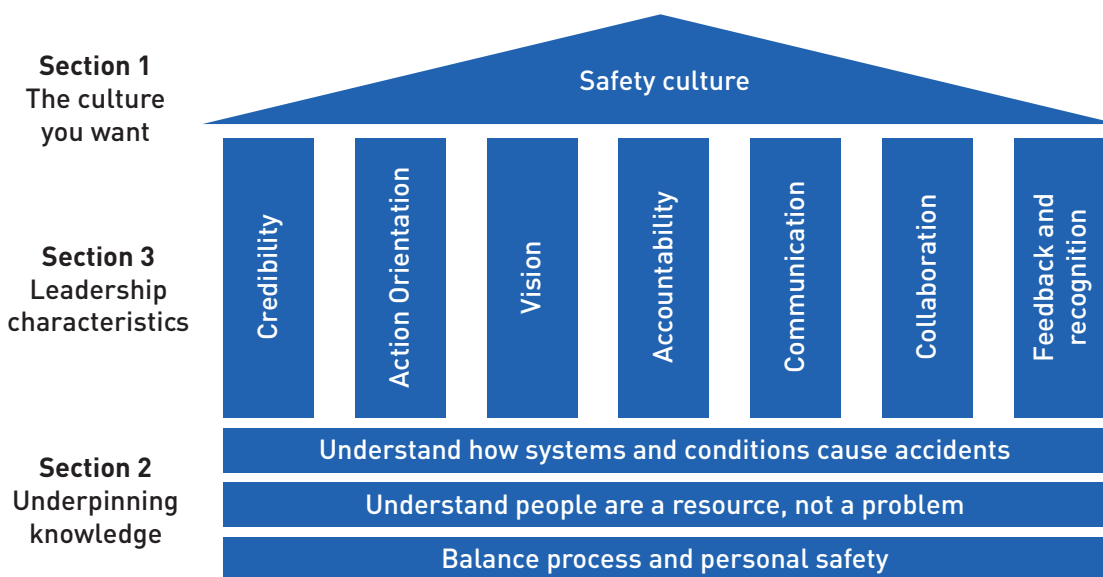
## Be systematic about developing all the leaders in your organisation

The safety characteristics are fundamental at every level, irrespective of the position in the organisation. Organisations are large, complex systems. If you rely on one, or a handful of great leaders to keep your organisation safe, you will fail. Think about how your training programs provide safety leadership development for specific roles within the organisation. Consider leaders outside the normal operational areas, to include Human Resources, Procurement, and Audit, all of which have important roles in facilitating safety.

## It doesn't matter where you start, but start

There is a lot here, we know. Pick some of the ideas that are discussed in this document and start working on one or two of them. As you get skilled in these, pick some more. Before you know it, your organisation will be looking to you as a role model for safety leadership.

Have another look at the Safety Culture 'temple' below, and consider how you can encourage and exemplify these traits and behaviors in your organisation.



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This guide has been developed to be used in conjunction with IOGP Report 452 – Shaping safety culture through leadership. This report is designed to support senior and/or middle management and supervisors in applying the Safety Leadership Characteristics described in Report 452 and creating a workplace culture that values safety.