The behavioural aspects of Learning from Incidents

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Introduction and purpose

Safety is of prime importance for all industrial organisations. A lot of effort is put into raising safety awareness amongst employees. Often the focus is on procedures. They are put in place with the objective to reduce the execution risk of activities.

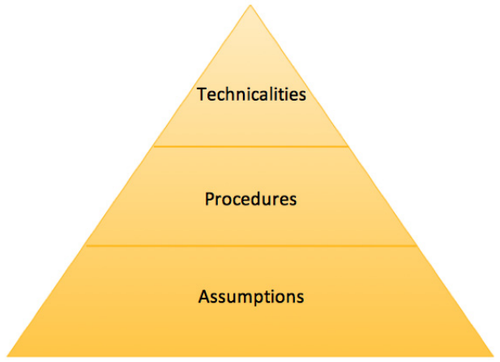
Over the last couple of years we have been working with a large oil and gas company in The Netherlands to help them with the behavioural side of working safely. This topic gets widespread attention in literature and a variety of behavioural safety programmes are offered and used. Despite all this effort incidents continue to happen. These incidents are to be considered opportunities to learn from and identify system weaknesses and allow further enhancements in hardware or the management controls such as procedures.

In this article we want to share our insights and offer a totally different approach, which is based on educational and learning practices and which offers an opportunity to provide a solid basis for an individual change in safety awareness and the accompanying behaviours. Furthermore the approach provides insight in the systemic issues influencing the execution of site activities.

Incident investigations: current practices

When an incident has occurred it is typical to form an incident investigation team, which factually tries to establish the root cause of the incident. These teams normally consist of a mixture of technical, line management and/or HSE specialists from the organisation itself. We concentrate here on incidents which can be addressed within the organisation itself and which do not require outside involvement from Government or other regulatory authorities. The incident investigation team normally consists of technical staff trained in analysing technical incidents. Furthermore the investigation teams often need to comply with a standardised investigation process with clear timelines for deliverables (e.g. the incident investigation report) and close out actions. It is therefore no surprise that recommendations are often of a technical and procedural nature. These fit with the prevailing technical mind set of industrial organisations and are easy to control from a management perspective. Learning is expected to occur by the distribution of a summary of the incident report or so called Safety Alerts to key staff in the organisation. The receivers of this information are expected to share the predefined lessons learned within their teams. Learning can be limited for example when the incident is very specific to certain equipment, which is not used everywhere. An often heard reaction is: “we

don't use this equipment here, so it doesn't apply to us", or "no use sharing this since we work differently". The common underlying behavioural aspects like individual assumptions on perceived time pressure or 'best intention' based deviations from procedures, which are relevant to all sites and activities are thereby lost.



The learning approach to incidents

So how do you get the behavioural aspects into the learning from incidents domain? In our work with a leading Dutch oil and gas company we have developed an approach, based on four principles:

1. **The topic demands a serious approach**
   Safety is serious business. Learning from incidents therefore requires a recognition of the technical and procedural aspects, an appreciation of the language in use whilst finding a balance with the fun of learning.
2. **Good quality invites participation**
   The transfer of learning from incidents to the shop floor is often challenging. Quality material both in content and pretty lay-out invite usage: it lowers the hurdle. Identification with person(s) involved is key: it allows for the material to be recognised and to come close-by.
3. **Depth requires leadership skills**
   Quality conversations are difficult at operational sites especially around behavioural aspects. How do you ensure the discussion is about your own behaviour and not only about the technicalities and procedures or why it could only happen to others? This requires leadership: skills in having a dialogue and the ability to take another stance compared to your own position.
4. **Fun of learning**
   Despite safety being a serious topic, there is also the desire to approach it with a certain lightness. It must be a pleasure to spend time on safety. Another practice, a wink in a film or a practical joke in a magazine helps. Surprise gives lightness.

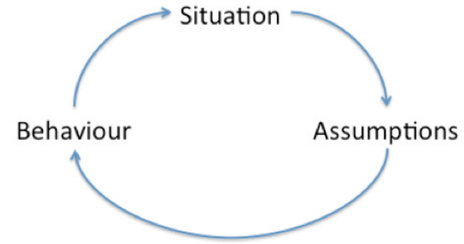
Based on these principles we have created a process consisting of the following steps:

1. Analysis of the incident from a behavioural perspective
2. Video interview, covering the technical, procedural and behavioural aspects, with the person involved about the incident he was involved in
3. In an integrated learning environment, offering the video and exercise material, focused at entertaining a generative dialogue on especially the behavioural aspects
4. Use by supervisors of the material in their regular on-site safety meetings

Lets explore these steps in some more detail.

1. **Analysis of the incident from a behavioural perspective**
   As stated the analysis of an incident is normally performed by an incident investigation team. Our experience shows that to surface the behavioural aspects a different relationship with the person involved (often referred to as the IP: injured person) is required as well as an inquiry mind set to explore the behavioural aspects. The incident investigation takes place within an organisational context where different interests are at play. One needs to think about the contractual relationship between the operator and the contractor or tension between an operational site and the head office. Talking about ones own behaviour and the underlying assumptions, which have lead to the incident, requires trust, which is not necessarily present within the organisational setting. Bringing in an external party with the skills to listen and inquire in an unbiased fashion helps to get behind the technical and procedural story from the incident investigation team. It is also often an emotional journey for the person involved to explore in depth the behaviour and assumptions, which have lead to the incident especially where physical injury is at play. The need for a safe environment in which these discussions take place is evident. The person involved needs the confidence that his personal reflections and the underlying behavioural assumptions are dealt with in a professional and trustworthy manner. It is therefore that following the analysis of the behavioural aspects, the story of the person involved is played back to him in the form of a script, which he needs to endorse as a proper reflection of what happened. The script is also the basis for the next step, the making of the video. It will be clear that the script can deviate from the official incident investigation report and throw new light on the incident. While not easy, this requires the acceptance by the organisation that multiple realities do exist and that the incident investigation was performed with a mainly technical and procedural focus and mind-set.

2. **Video interview**
   The script is used as the storyline for the video. The person involved tells his story in his own language. He shares the technical aspects of the activity at hand and informs the audience about the procedures which were used and applied. Following this he concentrates on his assumptions. The whole integrated story describes the incident. A typical video is some five minutes in duration. The raw material is edited and assumption circles are added to the material. The first one to see the draft product is the person involved who needs to give his stamp of approval. While the incident investigation report is normally anonymous, videoing the person involved puts him in a potentially vulnerable situation. Keeping incident reports and findings anonymous supports a culture in which incidents are seen as failures. Having the persons involved talking about the incident openly allows a move towards a culture where it is accepted to show ones vulnerability.



3. **Integrated Learning Environment**
   In addition to the video, learning material is developed. This material consists of additional background information about the incident (for example photo's) or clarifying schematics. These are intended to give the facilitator enough situational awareness to get the most out of the engagement with his staff. This material is developed with an educational mind-set: what are the lessons and how do people best learn from this incident? What exercises are appropriate and which intervention form suits best? Exercise material consists of the behavioural aspects to be addressed with respect to this specific incident. All the material is published on a website for supervisors to use in their safety engagements with their staff. We are now experimenting with blog functionality so supervisors can share their insights with colleagues.

4. **Use materials in regular safety meetings**
   The supervisors are requested to use the material and have been supplied with facilitator instructions. Our experience has shown that these supervisors find it difficult to entertain a generative dialogue. In a Train the Trainer programme we have worked with them to enhance these skills. This requires them to step down from their hierarchical often advocacy based position

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and truly act as facilitator. Another aspect, which must be stressed, is having respect for the colleague telling his story on the video. It is all too easy to ridicule a story and live in the assumptions that it would never happen to yourself. This attitude hampers personal learning and the supervisor needs to be able to handle such reactions in the meeting.

The results we have seen

What are the lessons learned from this approach and what are the benefits?

- First of all we have experienced the power of identification. Seeing a colleague, who you probably have worked with or know off, telling a personal story in which he shares his assumptions, leading to an incident, has a major impact on how a story is received. It comes close and an often heard reaction is "if I am honest, I would have done the same thing". A supervisor commented in one of the Train the Trainer sessions: "I am frightened, since I now see how my staff thinks and acts".
- Delivering quality material to supervisors who are already very busy with their day-to-day operational activities helps. We received comments that they could use the material straight away without having to do a lot of preparation work. So quality material invites usage.
- The supervisors are all surprised by what comes out of the dialogue following the viewing of the video and using the learning material. They are getting used to the fact that different realities exist in different peoples minds and that this influences the way they approach and execute an activity. It makes them realise that there is a power in the diversity of views and perceptions in their teams and that they need to explore these rather than close a conversation too quickly.
- From a safety culture point of view we noticed that the vulnerability demonstrated by the person involved is deeply respected by their colleagues. While initially the persons involved are worried and feel insecure about the approach, we have seen that they come out stronger and take pride in the fact that they have taken this step. They become advocates of the approach.

Further opportunities

With an increase in the number of incidents analysed in the way described, we expect to be able to identify reoccurring themes in the assumptions made by staff. These themes are very likely pointers to systemic issues at play within the organisation. If for example a reoccurring assumption is: 'I must agree with the client supervisor', this would point to systemic issues related to hierarchy and contractor-client dependencies. Getting these types of systemic issues on the table would provide a further opportunity to address the unintended consequences of the organisational structure and/or the prevailing management practices.

Further info

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