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‘Proactive Safety Investigations’ and Organisational Reality

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There has been a lot of talk in safety circles about ‘positive investigations’.

The notion is that by doing proactive, pre incident investigations, we can investigate things that ‘go right’, understand critical things we need for success, how to further improve them and increase organisaitonal resilience. Some academics and consultants advocate that traditional models, with their ‘too linear’ nature have limited ability to provide appropriate learnings, some even advocating ‘ditching’ traditional models in favour of ‘pre-incident’ investigations and their particular models.

Any proactive methods applied to identify vulnerabilities, strengths and opportunities for improvement are indeed extremely valuable. Just like many other safety practitioners, this author did a number of proactive investigations, particularly by using an ICAM model, long before latest phrase of ‘pre - incident investigation’ was coined. Neither ICAM model nor others were found to be too linear or restrictive in any way. An art and success of any investigation, proactive or reactive, is not about the investigative model but entirely about the skills, depth and knowledge of the investigator, as well as an ability to explore and express various dimensions of the event within and beyond the investigative model itself. The model is only a handrail. In today’s world of safety and risk, where there is a tendency to turn everything on its head and proclaim it ‘different’, and ‘better’, business and safety professionals alike need to be cautious how they approach concept of pre – incident investigations.

This is why.

Experienced safety practitioners know that organisations do not have infinite resources and time to do investigations. On contrary, recent years have seen huge reductions in skilled and qualified safety staff across all industries and a push to reduce time taken in investigations, even for very serious events. Current oversimplifications in safety and risk management, implemented due to costs and under the mistaken belief that simple is always better are very concerning and completely misaligned with the reality we see in safety and compensation statistics.

I am aware of organisations which have limited their investigations by mandating no more than one single root cause and a single page investigation report. Others have oversimplified internal investigation processes, delegated it to supervision with only a basic training and some have completely discarded the need to address individual and task factors, missing the critical opportunity to probe and find out a range of issues such as workplace error promoting conditions or cultural and leadership factors. Due to cost, many popular reputable investigative training has been halved in duration and content.

Time is money and business and senior decision makers do not like to spend it unless absolutely necessary. Ask yourselves, how many businesses do you know which are prepared to commit a number of people,

including senior leaders, to undertake a day long positive investigation about something organisation is already doing well? If you have tried to instigate one of these, you will know the barriers you need to overcome. Proponents of proactive investigations, academics, lawyers and consultants often forget, or are simply not aware of the barriers practicing safety professionals face in organisations and reality of particular cultural stages those organisations are in, on their journey.

Even executing quality reactive root causal analysis often tests organisational commitment, resolve, resources and leadership values. The reasons, principles and mechanisms involved are the same ones responsible for so many industry examples where leadership and organisations were well aware of the vulnerabilities but did not act on them, simply because they collectively believed that bad things simply won't happen as they have not happened before, at least to them. Some would call this effect a risk denial but it is more a risk suppression due to complacency. This is a basic human tendency to trade uncertainty for tangible rewards in absence of visible negative effects, whilst at the same time supressing the inherited risk balance and internal warning mechanism through self – delusion that bad things simply won't happen to them. This effect is a massive barrier for all practicing safety professionals, and a fascinating effect to observe from the perspective of organisational and social psychology of risks.

Truth is, once in the high risk zone, bad things eventually do happen. Time needed for this to occur is usually the only factor of uncertainty. Similarly, to a large extent an old saying that there are no new types of incidents, only people with short memories is still valid. There are ample opportunities to learn from past mistakes.

When we talk about proactive investigations, we need to ask one fundamental question.

Have we actually reached the limit of traditional proactive analytical models and therefore need 'pre incident investigations' to reach where we cannot reach with traditional methods and tools? I think we are long way from this. Before we shelve traditional approaches and models based on work of prominent safety thinkers such as James Reason and others, and before we embrace different concepts, we need to understand why our traditional investigations and proactive analytical methods haven't delivered expected outcomes. Unless the organisation is fairly new, it has probably had ample opportunities to learn significantly from its own proactive risk assessments and incidents, as well as from other players in the same industry. Are traditional models applied in reactive investigations deficient or is the issue with the lack of organisational commitment to proactive safety methodology in general, culture in operation as well as skills and knowledge of investigators? Is the culture of risk assessments, evaluation of critical controls and change management imbedded in the overarching organisational culture, as a start? If this is not the case, how is any pre – incident investigation going to get commitment or deliver any additional value?

Safety is so eager to jump from one shiny thing to another, looking for easy answers, often oversimplifying key concepts along the way and in never ending search for a panacea, a short term solution, just to put the feather in the cap and off to another search for shiny and attention grabbing. We often forget to stop, ask ourselves why something is not working and generate organisational conversations around this, as change agents. This is ultimately one of the biggest shortcoming in safety profession today and it seemingly exist in a good part due to perceptions amongst many senior decision makers that safety is something simple, people based, and relatively easy to manage. Truth is of course completely contrary to this belief.

In the view of this author, lack of proactive insight and failure to create effective organisational learning culture through investigative processes, are not problems associated with deficiency with traditional models such as ICAM, Taproot, MORT and others, but rather the way they are applied. Three critical issues exist in this space.

Lack of knowledge and experience

Firstly, we expect people who go through a typical two day long incident investigation courses to become good investigators. This is simply unachievable goal, but many organisations almost completely rely on this fallacy towards their effort in trying to create a culture of learning. Investigation of accidents, especially complex organisational events is an art which needs to be mastered and this unfortunately requires practice and takes a long time. In addition, strength of character, depth of thinking and level of knowledge required, specifically around human factors, operational processes, organisational culture, leadership, safe systems of work, systems and process safety, are just some of critical attributes good investigator needs to have to be able to penetrate deep enough and guide the team towards deep underlying causational factors. Deficiency of current strategies in some organisations which delegate investigations of serious events to supervisory ranks without adequate expertise are clearly visible in shallow findings and persistence of 'people at fault thinking' where 'not following procedures' and 'human error' are prolific root causes of serious events.

In author's experience, even a good portion of safety professionals, especially at advisory levels struggle in this particular technical area, for a number of reasons associated with the lack of adequate content in VET and tertiary curriculums, lack of coaching and mentoring as well as relative rarity of high quality investigation training. In many cases, lack of self-initiated professional development is the culprit. To illustrate, to be able to properly understand and apply Swiss cheese accident causation model and its investigative ICAM model in practice, safety professionals need to cover off good portion of Professor James Reason's work, amongst other literature in organisational accidents and human factors. Simply relying on the basic training and an investigative model is a massive oversimplification and a common cause of shallow and linear findings and inability to probe into auxiliary but also critical factors such as those which create 'things that go right', reliability and ultimately organisational resilience.

Most organisations are far better off carefully selecting their safety professionals and a small number of internal and external subject matter experts as investigators rather than spreading the function of accident investigator far and wide, especially when it comes to serious and high potential events. In many cases, external resources are able to provide better transparency, breach certain internal cultural and political barriers otherwise inaccessible or too sensitive to internal investigator, and deliver the findings aimed to enable just and informed cultures to be improved at organisational level. They are also more effective in delivering uncomfortable but critical findings to senior management. Internal investigators are best used by via cross divisional coverage, ensuring independence and transparency.

Serving the Model

Secondly, many lead investigators fall into the trap of serving the particular model, rather than using the model to serve the investigation. Many investigations have been deadlocked over the need to 'fill the gap', find that missing 'piece of cheese' individual factor or a failed defence, even though none failed, whilst at the same time steering away from deep organisational or leadership factors, or obvious business improvement opportunities, simply because they are perceived not to be 'causational' in nature. The perception that 'the model must be completed' is an absolute detriment to having a deep and wide investigation approach. This bureaucratic thinking is surprisingly common and disabling, robbing the lead investigator and the team of learning precisely the things 'positive investigations' claim to be able to focus on. Reactive investigations have the same opportunity, however this opportunity needs to be explored and used effectively. Ultimately, proactive or reactive, quality investigations critically depend on the maturity and level of knowledge of people involved, especially senior leaders and a lead investigators. Regardless which accident causation theory and investigative model is used, the model is there to serve the investigation process and not the other way around, as it is so commonly the case.

Organisational Preparedness

Thirdly, many organisations are resistant and hesitant to self-reflect, when it comes to incident investigations and their findings. The same can be said about the organisational maturity as well as the ability and willingness of leadership to exercise critical thinking, be prepared to make significant changes and allocate resources towards mitigation of critical risks identified in reactive investigations or proactive risk assessments. Some organisational cultures are not supportive and do not allow deep and wide investigative approaches, regardless whether they are proactive or reactive. Those environments often support practices of pre-emptying investigative findings by taking punitive actions before investigation even begins, clearly passing subliminal messages to investigative team towards where the causes should be found and blame allocated, usually away from operational decision making, accountability of managers, provision of resources and systemic organisational failures.

Judging on feedback from safety circles and social media, in some cultures, delivering deep and accurate investigative findings can be very career limiting and in those environments no matter what type of investigation is applied, the pressure not to look into certain areas will persist, which will continue to disable the progress of those organisations towards more developed culture of safety. Practices of having internal investigation reports significantly 'adjusted' by senior corporate figures and lawyers can be very destructive to creation of an organisational learning culture and prevention of serious accidents and losses. This is especially the case in organisations where senior, knowledgeable and experienced safety professionals are not present at executive ranks to challenge and balance such practices. Silencing critical organisational risk alarms this way makes as much sense as taking out a fuse from aircraft fuel gauge alarm because it reads empty, but this is precisely what happens in some organisations.

It remains to be seen if pre incident investigations will be subjected to the same level of internal organisational scrutiny, as once found, critical improvements and upcoming failures can be described as a 'state of knowledge' potentially demanding urgent and expensive corrective actions to avoid creation of negligence and individual or organisational exposures.

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In summary, ‘positive, pre - incident investigations’ and their focus on ‘things which usually go right’ do not appear to have any additional benefits when compared to traditional proactive OHS tools, critical risk management, human error predictive analysis or root causes analysis done well, other than their obvious proactive benefit and generation of conversations aimed at increasing importance of safety management. Obtaining commitment, time and appropriate organisational resources needed for their implementation is bound to be problematic. It remains to be seen to what degree organisations adopt the concept of proactive investigations, especially willingness to commit resources and time towards investigating things which will certainly be perceived by some leaders as ‘things we already know’. If experiences and feedback from senior practicing safety professionals are anything to go by, this will be a very hard sell.

There is absolutely no doubt that organisations need to initiate proactive initiatives aimed at identifying risks and particular scenarios these risks can be materialised, however rather than to apply partial approaches with ‘positive or pre - incident investigations’, organisations should be ensuring their existing investigation processes are effective and meaningful. This should be combined with carefully planned and properly resourced proactive critical risk management program (CRM) as well as failure mapping & prevention process aimed at particular work execution scenarios. Many early versions are currently applied in some of larger mining and O&G organisations.

One particular stage of the CRM process is or particular interest due to its similarity to publicised concept of ‘pre incident investigation. This is a combined workplace subject matter expert’s group conversation around risks, positive and negative work execution practices, various scenarios where things can go good or bad and how those factors can combine to cause, or prevent serious incident. This stage of proactively evaluating particular work execution practices and scenarios is just one of the steps in the overall CRM process. Organisations need to resist the temptation to jump straight into it without doing the analytical pre - work as this step in isolation can easily miss many critical risk factors and produce limited results.

Ultimately, no matter how good the proactive approaches are applied, there is no perfection. Reactive investigations are critical factor for building of organisational learning and informed culture and are currently significantly underutilised. Regardless of the investigative method, proactive or reactive nature of the enquiry, its success will always be hinged on organisational culture, strength and quality of leadership as well as technical knowledge of those leading these initiatives. Organisations need to be very mindful of who they select to lead investigative initiatives and choose their safety professionals carefully, firstly at the operational support levels and even more importantly, at the most senior levels, so they can interpret the information received, provide appropriate advice to executive ranks and influence overall organisational behaviour and operational decision making practices.

Competent senior safety professionals should be able to steer the organisation towards initiatives and practices which are suitable for that particular organisation, its maturity and particular developmental stage, as not everything which is being labelled today as ‘different’ in safety and risk actually has positive value or can be implemented successfully.