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# Strategic Safety Management Session

Presented by

Stephen Evans, BISC Chairman (Pacific Western)

# WELCOME !!

Findings:

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#### "Air France Panel Cites Wide Safety Deficiencies"

The Wall Street Journal, Wed Jan 26/11

## An independent study of Air France was conducted in 2009 and found:

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**Air France A330-200; Flight 447; Atlantic Ocean:** The aircraft was on a scheduled flight from Rio de Janeiro, Brazil to Paris, France. The aircraft crashed in the Atlantic Ocean in the early hours of 1 June 2009.

There were no emergency or distress messages sent by the crew. The last contact between the airplane and Brazilian air traffic control happened around 35 minutes before the crash.

Debris from the aircraft was found near the estimated position of its last radio communication. There were 216 passengers and 12 crew members on board.



Most of us would probably not have considered Air France to be an unsafe airline

Despite the significant resources and effort dedicated to safety, passing audits & compliance reviews, etc.. etc....

...their organization was entirely surprised and devastated when this incident occurred What do you think their safety priorities were?

### **Regulatory Compliance**

#### **Regulatory Compliance**

Due Diligence

But doing good work in...

#### **Regulatory Compliance**

### Due Diligence

...does not prevent accidents

In the bus and motorcoach industry, what are the issues that tend to dominate our safety discussions?

What topics are often covered at industry association conferences?

### **Regulatory Compliance**

#### **Regulatory Compliance**

Due Diligence



### **Education Session**

"Strategic Safety Management"

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#### The stereotypical "Safety Expert":

Arrives with the hard hat, goggles, visi-vest, gloves, clipboard, thick rule book...and a swagger !!

#### The stereotypical "Safety Expert":

Arrives with the hard hat, goggles, visi-vest, gloves, clipboard, thick rule book...and a swagger !!

Within 10 minutes they have figured out your entire organization and begin telling you how to run your business better.

#### How some Safety Experts make their point:

- 1. I am the expert, I know more, I am better trained & qualified, and this is official/technical/safety stuff that you won't understand.
- 2. These are the facts, it has to be done this way.
- 3. You don't really have a choice because it's the right thing to do
- 4. And at the end of the day it doesn't matter what you think because it is the law and you have to do what I say

They use Blame and Shame, and often look for a Scapegoat

## I call this the <u>Black Hat</u> approach.

Back in the old days of the Saturday movie matinees, westerns were big.

The bad guys wore black hats, and the good guys wore white hats.



Billy the Kid



**Buffalo Bill** 

#### The Black Hat Approach:

...focuses on blaming individuals for inattention, forgetfulness, mistakes, & stupidity...and they need to be **disciplined** 

The White Hat Approach:

...accepts that humans are fallible and errors are to be expected, even in the best organizations...and recognizes that **systems and processes** are required to minimize the number and severity of mistakes

# "Error must be seen as an opportunity to learn...

...not as a reason to punish"

#### Human error is:

#### - normal

#### - inevitable

#### - almost never intentional










Some safety experts seem to think they can inform or force people out of human error

They think that by telling people about the risks and the rules

and explaining in clear well defined terms the consequences if they don't comply

that people would finally say "ah hah, now I get it", and then would immediately stop making mistakes

...but despite the best of intentions, and lots of rules/regs, human error is:

- normal

- inevitable

- almost never intentional

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## Safety in our industry can be compared to a cliff.





### How drivers get into trouble at the top of the cliff:

- trying to pass
- speeding
- talking/texting on the cell phone
- fussing with tunes
- rain/snow/ice/strong winds
- racing
- not paying attention to the road
- not properly trained
- poor driving skills
- in a hurry
- didn't think the warning signs applied to them







#### **Emergency Response**



#### Recovery



#### Investigation



### - We get noticed

We get noticed
We get to do something

We get noticed
We get to do something
We get a budget

#### We own the bottom of the cliff !!







The other approach is to focus on the top of the cliff



### How we get drivers out of trouble at the top of the cliff:

- checklists
- systems
- procedures
- training
- standardization
- safety meetings
- inspections
- audits
- performance monitoring
- coaching/mentoring







#### Top of the cliff: **Prevent**

OR

Bottom of the cliff: **Respond** 



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# Performing "CSI" style investigations





Collision investigators, accident reconstruction specialists, police, insurance adjusters, and other experts explore -

What When Where Who How

It's about blame, liability, fault, who should go to jail

The piece that is often missing from their investigations, and the piece that safety folks really need to do their work, is the -

### WHY

For the most part our internal reviews/investigations have *not* really been about "prevention".

The Collision Review process is mostly just deciding if the driver was "<u>at fault</u>" and whether the incident was "<u>chargeable</u>".

And the outcome is nearly always either disciplinary action and/or training for the driver...and then the collision file is closed.

Most of the published manuals, handbooks, & guides only examine the actions of the driver and determine if he/she made a mistake or a poor choice.

But we already know that someone made a mistake.

I don't really care as much about who or what caused an accident...I want to learn why so I can figure out how to prevent it!
Our internal investigations need to go deeper and look beyond the driver

### An example:

A bus driver and several passengers saw and smelled smoke coming from the left front wheel area of the bus.

The driver pulled over and called dispatch on the 2 way radio and asked what he should do.

Dispatch told him to keep coming to the Terminal (about 15 minutes drive) where they would switch buses with a spare.

When he arrived, the left front brake rotor was a smoldering brilliant red.

### Safety Dept Analysis:

- Defective Equipment brake rotor overheated due to caliper malfunction
- Driver Failed To Address Hazard driver should have conducted an inspection
- 3. Inadequate Direction/Information dispatch should have got more info from driver

(Did they go deep enough to prevent?)

1. Why did the caliper seize up?

Why wasn't this caught during the last service? Problem with installation? Design issue? Improper maintenance? Is this failure possible on our other buses?

### 2. Why would the bus driver smelling and seeing smoke, and risking a possible outbreak of fire, decide to blindly follow his dispatcher's instructions and continue the trip?

Training? Driver/Dispatcher issues? Lack of confidence? Communications? Schedule is the priority? 3. Why would the dispatcher, knowing that there was smoke coming out of the bus with the potential for a fire, tell the driver to continue driving to the Terminal?

Communication issues? Training? Lack of trust? Is schedule the top (only) priority? Does the driver have the authority to say no? Prior accidents give us a heads up on what is going to happen again, unless we change something Prior accidents give us a heads up on what is going to happen again, unless we change something

They predict the future, just like a crystal ball



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## A system to catch and respond to...



"Red Flags" are information about impending problems, concerns, issues, challenges, etc.. that could significantly impact our business or personal lives.











## "Good to Great" by Jim Collins

# Why some companies make the leap, and others don't.

Collins and his team identified companies that leaped to great results for at least a fifteen year period, and also identified a comparison group that failed to make the leap.

The research team studied these 28 companies over 5 years to <u>discover the keys to making the leap from good to great.</u>

The good-to-great companies had a process to listen to, learn from, and respond to "Red Flags"...and as a result made many more right decisions. "Indeed, we found no evidence that the good-to-great companies had more or better information than the comparison companies...None.

Both sets of companies had virtually identical access to good information.

The key then, lies not in better information, but in turning information into a timely response."

### Red Flags - Previous Violations:

### HIGHER ODDS OF ACCIDENTS WITH CATEGORICAL VIOLATIONS

Reckless driving violation	325%
Improper turn violation	105%
Improper or erratic lane change conviction	100%
Failure to yield right of way conviction	97%
Improper turn conviction	94%
Failure to maintain proper lane conviction	91%
A past accident on record	87%
Improper lane change violation	78%
Failure to yield right of way violation	70%
Driving too fast for conditions conviction	62%

(FIG. 2)

# Red flags give us a heads up on what is going to happen again

... unless we change something !



Bus & Motorcoach Safety will significantly improve as we become more aware of "Red Flags" and respond/follow up on them

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### Follow Up on Red Flags

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It is not about what we say. It is not about what we write. It is not about what we think.

### It is about what we do and how we do it.

Our actions tell the story. A visitor can immediately sense how important safety is to our organization because of the way we conduct ourselves. Many organizations have all the proper written standards and procedures in place.

And they say all the right things at the right times.

But they never actually get around to <u>doing</u> any of them.

### **A Poor Safety Culture:**

- My boss doesn't know I exist
- No one cares about what I do or how I do it
- Nobody asks me what I think
- The last time I reported a problem I got in trouble with my co-workers for rocking the boat
- I tried telling my boss about an issue but he told me to mind my own business and get back to work
- The safety committee is a joke, all talk and nothing gets fixed

### STATE OF THE AMERICAN WORKPLACE EMPLOYEE ENGAGEMENT INSIGHTS FOR U.S.BUSINESS LEADERS

By Jim Clifton, Chairman and CEO Gallup

Of the approximately 100 million people in America who hold fulltime jobs, 30 million (30%) are engaged and inspired at work, and feel they have a great boss.

Roughly 20 million (20%) employees are actively disengaged. These employees have bosses that make them miserable, and so they spend much of their time spreading discontent.

The other 50 million (50%) American workers are not engaged. They're just kind of present, but not inspired by either their work or their managers. Gallup research has found that the top 25% of engaged and best managed teams:

- have nearly 50% fewer accidents
- have 41% fewer quality defects
- incur far less healthcare costs.

Only 41% of employees felt that they know what their company stands for and what makes its brand different from its competitors' brands.

# One of my pet peeves around safety culture:

**Clear and Concise Communications** 



Cover:

Cleanse:

Scrub:

Soften:

Wash:

Freshen:

Tame:
Cleanse:

Scrub:

Soften:

Wash:

Freshen:

Cleanse: Soap

Scrub:

Soften:

Wash:

Freshen:

Cleanse: Soap

Scrub: Bath Gel

Soften:

Wash:

Freshen:

Cleanse: Soap

Scrub: Bath Gel

Soften: Lotion

Wash:

Freshen:

Cover:	Shower cap
Cleanse:	Soap
Scrub:	Bath Gel
Soften:	Lotion
Wash:	Shampoo
Freshen:	
Tame:	

Cover:	Shower cap
Cleanse:	Soap
Scrub:	Bath Gel
Soften:	Lotion
Wash:	Shampoo
Freshen:	Mouth Wash
Tame:	

Cover:	Shower cap
Cleanse:	Soap
Scrub:	Bath Gel
Soften:	Lotion
Wash:	Shampoo
Freshen:	Mouth Wash
Tame:	Conditioner

# Visitor off the street test (my wife test):

If I give this (document, manual, policy, etc..) to a stranger on the street...

... is it clear and concise enough that they will understand it?





**ELEMENT: HOISTS OPERATIONS** Document Name: Hoists Document No.: 3.3.3 Page Reference: Page 1 of 10 Controlled By: xyz Effective Date: October 2009 Revision No.: Rev 1 Approved By: abc Revision Date: October 2012 Printed on: 1/22/2010 3:38 PM *Document Uncontrolled if Printed* 

#### 1.0 PURPOSE

The purpose of the procedure for hoists is to provide a standard for all mechanical shop employees to guard against and control injury to workers, and otherwise provide for the protection of life, limb and property by prescribing standards for safe operation and inspection.

#### 2.0 SCOPE

All mechanical shop employees and contractors must comply with this procedure.

#### **3.0 APPLICATION / EXCEPTIONS**

This procedure applies to all employees.

#### **4.0 ROLES AND RESPONSIBILTIES**

#### 4.1 Employees will:

Only operate the hoist after being properly trained: Use all applicable safety features provided with the hoist: Operate the lift in accordance with the manufacturer's instructions; Be responsible for the cleanliness and orderliness of the lift and its surroundings; Inspect the hoist daily; Advise the manager **immediately** if there are concerns about the safety of the hoist.



#### 4.2 Maintenance Managers will:

Ensure employees / operators are properly trained on the safe operation of the hoist; Ensure that a pneumatic or hydraulic hoist has controls operated by constant manual pressure;

Set-up a paper or electronic log book that is readily available for inspection containing the following:

orientation / training records

daily pre-use checklist for hoists / cranes

maintenance and troubleshooting instructions

records of annual inspections / certificationEnsure that hoist meets the requirements of the following:

(A) ANSI Standard ANS/ALI ALCTV – 1998, American National Standard for Automotive Lifts – Safety Requirements for Construction, Testing and Validation;

(B) ANSI Standard ANSI/ALI ALOIM – 2000, Automotive Lifts – Safety Requirements for Operation, Inspection and Maintenance.

(C) Alberta Occupational Health and Safety Code, Part 6 section 112

• STOP WORK for serious safety or mechanical concerns.

#### 4.3 HSE Specialist will:

During quarterly shop inspections, check that hoists are being used in a safe operation and that daily log books are being kept; Investigate any complaint or concern of an OHS violation.

#### 4.4 Director, HSE is responsible to:

Ensure employees / managers are trained on OHS requirements; Monitor compliance to this procedure; Report on OHS compliance as required; STOP WORK for serious safety concern.

#### **4.5 Director, Maintenance** is responsible to:

Ensure annual inspections are performed in accordance with OHS requirements; Monitor compliance with this code of practice; **STOP WORK** for serious safety or mechanical concerns.

#### 5.0 METHOD

#### 5.1 Testing

All hoists shall be tested annually to ensure the safe operation of the hoists and to ensure the safety of employees and equipment. The testing shall be done by a qualified third party inspector of hoists and shall include but not limited to the following tests:

Proof Load Test Operation Test Lowering Speed Test Lateral Synchronizer Test Out of Level Test Load Holding Device Test

Hydrostatic Strength Test Hydraulic Relief or Regulating Valve Test Air – Oil Low Oil Control Device Test Stability Test

The third party inspector shall annually issue an Inspection Certificate that is kept on file.

#### **5.2 Inspections**

All hoists shall be inspected by a qualified operator prior to the start of shift and/or each lift on the hoist. The operator will check the following but not limited to the following items: Accessibility and readability of operating labels;

Accessibility and readability of safety warning labels;

Readability of the rated load capacity of the hoist;

Proper operation of the hoist controls, restraints and locking devices;

Deformation or excessive wear of hoist structural components; Deformation or excessive wear of components such as hoses, electrical wires, drive chains, cables or screws;

Damage or excessive wear on any of the lift contact points which engage the vehicle during lifting, whether they engage the tires, frame, body or axles;

Evidence of hydraulic or pneumatic leaks;

Unusual noise, sudden movements, erratic operation or evidence of chips or filings during use;

Check the concrete floor for any cracks or loose concrete around the hoists.

#### 5.3 Log Books

An electronic and/or paper log book shall be in place for each hoist. The log books shall be readily available to operators and inspectors. The log book should contain the records of daily inspections, a copy of operator training records and the third party annual inspections.

#### **5.4 Training Records**

All shop employees are to have a training log sheet completed on the hoist/s they will be operating. The training log sheet will contain the owner's or employers' name, the employee's name and employee number, make and model of hoist, lift capacity, serial number, date of training and signature blocks for operator and the trainer. A record of the training log shall be kept on the personnel file of the employee.

#### 6.0 Training

All employees who are required to operate a hoist shall be trained by a professional trainer or a person deemed qualified through experience, skill and knowledge by the Director of Maintenance. If an employee moves to another shop they will be trained on the hoist in that shop. A training log shall be issued for all training.

#### 6.1 Record Keeping

The maintenance manager shall create a file on each hoist and have that file readily available at the hoist's location. The file shall contain the manufacturer's instructions for installation and use, annual inspection certificates and any documentation for maintenance or repair. The employer shall create a training log on each employee who has been trained to operate a hoist and the training log shall be placed in the employee's personnel file.

#### **7.0 DEFINITIONS**

#### 7.1 Hoists

A hydraulic, pneumatic or mechanical means of lifting a vehicle off the ground to perform mechanical work.

#### 7.2 Portable Hoists

Not permanently fixed in one location and able to be moved from one place to another.

#### 7.3 Operating Controls

The mechanisms which must be manipulated by the operator to govern the starting, stopping, direction of motion, acceleration, speed and retardation of the moving parts of the hoist.

#### 7.4 Authorized Personnel

Employees who have been instructed in the safe operation and/ or maintenance of the hoist and designated by the employer to use or maintain the hoist.

#### 7.5 Pneumatic Power Source

A device that utilizes compressed air as the force transmitting medium.

#### 7.6 Hydraulic Power Source

A device that utilizes hydraulic oil as the transmitting medium.

#### 7.7 Filler Plug

A removable component to allow maintaining proper fluid level in a hydraulic hoist.

#### 7.8 Saddle

The portion of the hoist which comes in contact with and / or engages the vehicle or vehicle component.

#### 7.9 Lift Point

The location at which the hoist lifting member or saddle contacts the vehicle component as designated by the manufacture.

#### 7.10 Lifting Member

The moving portion of the hoist upon which the saddles are mounted.

#### 7.11 Load

The total superimposed weight of force to be overcome by the hoist.

#### 7.12 Internal Load Limiting Device

A device that limits the lifting capacity of the hoist.

#### 7.13 Pawl

A pivoted component that, when engaged with the teeth of a ratchet, prevent undesired movement.

#### 7.14 Ratchet

A toothed member for engagement with the pawl.

#### 7.15 Rated Capacity

The maximum published operating load that the hoist is designated to lift, support, or transport throughout its range of travel.

#### 7.16 Proof Load

A load, greater than the rated capacity, applied centrally to the lifting or attaching points of the hoist to confirm the integrity of the structure.

#### 7.17 Raised Height

The distance from the ground to the top of the saddle at the full extension of the hoist.

#### 7.18 Lowering Speed

The average speed of descent over full travel with or without a load, up to the rated load capacity.

#### 7.19 Hold To Run Control

A control device which requires the employee to hold the control in the engaged position to initiate and maintain operation of the lift elements. This control automatically returns to the off position when released.

#### 7.20 Pinch Points

A point where it is possible to be caught between moving objects, or between moving and stationary objects.

#### 7.21 Frame Engaging Type Hoist

A hoist that engages the frame or body structure of a vehicle.

#### 7.22 Fork Type Hoist

A hoist that engages the vehicle by its individual wheels.

#### 7.23 Operator

An employee who controls the use and operation of the hoist and who may clean and inspect the equipment other than in the course of periodic inspection, servicing, repairing or maintaining the hoist.

#### 7.24 Inspection

To visually inspect the hoist before each use, checking for abnormal conditions, such as cracked welds, leaks, and damaged, loose, or missing parts.

#### 7.25 Testing

To run the hoists through a number of load tests by a qualified inspector.

#### 7.26 Attachments and Adapters

Only attachments and / or adapters supplied by the manufacturer shall be used.

#### 7.27 Manufacturer

The manufacturer includes the original fabricator or that person effecting final assembly of the hoist except for that assembly accomplished upon installation.

#### 7.28 Log Books

A paper or electronic record of recording inspections or maintenance.

#### **8.0 RESOURCES**

Trained hoist operators may be used to train new shop employees on the hoists at the discretion of the Director of Maintenance.

#### **9.0 ATTACHMENTS**

Annex A: Operator Training Log Annex B: Daily Inspection Checklist

#### **10.0 REFERENCES**

Alberta Occupational Health and Safety Code, 2009 Part 6 (112 -

#### 113)

ANSI Standard ANSI/ALI ALCTV – 2006, American National Standard for Automotive Lifts - Safety Requirements for Construction, Testing and Validation

ANSI Standard ANSI/ALI ALOIM – 2000, Automotive Lifts - Safety Requirements for Operation, Inspection and Maintenance

Although it easy for a rule book focused safety specialist to defend each entry...

...the reality is that virtually nobody is ever going to read those 9 pages!

Clear and concise gets the best results...

...not artificially formal, using long words, pages and pages of useless details, or insider acronyms...

...as much as possible our safety programs should match our audience

### Strategic Safety Management Session



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# The Sniper Rifle vs. Shotgun approach













### The Shotgun:

The force of the exploding gunpowder is spread over all of the pellets therefore none of them by themselves will do much

The pellets begins to spread out as they leave the muzzle and continue to spread over distance

Good only at relatively short distance

Is not really aimed, just pointed in the general direction and hope enough pellets hit the target to take it down

















Range at sea level

### The Sniper Rifle:

All of the force of the exploding gunpowder is directed at a single bullet

Expectation is that one shot takes out target

Good both short and long distance

A precision rifle scope lets shooter identify specific target, accommodate last minute variables, and accurately pin point where the shot will go

There are limits to the amount of resources that can be assigned to "safety".

The shotgun approach of trying to do a lot of things all at the same time often means limited progress or success.

Instead pick a very specific safety target, then put all your energy, time, and resources towards that accomplishing that target. Do little of anything else safety wise until your target is accomplished.

It will feel uncomfortable not trying to fix the world, but you'll make more progress just focusing/fixing one thing at a time.

### Creating a Focus (by Terry Mathis)

I was asked to help an organization improve their poor safety performance. The organization performed heavy and dangerous work. The workers were well experienced and their safety manager was organized and caring. I was told that the safety efforts were currently focused on two items: **PPE** and **Housekeeping.** 

But, after completing an analysis of the organization's accident data, I determined that completely <u>fixing these two issues</u> would not have prevented any of their incidents from the previous year from occurring.

I then interviewed 100 workers and asked them what they perceived to be the most likely way to get injured on the job. I received <u>85 different answers</u>.

### Creating a Focus (by Terry Mathis) cont...

When the results of the analysis were shared, and the safety efforts were refocused to the top four items from the analysis, this company reduced their incidents by <u>82%</u> the next year.

Both managers and workers who do not accurately understand their greatest risks often waste their limited safety efforts on ineffective strategies.

The problem is not lack of effort, but lack of accurately focused effort.

Safety excellence lies not in the yearning, but in the focus.

Yet many organizations continue to push safety energy at the wrong target(s).

pick the right goal
link all activities to that goal

# The main thing is to keep the main thing, the main thing

(Stephen R. Covey, author of "The 7 Habits of Highly Effective People")






### "Throwing Down the Gauntlet"

2013 PWT Training Workshop Nov 5 – 7, 2013 Edmonton, AB









Training obviously can't fix everything. But, where training is the appropriate tool, it has to yield results.

My feedback to you as the trainers at PWT is that we are <u>not</u> getting results.



#### Collision analysis shows that drivers:

- had passed your ride checks
- had taken your defensive driving course
- had been through your collision avoidance training

BUT...are having multiple collisions



### So, it appears that although we are going through the motions, much of our training is not "sticking" as well as it should.

### ...Why?

### Two components of Training:

- Content

- Delivery

### Content:

- canned, generic, one size fits all
- not focused on the specific driver actions that caused the accident

## **Delivery**:

- literacy
- technology
- different cultures
- language

### Training is not about

- *Giving* a lesson
- *Covering* the materials
- Delivering content
- Presenting facts

# Training needs to measurably improve employee performance,

....or why bother?





### Safety Specialists see things differently

We try to use that unique point of view to:

- a) identify things that could go wrong, and
- b) make suggestions on how to improve

But we often overlook that people...

- a) don't like others pointing out what is wrong
- b) don't like being told what to do

And we don't have any authority to make things happen anyway I encourage a pragmatic approach:

-Keep it simple

-Keep it practical

-Keep it clear

-Keep it positive



#### **Alan Quilley**







Shawn M. Galloway President and Chief Operating Officer



## Strategic Safety in the Future:

- Safety will be considered just another aspect of business management
- "More is better" will move to a focus on effectiveness
- Will incorporate leading indicators
- Goals and objectives will *"more realistic and less idealistic"*
- Safety strategy will be aligned with business strategy



### - "Safety First" was described as highest priority by management, but did not appear to have penetrated to the work force

- Lines of responsibility for safety blurred
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- Incident data not being used to learn and prevent reoccurrence
- Staff who violated safety rules/procedures/etc. were not dealt with, instead management tried to fix by adding more and more unduly complicated policies

But doing good work in...

### **Regulatory Compliance**

### Due Diligence

...does not prevent accidents







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### Follow Up on Red Flags

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# THANK YOU !!