

Signals Before Harm:

Why Incidents Are Not the Beginning of Risk

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The Deepwater Horizon rig explosion that killed 11 people and injured 17 more has become a seminal case study in leadership and safety mismanagement. Incident analyses following this catastrophe yielded a myriad of cultural, leadership, equipment, and procedural failures that led to the event. Ironically, company executives were on the rig the previous night for a safety award celebrating 7 years without a lost time incident. Focusing solely on incident numbers as a gauge of performance is dangerous because it may create a false sense of security when the numbers are low.

The absence of incidents does not mean the presence of safety.

High-reliability organizations have effective engineering, administrative and cultural defenses to mitigate error precursors (U.S. DOE, 2009).¹ Less mature organizations often have deficiencies in leadership, culture, systems, and processes along with higher levels of stress and fatigue. The graphic to the right illustrates that the **contributing factors underlying incidents are often hidden beneath the surface**. To achieve world-class safety, leaders should actively address these issues to reduce exposures and decrease the probability of SIFs.

Outcomes

- Fatality
- Lost Time
- Recordable
- First Aid



The absence of injury does not mean the presence of safety.

Exposures

- Leadership Weaknesses
- Cultural Challenges
- Weak Systems & Processes
- Stress and Fatigue

Chasing Numbers

While tracking and addressing all incidents is important, leaders sometimes focus on the total number of incidents without sufficiently investigating SIF potential. Over the last few decades, the number of workplace incidents has dropped considerably. However, the number of serious incidents and fatalities has remained relatively unchanged.² The error precursors for common incidents (sprains/strains) are typically different than those that result in SIF incidents (falling from heights). **This requires a new way of thinking.** Leaders need to proactively seek out factors that signal the potential for serious incidents and fatalities.

Signals of Risk: Substandard Leadership

The risk for injury in high hazard workplaces is 3.5 times higher when employees report a lack of supervisor support.³ At executive levels, ineffective leadership occurs when decisions are made in a vacuum which may compromise safety. Examples include not investing resources into facility improvements, not hiring enough qualified employees, and stressing production over safety. At field

levels, common leadership mistakes include modeling at-risk actions, looking the other way when safety shortcuts are observed, and failing to recognize and appreciate positive safety behaviors. One of the best things that leaders can do is to **spend more time in the field** openly and actively engaging with employees. This includes spending more time listening vs. talking and asking open-ended questions with a sense of curiosity and humility. In addition, leaders should develop and showcase their Personal Safety Vision (PSV) which highlights why safety is important to them and the actions that they'll take to demonstrate their safety commitment. Elements of this PSV should be naturally infused into daily conversations along with formal meetings. This shows authentic caring beyond day-to-day responsibilities.

We use our Leadership Diagnostic Instrument (360 degree feedback) to help leaders understand their current leadership strengths and gaps. By realizing how others view their actions, and comparing them to our norms base of more than 12,000 leaders, these individuals set a **personalized plan for improved safety leadership** to bolster their culture and fuel safety excellence.

Signals of Risk: Unhealthy Culture

Strong safety culture is associated with increased employee engagement and engaged employees (versus disengaged) are 5 times less likely to have workplace incidents and 7 times less likely to have lost-time incidents.^{4,5} Our Organizational Culture Diagnostic Instrument (OCDI) consistently shows that unhealthy cultures tend to have disengaged employees, silos between groups, and weak safety systems and processes. One of the fastest ways to improve culture is **to listen to employees, get their input, make changes based on this input, and then aggressively advertise improvements**. Focusing on the relationship side of leadership is critical. As an example, a new leader (named Bob) of a steel mill took over a plant that had a toxic culture because of a very difficult leader that he replaced. His first order of business was to set up one-on-one "30 minutes with Bob" meetings with all 200+ employees in the facility. In these meetings he simply asked people about themselves, their families, favorite hobbies etc. He also asked about safety (and other) improvements he could make to make their lives safer and better. The impact on culture was profound and immediate.

Signals of Risk: Weak Systems and Processes

Common signals of weak systems and processes include poor close call reporting, insufficient recognition, and excessive production pressure. Close call reporting is an essential process to identify and mitigate hazards to reduce exposure. Too often, these processes turn into "check the box" exercises where the primary concern is the total number of close calls reported. There should be an ongoing, active cycle of reporting close calls, making system changes for future prevention, and sharing the details of close calls with all employees. **Close calls are teachable moments** that, when done correctly, minimize the probability of future SIF events.

Here are a few guidelines to consider with your close call reporting:

- Keep the **reporting process as simple** as possible. It should be simple and easy to report a close call.
- Create a **learning environment** to openly discuss the details of near hits. Information should be shared informally and in group meetings.
- **Share close call information** with all employees to raise situational awareness. This includes communications across different business units and locations.
- **Prioritize and address close** calls depending on the severity and likelihood of incidents

Safety Leadership





occurring. Close calls with SIF potential need to be immediately and thoroughly analyzed with resulting findings disseminated across the organization.

- Use close call information to **identify system weaknesses** and failures. Often times, poor procedures, equipment, scheduling etc. lead to close calls. These system deficiencies need to be immediately addressed.
- **Identify solutions** (e.g., facility improvements, training) for close calls with input from employees when appropriate. Front-line suggestions often yield the best solutions and also increases the likelihood of future reporting.
- **Advertise these improvements** with all employees based on hear hit analyses to demonstrate organizational commitment to safety and boost morale.

Leaders should also provide more positive reinforcement and recognition for safety. **This is sometimes viewed, incorrectly, as a soft concept. It's behavioral science.** Employees are more likely to exhibit safe work practices (even when no one's looking) when their leaders provide genuine appreciation for their safe actions. This, in turn, reduces the likelihood of incidents. This is especially important because employees are typically praised for production. All of the safety messaging in the world won't convince people of "Safety First" if they only get praised for fast production. This is compounded when workers take safety shortcuts on the front end and then get praised for their production on the back end by their leaders. It's even worse if leaders "look the other way" when risks are observed along the way. Excessive production pressure itself is a serious signal of risk. Human beings are naturally hardwired for speed and efficiency (fast brain thinking). This can lead to mistakes. This condition is amplified with overly aggressive scheduling, too much overtime (often due to manpower concerns), and excessive time pressure. One of the biggest dangers with excessive production pressure is the stress and fatigue it causes for employees.

The dangers of fatigue are often underestimated. Fatigue increases the probability of human error and corresponding injuries. Consider the statistics below:

- Working **17 hours straight** is equivalent to being legally drunk.⁶
- There's a **23% higher rate of injury** for employees working more than 60 hours a week.⁷
- There's a **61% higher rate of injury** for those working overtime.⁸
- There's a **265% greater chance of injury** for employees getting less than 5 hours of sleep compared to those getting 7 hours or more.⁹
- **43% of employees** report being sleep deprived.¹⁰

Like fatigue, stress is a hidden factor that impacts safety. Neuroscience shows that increased stress leads to the release of cortisol and the inhibition of dopamine. This decreases brain volume in adults and causes impaired decision-making, judgment, attention, and memory along with increased risk-taking behavior. In fact, workplace stress is reported as a contributing factor with approximately 120,000 deaths in the US each year.¹¹ Employees report less stress when their leaders create strong relationships, regularly use safety recognition, and guard employees against production pressure.

Take Action

Returning to the iceberg model, leaders are acutely aware of incidents above the surface. They should be equally mindful of hidden signals below the surface that may contribute to these incidents. By focusing on these hidden signals, leaders will forge a path to fuel better leadership, ignite healthy culture, bolster systems/processes, and minimize stress and fatigue. This will reduce exposure and help prevent life altering events.

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