

<b>Subject:</b>	Transition to ' <i>Safety Differently – Fail Safely</i> '	<b>Date:</b>	April 2026
<b>Genre:</b>	Human and Organisational Performance (HOP)	<b>Function:</b>	Safety, Operations, Technical & Reliability
<p><b>Summary</b></p> <p>Organisations are experiencing a plateau in safety performance, following many years of process improvements and safety initiatives. Metrics show up as an asymptotic curve, approaching but not quite achieving zero incidents.</p> <p>Everyday work has evolved to become more technically challenging and complex, where systems overlap and are co-dependent on delivering expected outcomes. This modern work environment requires our staff to adapt our processes and procedures to problem-solve everyday work variability. Serious injuries and fatalities can “hide” in this risk variability, resulting in senior leaders being shocked and surprised as a consequence of these horrible outcomes.</p> <p>The next evolution of safety performance focuses on a shift from our current beliefs of ‘Zero events are the only safety outcome acceptable’ to a new Human Performance mindset of '<i>Safety Differently – Fail Safely</i>'. This mindset shift will require us to measure safety performance through a new lens of <i>Organisational Capability (capacity)</i>. A step-change will be needed for this ambition to be realised.</p> <p>Business leaders (and safety professionals) will need time to think about and practice some of these new ideas – which will feel unsettling to leave behind the traditional safety norms that they are familiar with. Employees will not need much training in these new ideas – they have plenty of ideas in how to improve work and are used to adapting to make work successful.</p> <p>Implementing a '<i>Safety Differently - Fail Safely</i>' approach includes the following:</p> <ol style="list-style-type: none"> <li>1. Reframe the roles and responsibilities of your safety professional organisation to align with the philosophy of '<b>Safety of Work</b>', <u>not</u> the '<b>Work of Safety</b>'.</li> <li>2. A new approach to learning from events and system-focused analysis of operational risk activities through applied 'Learning Teams'.</li> <li>3. Declutter of safety bureaucracy.</li> </ol>			

## 1. Opportunity – Context

Traditionally, organisations audit for compliance in the belief that if the worker follows the process, then nothing bad will happen.

There is a huge difference between how managers *think* work is being performed and how work is *actually* being performed (i.e. work-as-imagined vs work-as-done). The latter is not about a non-compliant workforce; rather recognition that our people are expected to adapt our processes and procedures in problem-solving everyday variability of our complex work environment.

Our *traditional beliefs* on safety are:

- a. Zero events are the only safety outcome acceptable
- b. Every event has a root cause

Not everything goes right. The safest organisations are prepared for inevitable failure.

Numbers of injuries are inversely related to the number of serious injuries and fatalities (SIFs). Using Near Miss and injury data to prevent future injuries is worthwhile, of course. However, our insights and learning from low consequence Near Miss pre-cursors are widely different to potential SIF pre-cursors. Therefore, we need to consider a *new paradigm* to protect our workforce from these high-consequence outcomes by managing and measuring real-time **Organisational Capability** (i.e. *'Safety Differently - Fail Safely'*).

Consequently, we should consider promoting new KPIs that identify capacity to recover, and demote our *existing hindsight* approach of measuring event outcomes. (*Appendix 1*)

*'Safety Differently – Fail Safely'* recognises **safety as a capability (capacity) to recover from events that could seriously injure or kill someone**. *'Safety Differently – Fail Safely'* assumes that when controls fail (not “if”), event recoverability is structurally built into the work planning. Examples include:

- Wear a fall arrestor (safety harness) when working at height;
- Lifeboat testing without people in the lifeboat;
- When working over water, require a manned safety boat in proximity;
- A nearby hyperbaric chamber during diving operations;
- Anchor securing systems are designed to remove the need for checking in heavy weather;
- Heavy lifts are planned when the ship is alongside or at anchor in benign weather.

*'Safety Differently - Fail Safely'* recognises that an undesired event is a consequence of a complex work environment with insufficient capacity planned into the work to ensure recovery.

*'Safety Differently - Fail Safely'* recognises that not all accidents are preventable – by definition, an accident is “an undesired deviation from an expected outcome”. Accidents are only preventable in hindsight.

*'Safety Differently - Fail Safely'* does not consider human error as a root cause, recognising that people do not intentionally make mistakes.

*'Safety Differently - Fail Safely'* does not rely on people as the critical line of defence in preventing a serious injury or fatality; this new philosophy recognises people as key experts to ensure prevention and recovery from such an extreme outcome.

*'Safety Differently - Fail Safely'* adopts the approach that “*workers are the solution to a problem*”, not the traditional view that “*workers are a problem to be fixed*”.

The groups that will need to change their mindset most are leaders and safety professionals. The old ways of command and control, and centralised safety instruction, will need to make way for the new leadership of front-line engagement and empowerment.

## **2. Help leaders succeed in implementing “Safety Differently”**

*“Those who never change their mind, never change anything.”* – Winston Churchill

Business leaders will need time to think about and practice some of these new ideas on *'Safety Differently – Fail Safely'*; which will feel unsettling to leave behind the ‘old/traditional’ safety norms that they are familiar with. (*Appendix 2*)

Leaders should never be hesitant to have the same conversation many, many times. Leaders will, quite rightly, challenge these new ideas. Safety professionals should be instructive, not defensive, in supporting business leader engagement.

Workers don't need much training in these new ideas – they have plenty of ideas in how to improve work. You will never make a group smarter by telling the group how uninformed they are.

Informing the workers that change is happening is important – but they won't need every detail. They will judge success by the actions they experience, not in words.

### **3. Recognise the Challenging Transition for Safety Professionals' Mindset - Focus on the 'Safety of Work', not the 'Work of Safety'**

Consider a flight safety briefing requiring you to wear your oxygen mask before assisting a child – to ensure your own personal 'stability' before you can assure the stability of others.

The transition being made for your organisation also needs the safety professionals tasked with supporting your employees to be stable with the knowledge, capacity & resources to support the change needed for others to implement.

In a traditional safety organisation 'totalitarianism' applies – all decision-making is centralised within a small team. Decisions are directed on others without opportunity to input, dissent or protest. Modern business safety departments have transitioned to a hybrid approach where a central team directs others, and also takes into consideration employee input. Much more effort is needed to directly involve employees in '*Safety of Work*' decisions, process development and event learning.

Innovating your safety professionals is critical in the new view of '*Safety Differently – Fail Safely*'. If they work in the traditional way of a centralised safety structure, then that is **not** the world in which your employees work! Your safety professionals will require to transition their focus on the '*Safety of Work*', not the Work of Safety! (*Appendix 3*)

With this new shift in mindset, Safety professionals can combine a range of perspectives to come up with novel insights, and sense early signs of trouble ("risk foresight"), recognising that all systems degrade over time.

### **4. When Things Go Wrong: Learn Differently**

An investigation and its findings are an outcome of how an organisation has chosen to respond to the event – as a deliberate choice. The organisation decides how to proceed, learn, message and "score" the event.

Why do we conduct investigations? TO LEARN! Improvement won't happen without learning. Fixing comes as a consequence of learning!

The application of a new easier, quicker and simpler model, self-explanatory named '**Learning Teams**', takes an approach by asking the workers to frame a suitable Problem Statement (related to either an event or to an operational theme/risk), and to identify systemic learning. 'Learning Teams' uses a group of workers to walk through a work process, initially supported by one trained facilitator. With more practice, the need for an independent facilitator is removed. (*Appendix 4*)

Existing incident investigation methods can be narrow in approach ('5 Whys') in a search for a single 'root cause'; or unnecessarily overly complex and resource intensive ('Root Cause Analysis' and 'Causal Reasoning'). A recent academic study has shown that application of Learning Team approach can identify more latent weaknesses than using Root Cause Analysis for most events/incidents. (*Appendix 5*)

Bad things happen because many small contextual factors have collectively combined in such a complex way. People crave simplicity – however the operational world is a complex one.

An example of administration 'simplicity' is the use pull-down menus which try to identify "common" themes. This is a legacy of the traditional view of safety, and not a function of doing 'Safety Differently – Fail Safely'.

- We don't investigate trend data to predict the next accident; we investigate to learn and improve
- Forcing classification of events into broad categories is not helpful and offers limited predictability for future failure prevention.
- By trying to force-fit learning into common themes we assume the specific unexpected event context has the same organisational latent system weaknesses that apply to other work activities.

## **5. When there is Too Much Compliance: Declutter Your Safety Bureaucracy**

Organisations are cluttered with rules and expectations that provide little or no value<sup>1</sup>. We have kept our systems cluttered because we have been told that the clutter makes us better or safer. However, academic literature shows that when safety injury is less than 1 in 100,000 any additional processes indicate no added value.<sup>2</sup> More than 70% of our processes and procedures are created by our own organisation, which have little or no direct reference to national or international law.

"Safety Clutter" is the accumulation of rules, policies, safety procedure, documents, roles and activities performed in the name of safety but do not contribute to the safety of operational work. They become a distraction. (*Appendix 6*)

- Clutter by duplication (e.g. cross-checking) is not the same as intentional repetition or redundancy.
- If a safety group is given too much influence in operational front-end activities, then there is a risk of "bureaucratic entrepreneurship".
- Over-specification tends to de-professionalise an activity.
- Rise in safety clutter is a function of deregulation. Regulators no longer check regularly as they don't have the scale of in-house expertise. Their expectation is that businesses need to demonstrate that they know their risks and these are under control.

Set the boundaries (framework) for your people to have the freedom & discretion to work within professional autonomy & trust. (*Appendix 7*)

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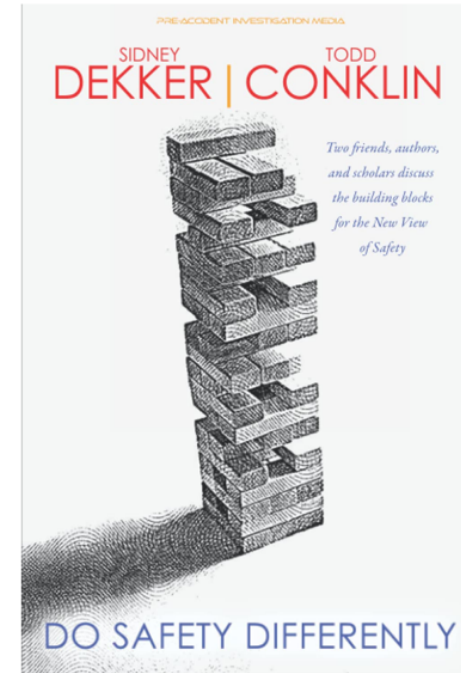
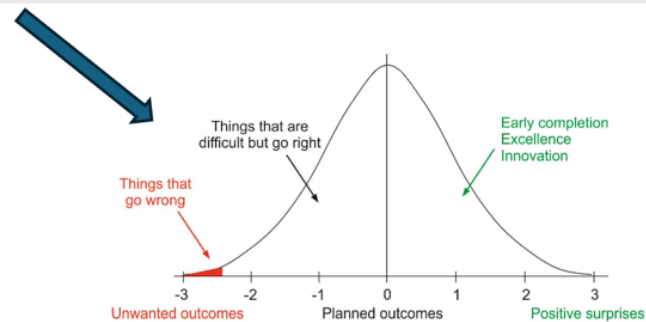
<sup>1</sup> "Iron Law of Bureaucracy", Pournelle pre-2008.

<sup>2</sup> Academic literature: *Safety Science*, 37(2-3), 109-126, Amalberti 2001.

## Problems with Traditional Measurement of Safety – Conklin/Dekker

### Absence of Bad Outcomes - Issues

1. Not having any bad outcomes doesn't mean you're safe. It just means that you haven't had any bad outcomes.
2. The absence of negative outcomes doesn't automatically imply the presence of positive capacities. It could be due to luck, or to smart counting.
3. You can help your run of no bad outcomes by calling bad outcomes something else, or by allowing your people to under-report.
4. Most things go well, rather than badly. If you are focusing your safety efforts on those few things that go wrong, you're only using a tiny portion of the data available.



## Engaging Leadership in ‘Safety Differently’ – Conklin/Dekker

Help leaders succeed in implementing “Safety Differently”	
1. You must start at the point where the leadership are in this process, not where you want them to be.	<ul style="list-style-type: none"><li>• Don’t assume leaders already know this information – most will likely not have been exposed to many of these new ideas.</li></ul>
2. Help your leaders move from their definition of safety as an outcome, to the new view of <b>safety as a capacity</b> .	<ul style="list-style-type: none"><li>• This change in mindset is fundamental to every other change that will happen.</li></ul>
3. Build sufficient time with leaders for presenting these new ideas.	<ul style="list-style-type: none"><li>• The hardest time to get is time with leadership. Leaders are not only being asked to change the way they lead, but also the way they are thinking about the act of leadership. Leaders need x3 engagement time compared to workers.</li></ul>
4. Leaders will need time to think about and practice some of these new ideas – which will feel risky to them.	<ul style="list-style-type: none"><li>• Use case studies, other peer leaders from other organisations, and discussion time to build competency in responding differently.</li></ul>
5. Key to success is providing the opportunity for your leaders to become experts in this new way of thinking.	<ul style="list-style-type: none"><li>• Tell leaders that the organisation needs them to be experts in operational reliability and safety.</li></ul>
6. Help recognise and reinforce leadership peer groups within your organisation.	<ul style="list-style-type: none"><li>• Your leader’s co-workers are their fellow leaders. Change is less scary when shared among peers.</li></ul>
7. Tell stories of success during this transition.	<ul style="list-style-type: none"><li>• Discuss what you have learned. Share stories with the organisation – they are used to failure messages and will take inspiration from positive outcomes.</li></ul>
8. Know that your leaders will move forwards and backwards in leading the organisation in this new way of thinking and responding.	<ul style="list-style-type: none"><li>• It takes a while to change years of previous experience!</li></ul>

## Appendix 3 – Focus on the ‘Safety of Work’, not the ‘Work of Safety’

### ‘New View’ of Safety Interventions to Support Frontline Work – Conklin/Dekker

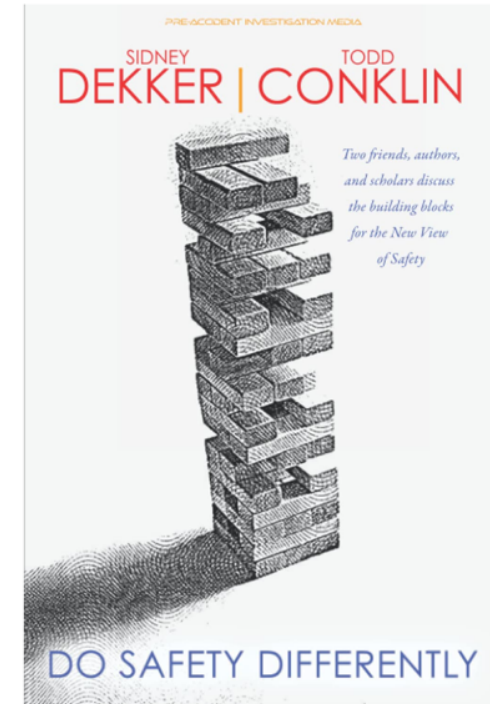
Safety of Work	How To Do This	Why To Do This
• Learn about everyday work-as-done	• Engage with workers and gain their trust to understand how stuff actually gets done.	• Discover how safety is created every day by work-as-done. Learn about obstacles & difficulties that get in the way of getting stuff done.
• Support & improve work-as-done	• Understand local practices and help workers with how to adapt better and safer.	• Safety interventions won't have staying power if safety people don't take work-as-done seriously
• Find & try to reduce goal conflicts	• Ask about & identify places where workers need to do multiple things simultaneously that (may) conflict. Help convince others to re-allocate operational resources to alleviate these goal conflicts.	• Goal conflicts are at the heart of deviances and drift into failure. Without understanding them there's neither any hope of being taken seriously by workers, nor of doing much that helps improve the safety of work.
• Facilitate information flows & coordinate actions	• Create mechanisms to get information where it needs to be (even if it's not welcome there!). Coordinate actions across team boundaries to prevent fragmentation of safety initiatives.	• You must get information to those who can make decisions about resources. You may need to prepare them to receive 'bad' news (e.g. WAI is not the same as WAD); and that there are other ways to support safe working than telling workers to be compliant.
• Generate future operational scenarios	• Try to sketch possible future scenarios that might come with operational or technological changes.	• The world is not static. Safety risks change as work changes. Without anybody looking out for them, the organisation may unwittingly embrace risk operational changes or descend into techno-optimism.
• Help leaders & others make sacrifice judgements	• Make trade-off decisions visible for organisational leaders and others, so that they know that there's no 'free lunch'.	• The organisation has other priorities than safety, despite what it says, otherwise it wouldn't exist. Economic & production pressures almost always interact with safety. Finding ways to make these interactions visible can support leaders and others in their decisions.
• Facilitate learning	• Keep the model(s) of risk in an organisation up-to-date. Find sources of blame. Hunt down anything that puts downward pressure on people's openness & honesty (e.g. "Zero Harm" policy).	• Models of risk tend to go stale over time. What may cause incidents today can be very different from before the introduction of a particular technology or operational change. Without trust & confidence that people are in this together, there's no basis for learning and improvement of any of this.

### Typical *Traditional* Safety Interventions in a Centralised Control Structure

Work of Safety	Official Justification	Reason for Safety Team Disenchantment
• Surveillance of work	• Identify deviations that lead to unsafe outcomes	• Surveillance only provides distant, fragmented view of work
• Hazard and Risk Analysis	• Analyse the factors and permutations of failures that can lead to unsafe outcomes	• Manipulation of ratings to satisfy a-priori demands or constraints
• Implement controls	• Put in more barriers or controls to manage hazards	• Workers see controls as 'big brother' and obstructive
• Monitor compliance	• Control worker behaviour through more surveillance, audits, controls and policies	• Workers will do things their own way when you're not watching
• Delegate authorities	• Safety decisions to be made by line managers and safety people	• Line managers get listened to more than safety people
• Implement safety culture campaigns	• Standardise values, attitudes and beliefs with slogans and posters to prioritise safety above over all else	• The organisation has other priorities than safety, despite what it says , otherwise it wouldn't exist
• Record & report deviations	• Tallies of deviances for different stakeholders	• Abstracted numbers pushed up the organisational hierarchy to fulfill bureaucratic accountability obligations & manage liability.

## When WAD is Different to WAI: Do ‘Learning Teams’ – Conklin/Dekker

Process of a ‘Learning Team’	
1. <b>Seek potential learning targets</b>	<ul style="list-style-type: none"> <li>Any Near Miss or success, where the organisation does not know or understand fully what happened</li> </ul>
2. <b>Select or invite a group of workers to be a member of this learning review</b>	<ul style="list-style-type: none"> <li>Find people who know the work activity who are interested in improving the work environment. Bring in people with special expertise if needed.</li> </ul>
3. <b>Schedule two meetings with a gap between meeting #1 &amp; meeting #2</b>	<ul style="list-style-type: none"> <li>Schedule 1 or 2 days time delay between meetings #1 &amp; #2. These allow the group to separate problem identification from solution generation.</li> </ul>
4. <b>Spend meeting #1 on framing a problem statement</b>	<ul style="list-style-type: none"> <li>This is the most important meeting of the two. Don’t be surprised that the group’s identification of the problem statement differs to that of leadership (LTs are able to look outward with a more informed understanding).</li> </ul>
5. <b>Take some ‘soak time’ to think about what you identified as the the problem</b>	<ul style="list-style-type: none"> <li>The gap between meetings allows the group to review and think deeper about the problem. Very productive and brings in content missed in meeting #1.</li> </ul>
6. <b>Spend meeting #2 reviewing the problem statement, and start generating solution ideas</b>	<ul style="list-style-type: none"> <li>The solution ideas will often generate content where workers have thought about for years!</li> </ul>
7. <b>Have the Learning Team prioritise the solution ideas</b>	<ul style="list-style-type: none"> <li>Have the group prioritise into “Immediate”, Medium-Term” and “Long-Term” lists.</li> </ul>
8. <b>Micro-experiment these solutions in a safe-to-learn / safe-to-fail environment</b>	<ul style="list-style-type: none"> <li>Prototyping allows data collection and movement to more sustainable solutions. It’s exciting for the group.</li> </ul>
9. <b>Present information to leadership</b>	<ul style="list-style-type: none"> <li>Tell the stories to leadership, which will be impactful, and will breed more success.</li> </ul>



## Evaluation of Learning Teams vs Root Cause Analysis – UK NHS Incidents

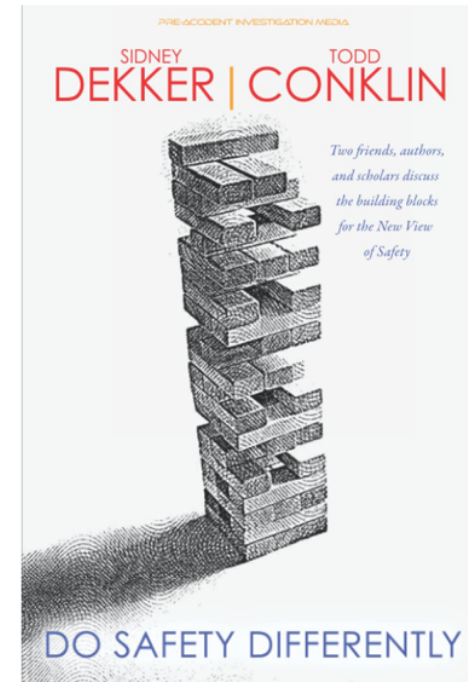
- Published in the [‘Journal of Patient Safety’](#), Vol. 17, Number 8, December 2021
- Retrospective mixed methods evaluation of Learning Teams compared with Root Cause Analysis
- 22 LT investigations compared with 22 RCA investigations, with quantitative assessment of the number of ‘system-focused’ and ‘person-focused’ actions generated
- Methodology assigned was not random. LT were initially selected for cases judged to have process-focused problems
  - LT investigations yielded a median of 7.5 actions, compared to 3.5 actions for RCA
  - 57% of LT actions were system-focused, compared to 30% for RCA
  - Variations in personnel involved, culture of the investigation and differences in the investigative approaches are potential drivers for the quantitative differences observed
- Conclusions:
  - Learning Team investigations that target process-focused problems generated more actions overall, and a higher number of system-focused actions
  - There is a difference in culture (*sic. more open-minded*) created during learning team investigations
  - Although Learning Teams are not suitable for all investigations, they represent a readily reproducible and valuable addition to the investigative toolkit.



## Response to Unnecessary Safety Clutter – Conklin/Dekker

### Ways to Push Back...

1. Most of your safety clutter is self-imposed. You have the power to change it.
2. A lot of Safety Clutter is knee-jerk to traditional incident investigation outcomes.
3. Resolve that for each new rule you put in, you take at least one out (or more!)
4. More internal rules do not equal better legal protection.
5. The more self-imposed rules you have the more you will be found out of compliance!
6. Start decluttering by asking “*what’s the most illogical thing we’re asking you to comply with to work here today?*”
7. To declutter ensure you only have operational people in the room . Others can have their say later.
8. You can safely declutter by making sure that rules must have directly traceable to a regulation, law or government requirement.
9. You can safely declutter by micro-experimenting.



## “Freedom in a Frame” – Conklin/Dekker

**“Freedom in a Frame”** – set the boundaries for your people to have the freedom & discretion to work within (professional autonomy & trust)

### Three pillars of motivation:

- Autonomy – the ability to control & direct your work (what, when and with whom)
- Mastery – the ability to develop your own knowledge, skills & expertise
- Purpose – the sense that you’re part of something larger, together with others

### Prussian Army – Field Marshall von Moltke (1869)

1. Don’t order more than necessary and avoid planning beyond the situation you can foresee.
2. Subordinates are justified in modifying or even changing the task assigned, as long as it supports the higher commander’s intent.
3. Look for those who have willingness and a joy at taking responsibility for others and for the work they need to jointly accomplish. They like taking ownership and take pride in doing so.

