Social SENSEMAKING

A Reflective Journal; how we make sense of risk

ROBERT SAMS

UP OVER FAR
NEAR HERE THERE

I KID YOU NOT!

TOWN

ADVENTURE

FIRST EDITION

Social
SENSEMAKING
A Reflective Journal;
how we make sense of risk
ROBERT SAMS

To Laura

While I would never wish harm on you, I also know that wrapping you in cotton wool to protect you from all that the world has to offer would stifle your learning and being.

May your own learning adventure in life be filled with love, understanding and plenty of *Social Sensemaking*™.

Dad

And in memory of Beavo and George.

"Even when we share the same values and try to live in harmony with the same virtues, we won't always agree with each other about what's right and wrong in particular cases. But wise decisions will always acknowledge our interdependency: our moral choices are ours alone, but they bind us to all those who will be affected by them. So deciding for yourself what's right and wrong does not mean deciding in isolation. Though we may sometimes feel like independent little boats bobbing about on the surface of some trackless ocean, we are actually more like the strands of a vast, evolving web. We depend on our connections with each other for our sense of identity, morality, emotional security and psychological well-being; in that sense, we belong to each other."

Hugh McKay in:
Right & Wrong (2014, p. 283)

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Foreword

By Dave Collins, publisher of www.safetyrisk.net

I quit 'Safety', as I knew it, in 2009, a decision that I now recognise as significant in my life. I reflect on this decision and contemplate just what it means to work in risk and safety. This reflection is critical in my learning, growing and developing as a person.

As you read through this book, there are many references to reflection and taking time out from planning, acting and reacting, in order to try and make sense of our busy, and at times messy lives. As I continue to reflect on why I quit 'Safety', I recognise that it is this messiness in particular that seems to trouble our thinking in risk and safety.

The last 2 years of my career in Safety were in a senior role with a large consulting firm. Before that I'd been in various production management, corporate risk management and insurance risk assessment roles that I enjoyed immensely. I learned a lot about people and risk, or so I thought.

By 2007 I was managing my own consultancy when a generous offer was made to lure me to a large safety consulting firm. They paid me to hand over my clients and commit to two years on their payroll. I count those two years as the worst in my life, from both a career and personal perspective. I won't go into detail here but many a true word about consultants is said in jest; I quit after two-years and one day! I walked away from 'Safety' and resurrected my business.

Even though I wasn't working directly in 'Safety' anymore, I still felt like I had a lot to share so I started my blog (www.safetyrisk.net). This was a way to give the many safety resources that I had collected back to people who would benefit. I put up hundreds of pages of traditional safety stuff like slogans, gory accident photos, PPE reviews, checklists and risk assessments. I even called myself "the Robin Hood of Safety".

The blog was, and remains, hugely successful, but for all the wrong reasons! I thought I was doing something for the Safety industry but as I reflected, I realised what I was doing was promulgating the same old stuff and deep down I still had that gut feeling that something was missing.

The turning point for me and the blog, was when the late George Robotham started writing in 2011. George had a long career in Safety in some tough environments. He was practical and he told it how he saw it. George and I became great mates and at last I felt I was part of making a real difference in risk and safety, but still something was missing.

In 2012 a guy called Dr. Robert Long wrote a comment on an article titled; *An Awesome New Safety App*. He wrote: "Sorry not awesome, pretty ordinary". Little did I know it but that comment was soon to send my life and that of many others, off on a most amazing trajectory!

Dr. Long has since written hundreds of articles and I cannot begin to express how profound an impact he has had on me and the readers of the Blog. I know Dr. Long has also heavily influenced the work and thinking of Rob Sams; this will become evident as you read through the book. Dr. Long helped me realise that something

wasn't missing, *everything* was! Not only did I have a lot to learn but I also had even more to unlearn!

This "psychology mumbo jumbo" that Dr. Long wrote about had George and I quite perplexed until one day we met over lunch and started discussing a few of his recent articles. George suddenly turned to me and said "You know I think this bloke is onto something"; he was right!

Sadly, George passed away suddenly in 2013; a heartbreaking day; however, George left an incredible legacy which is well articulated in an article by Phil LaDuke, which you can read here: http://www.safetyrisk.net/why-the-death-of-george-robotham-matters/.

In 2013 I received an email from Rob Sams. He told me that he was a student of Dr. Long's and would be grateful if I would publish an article of his called "*Piggy in The Middle*". That was followed quickly by "*My Story is Better Than Yours*"; "*Are you a Safety Leader or a Safety Crusader*" and "*I'm Just Not That Into Safety Anymore*". These and many other articles by Rob have proven to be the most popular articles I've published.

Rob's articles touch some nerves as they tell stories and reflections from his past in the context of his current learnings and in a way that many of us can easily relate to. He has managed to translate many of the complexities of the *Social Psychology of Risk* and certainly helped me to crystallise many of my own thoughts about it. I affectionately call Rob the "Risk Whisperer"!

In 2014, I had the incredible honour of speaking at the launch of the new book *Following-Leading in Risk* by Dr. Long and his long-time confidant Craig Ashhurst. The lead up to the event was nerve-racking for me, given the huge audience of safety thinkers present. However, thanks to reading an article the night before by Rob Sams; "*Reflection Makes Sense*", I realised that never before had I been given an opportunity to speak to an audience who all appreciated risk, improvisation, conversation and fallibility.

I rejected the sunk cost of my prepared speech and just winged it. I spoke for the first time publicly of my venture into the world of safety consulting, the challenges, the cognitive dissonance, the mentors, the disdain for traditional safety, my ultimate demise and then my resurrection through starting my blog.

The icing on the cake though, was the number of people who told me how they had been following my blog for years and enjoyed its transformation from a bulletin board for traditional safety to a source of inspiration, information and learning. They told me how they couldn't wait to read the new posts and share them with peers.

I count that moment as a career highlight, I arrived home that night having had an incredible burden lifted from my shoulders.

One of the best ways that I can introduce Rob Sams to you is to recall a comment that he recently made on my Blog that seems to sum up my own journey perfectly and I simply could not have put it better myself:

"I like to steer away from the word 'safety' now and instead think about dealing with risk. On my reflection of 'traditional safety' over the past two years, after a lifetime working 'in it', I see so much control, obedience and use of power in an attempt to limit people's freedom. I'm hoping that by understanding people better, both ourselves and the influence of our social arrangements and environment, that we can become better and more free people at work. There is such a seduction to want to reign in and control people to obey, but what Social Psychology has taught me to think about is the trade-offs and by-products that come from this approach."

My unlearning Safety journey has definitely been a highlight of my career and I thank Rob Sams for guiding me, inspiring me, educating me and listening to me. I appreciate our friendship.

To all the '*Safety Crusaders*' I have locked horns with over the years, I empathise with you, your fears and tension, that once was me. Only now do I see how ignorant, yet challenged I was. However, I now recognise this as a feeling of dissonance. It was that churning in my guts, and feeling that there had to be a better way, yet being stuck in what I knew. It was response to this feeling that started me on my current journey and I hope it does the same for you.

I am delighted to write this Forward to Rob's first book, we have become great mates, and this is even more special as we rarely see each other, but instead share mutual admiration, thinking and reflections. I commend this book to you and wish you well in your own '*Social Sensemaking*'.

Preface

Have you ever thought to yourself after something unexpected occurred or after hearing of an accident or mistake; "*That just doesn't make sense to me*"?

If you have, you've probably also asked questions like "*Why would someone do that?*" or "*What were they thinking*"?

Human beings have long been fascinated with the question of '*why we do what we do?*'. For some, the desire to understand this becomes a lifelong quest. For me, it was a fascination with this question that lead to me to commence a *learning adventure* to better understand people and risk. It is my reflection of this adventure that I wish to share in this book. That is, how we make sense of risk through a means that I've coined *Social Sensemaking™*.

Understanding risk and people can be quite a challenge, especially when we are trying to understand risk from the perspective of 'others'.

For example, how would you respond if you were to hear of someone who: sky dived; drove a fast car; fell in love; married; left a marriage; got married again; ate fatty/unhealthy food; drunk alcohol; smoked a cigarette; and/or, turned their back on their profession after working in it for 20 years?

The activities listed above may, for some people create anxiety (*How could you?*). Alternatively, they may elicit excitement (*I can't wait to…*) and for other people the feeling may be neutral (*so what?*). So what can this teach us about risk?

It is a common misconception that the way we think and feel about risk can be simply described in one way or another, that is; risk is either good or bad (binary) or perhaps neutral. We can be easily seduced into thinking that risk is objective and easily understood, but how can it be?

Here's a really challenging concept that goes to the very heart of this book.

What if I was to propose that perhaps for many situations, the feeling of, and our thinking about risk, is messy, complicated and constantly changing? Further, what if I suggest that it is only through our relationships and connection with others that we can start to make sense of risk?

That is the thesis of this book; making sense of risk is a social activity. In other words, people as individuals may have changing, conflicting, or even co-existing views and feelings about risk in their lives. Risk can often be simultaneously attractive, terrifying, rewarding, punishing, non-eventful or a mixture of these feelings at any one time. Understanding and dealing with risk can be messy.

However, when we '*sense-make*' things (ideas, feelings, thoughts, viewpoints) with others through communing and when our aim is for exploration, understanding and enquiry, we can make better sense of risk.

So why cite the examples of risks listed above? It's simple really, it's because I can relate to all of them personally as these are all activities that I have done.

I can recall from personal experience that some of the activities described were the toughest and most challenging periods in my life so far. Others were the most fantastic and enjoyable experiences. A few were terrifyingly exciting, while some were frightening and harmful.

I now recognise that it is really only after reflecting on and learning from risk activities in my life, that I can begin to understand that such experiences have contributed to me growing, maturing and developing as a person, however painful, thrilling or uncertain they were at the time.

I also reflect and realise that it was through making-sense of things with others that was possibly the most helpful of all activities in which I participated. But would I seek out such feelings of pain and suffering again, in order to continue to grow and develop?

Very few people I know actively seek harm, misfortune or pain on either themselves or others. However, there is a growing body of research (for example Barbara Fredrickson's work in *Positivity*, 2009) that helps us understand that experiencing uncertainty (risk) and pain, as well as a range of positive experiences, are essential if we are to learn and develop as humans. In a sense we have to allow pain and suffering (and all that is in between) to co-exist in our lives if we are to find meaning, purpose and fulfilment.

So I guess the answer to my question is that by 'accepting' pain and suffering it doesn't mean I desire it as such, however I do welcome the learning from future pain and suffering, whatever that might be.

Through my conversations with many people over the past three years, I understand that this paradoxical challenge is one that most people find difficult to comprehend, particularly those who work in my 'home profession' of risk and safety.

My aim is that, through sharing my reflections of a learning adventure, I can support those who share the quest to better understand people and risk, and to further explore; *why we do what we do*.

Welcome to *Social Sensemaking*. I hope that you enjoy reading through the reflection of my adventure as much as I have living it.

Acknowledgments - Friends, Family & Influencers

I am grateful to have shared a '*learning adventure*' in the *Social Psychology of Risk*[1] with many people over the past few years. A list of acknowledgements could continue for pages, and for those people I've not mentioned, I hope to share my thanks with you in person.

Firstly, my remarkably patient, supporting and loving wife De; she has encouraged me in so many ways. It is through our many conversations where we search for 'the truth' to the many questions of life that I have learnt so much.

To my mentor and teacher Dr. Rob Long who receives a special thanks below. Also to

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1. The *Social Psychology of Risk* is a term coined by Dr Robert Long who, to my knowledge is the first person in the world to bring these terms together, certainly in a formal learning environment.

Rob's special brother Graham who, through his amazing wisdom, thoughtful words, human/ fallible actions, infectious chuckle and powerfully moving book *Love Over Hate* has provided much inspiration to me and to so many others.

To Craig Ashhurst who, while playing a support role in the formal learning setting of University, has been instrumental in helping me understand some of the more complex topics. Then in the less formal setting of friendship, provided a great personal support during the most challenging times.

To my dear friends and fellow students; Gab, James, Max, Hayden, Dave C. and Dave W. and Scott, along with many others, you have left me with no doubt that learning is a social activity. Our friendship and *Social Sensemaking* have been a critical part of the adventure. Thank you especially for your contributions to this book.

To Ron Gantt, who after our initial discussions about providing a critique of the book, agreed to write a Chapter of his own. I thank you both for your time and wise counsel and look forward to a continuing friendship.

In particular, I thank Max Geyer for his guidance, counsel, patience and attention to detail in preparing the book. Max challenged, questioned and suggested many of the ideas and details in the book, and for this I'll be forever grateful. Further, to my good friend Roy Fitzgerald, who offered valuable advice and a second edit of book. Your thoughts, ideas, and importantly time are most appreciated.

To Aaron Westwood for your support in many projects over the years; our '*yin and yang*' approach has provided me with some great learning. To Shona and the team at Harris Farm Markets who have provided a great theatre to practice and implement *Social Sensemaking*. Your faith and trust in our approach has been instrumental in our learning.

I also thank Wendy, Ron, Missy, Glenn, Kasey, the Clouto's, and Hodgy for their support and permission in sharing a reflection of my special friendship with a best mate, Beavo. Sadly missed, but always remembered.

Finally, thanks to all of my family, especially Mum and Dad (Patty and Wayne) for contributing to the person I am today. That is, a person with the patience to listen, the aptitude to ask questions and the spirit to challenge ideas; all in an attempt to make sense of things. I thank you also for the courage to take the risk of then presenting my thoughts here for the world to critique! You've taught me so much.

In many ways, this book is about sharing publically my thanks, and love for, everyone who has touched and affected my life in so many ways.

A Special 'Thank-you' to Dr. Rob Long

I could not begin to write this book without first acknowledging and reflecting the influence that Rob Long had had on the *learning adventure* described in this book. Rob, who is Australia's leading expert in the field of *Social Psychology and Risk*, had a vision to start a Post-Graduate learning program and in June 2013 this vision became a reality. I thank Rob for his mentorship, guidance, personal support, friendship and for 'scaffolding' my learning.[2] I, like many others, am indebted to you and appreciate all that you have done and given.

You can learn more about Rob and his work at www.humandymensions.com and he can be contacted on admin@humandymensions.com

What I mean by key terms used in this book

- **By-products:** are either the intended, or unintended outcomes that become evident after a trade-off (see below) is made. In respect of risk, this refers to decisions made as a result of trade-offs about risk.

- **Cognitive Bias:** this is a critical term to understand. Our decisions are impacted by more than 250 different biases that mainly derive from our unconscious. Well known examples include hindsight bias, representative bias and availability bias.

- **Cognitive Dissonance:** is a theory advanced by Leon Festinger and refers to the uneasiness that we may feel when we are caught between conflicting feelings and thoughts as we seek to maintain consistency in those thoughts.

- **Collective Mindfulness:** was developed by Karl E. Weick and Kathleen Sutcliffe and refers to a construct outlined in *Managing the Unexpected* (2007). Weick and Sutcliffe's model refers to five key elements including: 1) a preoccupation with failure; 2) a reluctance to simplify interpretations; 3) a sensitivity to operations; 4) a commitment to resilience, and 5) deference to expertise.

- **Conscious Decision Making:** when mentioned in this book, is most often referring to the idea that some of our decisions seem more rational, logical and analytical than others. It's these decisions that I refer to as 'conscious'. It may be easier to think of 'Conscious' decisions are those that we are most easily aware of, or realise we are making at the time we are making them.

- **Heuristics:** are essentially 'mirco-rules', or 'mental short-cuts' that support us to make decisions more easily and quickly. These 'short-cuts' are often derived from experience and through trial and error from previous decisions.

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2. 'Scaffolding' is an important part of the role of an educator who, while considering the learning program for learners considers facets like readiness and preparedness when considering the most appropriate learning path. It is this concept of 'scaffolding' that Rob applies and that I am grateful to have been taught and now put into practice myself when considering how I support the learning of others. See http://edglossary.org/scaffolding/ for further details.

- **Non-Conscious/ Unconscious Decision Making:** refers to decision making that is often done 'behind the scenes' and without us being immediately aware of them at the time. It should be noted that the term sub-conscious is rarely used in this book; rather unconscious and non-conscious are favoured. This is mainly due to the association of 'sub-conscious' to the work of Sigmund Freud who, in his work on Psychoanalytics, tended to use the word 'sub-conscious' in a more negative sense and depicted it as evil; whereas my understanding and use of the unconscious is considered in a more positive (Jungian) sense.

- **Obedience to Rule:** Throughout this book the term 'obedience to rule' is used regularly. It is important to note up front a short definition of this term as used here. While I recognise that 'obedience' in its own right is required and important (for example, I am 'obedient' to the vowels I made with De when we were married and that is important to both De and I, 'obedience to rule' when referred to here means something different. It means a blind 'obedience' to instruction or rule, even when such rules and instructions do not make sense, for the sake of compliance and 'obedience to authority', rather than through faith and love (as is the case with my marriage). Further, I refer to 'obedience to rule' when I think of 'non-thinking' approaches that are often encouraged by organisations.

- **Paradox:** is where two things (beliefs for example) seemingly are not able to co-exist, yet do. The term itself is derived from the Greek word "*paradoxon*", which means "contrary to expectation, existing belief or perceived opinion". For example one of the most famous paradoxes is called the liar's paradox, and is evident in the following sentence: "This statement is false." Accepting the concept of paradox, and that many things in life are not clear cut and binary, is a key theme of this book.

- **Perception:** this refers to how we see, view and understand the world. Due to our varying backgrounds, experiences, sight and view, we all see the world in different ways, and this is the same with risk. Perception requires an interpretation of the world through our senses.

- **Priming:** is an effect that influences our understanding and hence responses. For example 'priming' may occur through words, symbols, smells or sounds, with all of these things impacting on our unconscious and therefore decision making, including decision making about risk.

- **Risk:** when used in this book refers to uncertainty and chance. Risk texts usually define risk through likelihood, consequence and severity. The concept of risk proposed here is one with an understanding and acceptance of the role that chance, emergence and subjectivity has on risk, rather than just on mechanistic, objective and somewhat fixed, traditional approach.

- **Risk Homeostasis:** was first referred to by Gerald Wilde in his book *Target Risk* (2001). In its simplest form, the theory is that everyone has their own specific understanding and views on what is (and isn't) an acceptable level of risk.

- **Sensemaking:** when we refer to 'Sensemaking', we are heavily influenced by Professor Karl E. Weick and his work on '*Organisational Sensemaking*' which is focused on understanding and dealing with ambiguity and uncertainty.

- **Social Psychology:** while more comprehensively defined within the text, a simple definition is that it is the study of understanding people, our social environments and arrangements and how these impact on our actions.

- **Systems:** The word 'systems' is referred to extensively throughout this book and like many words its definition is contextual. When referred to here, in the context of risk and safety, I am referring to systems that are usually fixed, focused on control (rather than encouraging thinking) and typically 'paper based'. Further, I make note that such systems adopt an approach where people need to fit in with the system, rather than the system meet (and be understanding of), the needs of people.

- **Trade-offs:** refers to factors that are 'given up' when making a decision about one thing or another.

- **Wicked Problems/Wickedity:** Is a relatively new field of research, led in Australia by Val Brown (*Tackling Wicked Problems, 2010)* and refers to problems that are unsolvable, yet are able to be 'tackled'.

Section 1

WELCOME AND INTRODUCTION
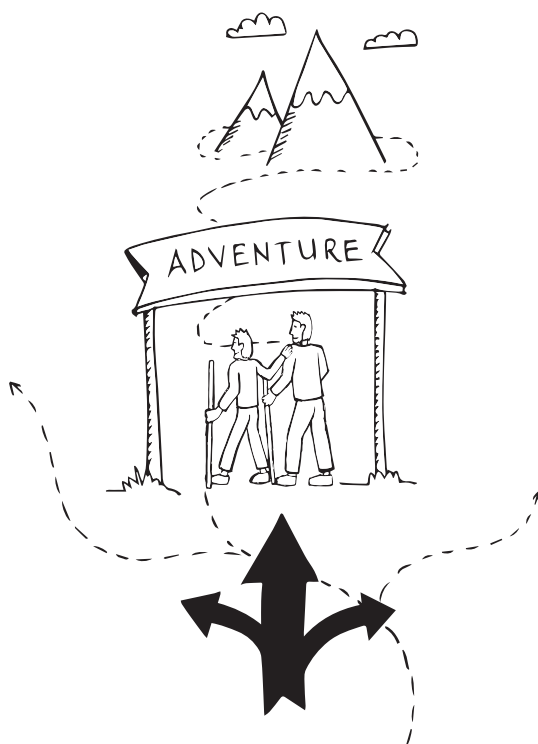
Chapter 1 – Reflections of a Great Mate

By Robert Sams

Risky backyard cricket

Mark Allen Beavis (Beavo) was born on 3rd of August 1974. Son to Wendy and Ron, and brother to Melissa (Missy) and Glen; Fiancé to Kasey, and mate to many. Beavo to me was a special friend.

Our friendship epitomized a 'love/hate' relationship. For most moments, we loved each other dearly, like brothers. Yet at other times we frustrated each other with great passion. If ever there was to be a friendship that could be described as a paradox, ours was it. It was special!

Beavo and I first met in 1983 during our first day of Primary School. We were in Year 'Three T' under the Tutorship of Mr. Phil Taylor. Beavo and I hit it off immediately; laughing and sharing stories; forming a bond that would continue for many years to come. We struck a chord with each other, the way you do when you meet a best mate.

Beavo and I shared in many memories. From playing 'puddocks' (a form of cricket) in the bottom playground at St. Josephs East Maitland, to moments at the sports shed near the incinerator (what happens near the incinerator, stays near the incinerator…); to Friday nights watching the Footy; to singing our rendition of The Beatles *A Hard Day's Night* at the School concert in Year 4; through to playing 'Miami Vice' in the bush behind Beavo's house in Verdant Drive. Beavo and I were best mates.

There were mostly good times, coupled with occasional battles. We regularly argued, then laughed; we debated, yet so often shared views; we sang yet also cried; we fought and later hugged; we loathed and then loved. That was the nature of our relationship. Beavo was a dear friend and taught me so much.

Beavo was also a smart bloke who excelled through school with considerable ease. His intelligence was obvious (and envious); he could pass an exam on the basis of a great mind and memory. Beavo was also passionate and lovable. If he were to pick up a cause, it would have his full backing. For example, in later life he would become a 'Labor Man', through and through.

Beavo valued relationships. When people in authority focused on their relationship with Beavo rather than seeing him as subservient, things were just fine. However, at times, he was also challenged by authority. For example, he respected many of his teachers and in return was much respected by them, however, if you showed him no respect or regard, he was known to 'play with you'.

I loved to join him in the fun on many occasions. For example, when we used to go into our classroom and lock the door, and then jump out through the window so that when the teacher arrived, they would have to head back to the office to collect keys, thus creating a good 10 minutes more 'play time' rather than sit through boring lessons in maths. I reflect now and recognise that the teacher didn't respect Beavo, rather his focus was to try to control him; was it any wonder Beavo went out of his way to cause trouble in return? I can also recognise many moments of 'social learning' in those moments of 'play'.

Beavo also had a dislike of silly, irrelevant rules. However, he did have a keen sense of justice, fairness and respect for relationships.

I recall a particularly memorable occasion where he felt these things were tested. It was in the latter years of high school when our school library introduced a system to detect books being stolen from the library. The new process was introduced with a whole lot of hoopla around not being able to trust students, so the school was forced to implement a new system.

No-one was quite sure at the time, how the system worked, but what we did know was that if you tried to take a book from the library without checking it out through the system, a buzzer would sound and you were busted. Not particularly happy with the school's sense of distrust for its students, Beavo and I went about giving them a lesson...

It didn't take us long to work out that the detectors were activated by a very small metal strip that was inserted into all library books. When you checked the books out of the library, it deactivated the strip, but if not, the alarm sounded. We came up with a plan to give the school a lesson of their own.

We ripped out a few of the metal strips from some books, then inserted them into our school ties and walked out of the library. Of course, the alarms sounded and we were both 'detained for questioning'. We hadn't stolen any books and the teachers could not work out what was going on.

Unfortunately, word soon got around about our trick and we were both caught. The result for Beavo was three days' suspension (due to some carry over offences) and for me weeks of detention. I have many similarly fond memories of great times with my best mate at school. There was much that we learned together through our adventures.

It's funny that I reflect back now and laugh at these stories. As I do, they provide much insight of the man that Beavo was to become; and help me reflect on my learnings about people and risk over the past few years.

After school, Beavo followed in the tradition of many from my home region and started an apprenticeship at BHP in our beloved steel town of 'Newie'. Beavo was a 'Sparky' (electrician). It made sense that he would progress into a job that required some smarts, because while a larrikin on the surface, Beavo was the smartest bloke I knew, without peer. I loved Beavo.

After some years working at the 'Steelworks', Beavo moved on to work on 'the railways', with Speno Rail Maintenance. While I didn't work with Beavo in this job,

the many mates that he made while working there were testament to the great mate he continued to be.

Regrettably, it was also in this job where things changed forever.

On Tuesday 8th of February 2001, the care free spirit and life, that was Beavo, would come to an end. Beavo was sitting atop a rail maintenance vehicle which was travelling through northern NSW. As the train travelled under a bridge his head came into contact with the bridge. He went into a coma, and died a few days later.

The NSW Industrial Relations Commission in their report[3] on Beavo's death described:

> "The train was approaching a pedestrian bridge over the railway line that connected Federation Street to Schwinghammer Street in Grafton. Darren Thompson was on the walkway of C carriage. He called out several times to Mr. Beavis to warn him of the approaching bridge, however, Mr. Beavis did not respond. The back of Mr. Beavis' head hit the pedestrian bridge. Mr. Beavis died on 8 February 2001 as a result of the head injuries he had received."

Beavo pictured here with Fiancé Kasey at their Engagement Party. Sadly, they would not marry, however Beavo's spirit continues to live on.

Beavo was taken early. He is missed by so many, and his death impacted on our local community in a way rarely seen. Beavo's funeral was in the church attached to our primary school, and was attended by a large number of people, it was a significant day.

I carried Beavo for the last time that day, down that long aisle in the church where we had previously shared in much mischief as Alter Boys secretly hiding from the Priest and sipping the Alter Wine. This time it was the Priest presiding over Beavo's farewell to the world as we knew it. It was a heart-rending day.

Beavo was cremated. Putting his coffin on the trolley so that he may exit the (physical) world for good was gut wrenching. Beavo the person was gone forever, but there was no way that bugger would let his spirit leave us that quickly. Welcome to Beavo's wake!

It started out as a pretty sombre and quiet event, a few beers with mates sharing stories about Beavo (there was no shortage). As the lubricants settled the discomfort and the sadness lifted, the night became a celebration of a wonderful life.

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3. As accessed at http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/nsw/NSWIRComm/2004/.
html?stem=0&synonyms=0&query=speno%20rail%20and%20Regulator accessed on 12 May 2016

First it was group songs, Cold Chisel, Midnight Oil and if I recall correctly (you'll understand shortly why my memory of the night is a little jaded), some Beatles too. The lubricants continued, we were celebrating a special life and this would be no ordinary night. Then the real fun began!

I can't recall the exact time, but boy did it take people by surprise. Pete (Hodgy) Hodgson started it all. He suggested, let's have a game of cricket, one of Beavo's favourite sports (after his death, he was honoured with Life Membership at his beloved Norths Cricket Club). The cricket started in a fairly nonchalant way, with a few of 'us boys' joining in. We were in Beavo's parent's backyard where around a hundred or so people had gathered. We were having a great time lamenting; doing all of the things that Beavo enjoyed.

Hodgy is a real larrikin himself who everyone loved (and still do). The cricket was going along just fine, but Hodgy thought we could step it up a level. I still recall clearly looking up and seeing Hodgy 'ripping off his gear' and declaring *"Nude Cricket! This is how Beavo would have done it and would have wanted it, so let's get the gear off boys!"*.

Right there in front of everyone, including Beavo's parents, Grandparents and so many others, Nude Cricket began. It was an absolute blast, and a real tribute to a guy who never seemed bounded by the social norms to which we so easily conform. I suspect that had Beavo been present in person, rather than in spirit that night, he not only would have joined in, he wouldn't have waited nearly as long as Hodgy did to start it!

As I reflect back on Beavo's wake and the sight of Hodgy and so many others running around nude, it was really no surprise and it seems so fitting as a tribute to him. Beavo was a risk taker, he was so often the first in our group to try something new; smoking, drinking, marijuana, driving fast (very fast!). It's no surprise that the song played at his funeral was Kenny Rogers' *The Gambler*.

The Weston Bridge, NSW.

For instance, I remember one-night driving through the sleepy town of Weston in NSW, not far from where we lived. The town is between Kurri Kurri (where I was born) and Abermain. In order to get from one town to the other, one is required to traverse the Weston Bridge. The bridge is rather unique in design in that it has a curve to navigate half way through. The photo to the left depicts this.

You may be thinking, what's the point of this story and how does it relate to sensemaking?

You see Beavo was no ordinary driver, as he was no ordinary bloke. He took a slightly different view of posted speed limits than most other drivers. For Beavo, occasionally, they were a challenge to see how far he could travel above the posted minimum speed;

not necessarily a safe driving speed. As an indication, double the limit was usually considered a success.

On the one night that I can remember (and in honesty, there were many), we cracked that challenge, achieving the goal of 80km/hour in a recommended 40km/hour zone, while navigating the Weston Bridge. As I reflect back now, I realise there was a fair amount of chance (luck) involved in Beavo and I advancing beyond our teens!

There were many other times during our friendship that Beavo would push the limits. He was fun to be around, he dared to do things that I often baulked at; he challenged me in ways that made me feel uncomfortable at times yet I learnt so much. However, I also reflect and realise that Beavo 'lived', mostly as he would have wanted to live, that is as a carefree spirit.

I wasn't there on the train when Beavo died, but I've spoken with the guys who were. They were the same guys on top of the train, yelling in vain to warn Beavo of the upcoming bridge. I can only imagine how this image and associated feelings stay with them through their life. They tried everything that day.

The company too seemed to have sound safety practices and a number of 'controls' in place (as acknowledged by the Court), where it might have been expected that Beavo would not be on top of the train smoking a cigarette when he came to his death. What more could anyone have done for a bloke who saw rules and authority as a challenge? What's more, he enjoyed a ciggy and his freedom. Beavo lived a good life in the few years that he was with us and I don't imagine him being controlled, would have worked well for him.

It's hard to imagine what I would have done had I been in a risk and safety role and came across a fella like Beavo. I'm pretty sure in my 'heyday' of *control and crusading* in risk and safety (Section 7), people like Beavo would have been met with a myriad of processes, training, more training and discipline; I suspect he would even have been sacked. Some might argue that this could have been a good outcome as at least he would still be with us. But would he have been? And what would this have done to a guy like Beavo?

As I reflect now, I can appreciate that at a very early age Beavo was clear about who he was as a person and what he stood for. He was free flowing and some might describe him as a 'wild child'. He didn't dislike all in positions of authority, but if you didn't treat him with respect, he could be a real challenge. The people in authority that Beavo respected were those who engaged with him, who sought his ideas and who shared theirs with him.

Beavo was smart, both intellectually and 'street smart'; he was also practical and hands on. It is likely that he would have known about risks and about rules and dangers, yet he still climbed up on that roof.

No-one can ever really know why Beavo did what he did on Tuesday the 8th February 2001, and many will wish forever that he didn't get on top of that train. However, that is the very nature of risk and human beings. There are some things we do, that sometimes just don't make sense, at least not at the time that they happen.

I doubt that Beavo would have been 'saved' by attending further training, instilling further rules or through discipline. He wasn't a 'stupid idiot' (as is often so commonly described in risk and safety) who made a choice to work unsafely. That would be the greatest insult anyone could portray of him. He most likely died because he didn't expect to come across that bridge on the day, not because of a lack of intelligence or awareness. Beavo was smart, he was intelligent and he was experienced, all of these things make understanding risk even more challenging. This goes to the very heart of this book.

So why do I include a reflection of my friendship with such a special mate at the beginning of this book?

If we want to better understand how we make sense of risk, Beavo is a great example of how an approach to dealing with risk that is focused on dealing with objects, numbers, rules, processes and binary thinking is limited. Instead, this book is a reflection on the importance of understanding people as subjects and beings, who often make decisions based on feelings. It provides an encouragement for more critical thinking in how we go about risk and safety.

I don't believe that any one approach to dealing with risk would have saved Beavo's life. I believe instead, that fate, chance and 'emergence' played a far greater part than a lack of 'Safety'.

Organisations, and people could have tried to control Beavo. Perhaps even, somehow they may have been able to prevent him from being atop that train on that fatal Tuesday in February 2001. However, I believe that would have just meant those control, and freedom-sapping efforts, would have 'killed' his spirit.

I miss Beavo and grieved after his death. There are still many occasions when I sit and reflect; sometimes sadly, sometimes while laughing but on most occasions with a feeling of peace. His was a life that provided so much for so many, and while most people would still love to have the bugger in our lives, it's hard not to feel that he achieved his reason for being on earth. I haven't played nude cricket since but would give anything for one more game with Beavo and the rest of the guys.

RIP Beavo, and thank you for helping me, in part, to make sense of things in life. This book is in memory of a best mate.

Samsy

Chapter 2 – A Learning 'Adventure' Begins

By Robert Sams

> "Life is either a daring adventure or nothing. Security does not exist in nature, nor do the children of men as a whole experience it. Avoiding danger is no safer in the long run than exposure."
>
> Helen Keller:
> *US blind & deaf educator (1880 – 1968)*

On reflection, and I suspect mostly unconsciously, I have been trying to make sense of Beavo's death for some years now.

I've certainly contemplated many questions related to what else could have been done. Was enough done? What controls could have been put in place? What was he thinking? What impacted his decision to climb on top of the train? Why did he do it? Why didn't the company stop it?

It is a key learning from my reflections over the last few years that helps me to now realise that these are probably not the right questions to be asking. In fact, these questions lead us to a view of the world that suggest that things can be controlled. This now has me pondering an alternative question; *what impact do such world views have on us, and how we relate to others?*

The question of how we make judgments and decisions about risk is captivating and mystifying. This is particularly amplified when you lose a best mate at such a young age. My grief at Beavo's loss has turned to intrigue.

This intrigue; along with a growing frustration of being part of an industry (in 'Safety'), that is fixated on controlling people; stifling their thinking and learning, has troubled me considerably for quite some time.

I've had feelings in recent years of anxiety, at what Safety was 'doing to people'; of frustration, at an industry that talks about care, but so often enacts fear. There has been a wrestling match going on in my mind, about the conflict between control and 'freedom'; the latter it seems is not in the grammar of Safety.

Thankfully though, there came a point where the wrestle ceased, or at least eased, and I made the decision that I no longer wanted to work 'IN' Safety. I no longer wanted to work in an industry that is focused on obedience to rule (and non-thinking) and has a blindness for humanising, and an ignorance of what it means to 'be' as a human. I was desperate for a change, I could no longer continue in Safety.

It was this desperation for change that lead me to search for a learning programme to help me better understand people and risk; essentially a search for a different way of not only working, but of living; one where the focus was on supporting, than to control people.

The *Social Psychology of Risk* programme, developed and led by Dr. Robert Long, (along with my extended reading) has been instrumental in my discovery of how

social arrangements impact on, and influence how people go about making decisions and judgments.

In June 2013, I began a *learning adventure* [4] in the *Social Psychology of Risk*, an adventure that I hope will continue for the rest of my life.

It is through this *adventure* that I've learnt about the way that we engage with others and how risk determines the effectiveness of that engagement. I've also learnt that if our aim is to support others to be able to discern and deal with risk, we must be aware of and be prepared to, suspend our own agenda when engaging with people.

This allows us to listen better, understand and respect the views and ideas of those we are talking with. If we don't suspend our own agenda, then we are likely to project it onto others and that may mean that they are less likely to lead in risk and safety, they are more likely to just follow directions, or indeed just clam up.

What I've seen is that this simply leads to 'obedience to rule', which in turn impacts on people's motivation and their ability to critically think and analyse what Deci (1995) refers to when he discussed '*self-determination theory*'. Those who foster 'obedience to rule' also foster non-thinking. Is it any wonder we hear so often in health and safety, people exclaiming: "*what were they thinking?*"

My learning adventure, in the *Social Psychology of Risk* has highlighted for me the importance that our social environments, our social arrangements and the context in which we interact with other people, has on how we make decisions, particularly about risk. I have come to realise that decisions and activities are not fixed and always controllable, they are 'situational', and continually 'constructed', re-constructed and de-constructed.

This adventure has also led to a deeper understanding of risk; both about its uncertainty, and about our strong craving as humans to manage and eliminate it. I am now extremely aware of our strong desire to rid ourselves of ambiguity and equivocality and to see risk as objective; while the reality is that risk is ambiguous, equivocal, uncertain and mostly subjective. And for this reason we are best advised to focus on discerning and tackling risk, rather than trying to eliminate it. Sounds easy, right?

Furthermore, we should also be prepared to accept risk in our lives rather than running from it as this stifles learning, it creates a sense of fear and reduces humans to objects, rather than 'beings'.

Social Sensemaking is a book written as a reflection of this learning adventure in the *Social Psychology of Risk*. *Social Sensemaking* is a term coined when a group of friends were sitting around talking about how we make sense of risk, as well as many other

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4. A special mention about the term 'adventure'. This came about during some work that my dear friend Gab Carlton (a contributor to this book) and I were doing together with a Health and Safety Team. We all agreed that the term 'journey' had become tired and overused, and further that it seemed too linear and straightforward. We instead wanted a term that described the 'messiness' that is life at times, a term that depicted ups and downs and most importantly a term that helped described the good times and bad, hence 'adventure' it was! The term adventure depicts something that is full of risk, uncertainty and fun. Contrastingly, journeys are usually mapped out and programmed – you'll understand my aversion to this as you continue through the book. The term adventure carries (semiotically) the feeling of risk with it. Whereas journey carries the sense that all is planned and known including the path, the timing and the destination. This is not the thing with life as it is not the thing with risk.

decisions in our lives. We were reflecting on how important it is to us all that we were able to share in our learning; ask each other questions; test each other's ideas and challenge thinking, all with the aim of making sense of things.

What is Social Sensemaking?

Social Sensemaking is literally making sense of things in a social context. With so many of our decisions and judgments impacted by (and made in) our non-conscious mind (Chapter 9); surfacing ideas, feelings and thoughts with others is critical in our discernment of risk. Importantly, if we are to 'make-sense' with others, we need to be aware of our own agenda in order to open our mind to new ideas and thinking.

The phrase itself, was coined to describe a manner of sharing, inquiring and communing with others in order to better make sense of the many 'grey', ambiguous and paradoxical aspects of our lives. So how does it work?

We can begin to understand *Social Sensemaking* by exploring the often talked about topic of 'common sense'. For example, people will suggest that in order to complete a particular task that you "*just need to use your common sense*" or, while in the full throws of hindsight bias, proclaim after hearing of an accident that "*anyone using their common sense would have known that was going to happen!*". I don't find this useful, or helpful or particularly valuable.

What do we mean when we suggest 'common sense'? How can we all have a common sense of risk (or anything)? Why would we expect others to have the same sense as us? Can you imagine a world where we all think and act in exactly the same (common) way? How, when we all have different backgrounds, could this even be possible? Why do we talk in such a manner?

It is much more helpful, supportive and beneficial to consider how we make sense of things (sensemaking). What is it that helps us to make sense of something when we are not sure? What is it that guides us to learn and 'know'? How do people go about gaining a sense of something that may initially seem uncertain (risky), unclear and ambiguous?

This book aims to provide some guidance on the topic of sensemaking and in particular, it's very social nature. So how have we come to this view?

Firstly, when I and the various contributors to this book talk of the term 'Sensemaking', we recognise that we have been heavily influenced by the work of Professor Karl E. Weick who has written many texts on the topic of how we make sense of risk. Weick is a social psychologist and his concept of 'Organisational Sensemaking' (1995) is a very helpful model in understanding how organisations can make sense of the often messy and contradictory nature of human decision making, especially when we gather and work together in groups, such as in companies, sporting clubs, service groups, church groups, car clubs, industry associations and the like.

Three of Weick's books; *The Social Psychology of Organising* (1979), *Sensemaking in Organizations* (1995) and *Managing the Unexpected* (co-authored with Kathleen Sutcliffe, 2007) have been pivotal in developing our understanding of human decision making and judgments about risk.

As you read this reflective journal you may gain a further sense of Weick's work and research.

A Reflective Journal

So why write a reflective journal about a 'learning adventure' in understanding risk?

I've worked in risk, safety and human resources for most of my life. In recent years I've noted much said and written about new paradigms, for both organisations and people, in doing things differently in risk and safety. There seems to be a greater desire to learn more about people, about how we make decisions and importantly, a focus on understanding just why it is that we do what we do.

However, despite the talk and promise of new ways and different ways, I'm left wondering whether things are changing that much at all?

If our aim is to understand *why we do what we do* (Deci, 1995), while we tackle the ever changing challenges of risk, perhaps we need to expand our thinking and understanding to fields of study and research that provide us with some clues about human judgment and decision making?

It has become clear to me that in order to better understand *why we do what we do* an understanding of Social Psychology should be an ingredient in the recipe of 'different'.

Without an understanding of the methodology and methods of Social Psychology, we run the risk of embracing an *anti-humanising* approach to dealing with risk. That is, an approach that is mechanistic and focused on efficiency and utility, rather than on 'being', 'living' and our inevitable fallibility.

An approach considering Social Psychology and humanising, is concerned more with love, with inquiry, with communing and with understanding humans as social *beings*, not *objects and resources*.

While the new approaches that I hear of might use *some* different language and talk more of understanding people and how we go about organising, mostly these approaches still seem focused on correcting behaviours and implementing more 'behavioural' controls. This in turn means being seduced by 'obedience to rule' (such as Golden Rules, Cardinal Rules, Company Rules, Safety Rules, Life-Saving Rules and others...) and all that comes with it.

The question that comes to my mind when considering an approach with a focus on 'obedience to rule' is: what does this do for how people discern risk for themselves? If the demand is that they follow rules at all costs, doesn't this mean that a natural by-product is less and less thinking over time?

Obedience to rule (non-thinking) and a focus on controlling others are not in my interpretation of *humanising*, instead they are oppressive and dictatorial. Humans are not motivated by such pre-occupations, rather, we are motivated by "*truth, value and control*"[5] (Higgins, 2014) and "*autonomy support*" (Deci, 1995).

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5. Note: in Higgins' research and findings 'control', refers to individuals having a level of control in their actions and decisions, rather than being 'controlled' in these things. Control in this context is in terms of 'self control'.

If the aim is for control through systems, defined behaviours and obedience to rule, then I don't think we are moving down a path that is very different at all.

So if you accept what I have proposed is a more useful path forward, let's now explore and define Social Psychology and what it has to do with risk and safety?

Hogg and Vaughan (2010, p.xxv) may provide some clues to the answer to this question when, at the commencement of their foundational text: *Essentials of Social Psychology* they explain that: *"We are all social psychologists – trying to understand why people do, say and think the things they do and why our social interactions play out as they do."*

'They' go on to describe that: *Social Psychology is the part of psychology that studies human interaction: its manifestations, its causes, its consequences, and the psychological processes involved."* (2010, p. 2).

And they further refer to the definition given by Gordon Allport, one of the first psychologists to focus on the study of the personality, who defined Social Psychology as; *"the scientific investigation of how the thoughts, feelings and behaviours of individuals are influenced by the actual, imagined or implied presence of others"*. (Allport as cited in Hogg & Vaughan, 2010, p. 2).

It is probably fair to suggest that Social Psychology may be considered a somewhat controversial field of study and further like most research fields, could be viewed as 'reductionist' (the search for one single cause or answer). If my focus of study in Social Psychology was to be purely for the purposes of research and science, I may share the same view; however this is not the path that I have chosen.

The approach that I have been wisely counselled to follow into Social Psychology is one that follows a path not strictly from a research, scientific, nor purely academic perspective. Rather my understanding of the key concepts and learning from Social Psychology are applied in a practical, as opposed to a theoretical setting.

My aim in learning from Social Psychology is not in pursuit of an answer as much as it is the search for the better questions.

This is a critical point and a key reflection for me. During my years working in 'Safety', the focus, and fixation, was on answers and solutions (e.g. 'root cause' and 'cause and effect'). This is what the Safety industry has become, focused on objects, rather than people. That is not going to help us better understand people and risk.

Indeed, rather than enhance our understanding of people, adopting reductionist approaches (reducing things down to parts) simply means that we become more ignorant to the multifarious and complex nature of what it means to be human, as we seek to simplify what it means to 'be'. It's much more enlightening (and fun) to search for the better questions, rather than seek answers.

With this in mind, it seems relevant at this point to pause for a short period to explore the term *Social Psychology of Risk* a little further. As noted earlier, the term was coined by Dr. Robert Long who; through a unique blend of formal qualifications, vast practical experience, extensive reading, along with an unmatched understanding of; education, learning, Social Psychology, fundamentalism, theology, risk management, safety management and academia, created a field of study and learning that is set to challenge the risk and safety industry.

It is the combination of these fields of research, plus Rob's many 'lived experiences' and work with a range of organisations, with leaders and many other people that make the *Social Psychology of Risk* a specialist field that may well stand on its own in the years to come. Bringing these factors together provides a more holistic approach to understanding how people make decisions about risk, and importantly of the impact of social arrangements on these decisions.

It is difficult to describe the *Social Psychology of Risk* through text alone. To assist with a better understanding of the term, I have included on the next page a 'map' developed by Dr. Long who notes about the map:

> The important distinction about representing a body of knowledge relationally (via concept map) is that it demonstrates the social nature of the knowledge itself. Rather than write a book with 50 chapters it is much better just to show what kinds of subjects, disciplines and researchers comprise knowledge in the *Social Psychology of Risk*.

<div align="right">

Source: http://www.safetyrisk.net/social-psychology-of-risk-body-of-knowledge-2/
as accessed on 05 June 2016

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MAPPING THE SOCIAL PSYCHOLOGY OF RISK
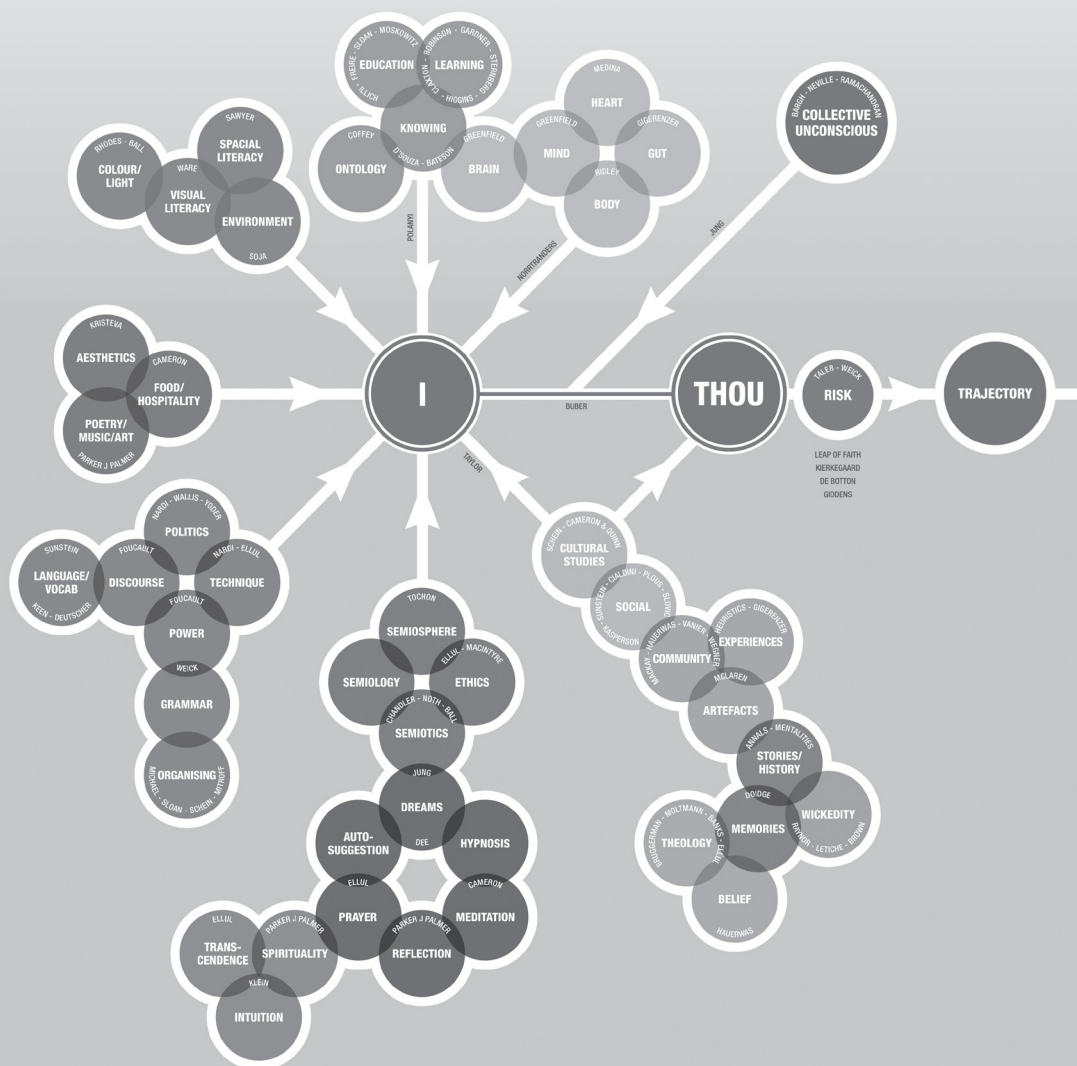
Figure 1 The *Social Psychology of Risk* Map© (Long, 2016) was developed by Dr. Robert Long and provides a semiotic overview of the composition of the *Social Psychology of Risk*

used with permission of Dr. Long

Thus my reflections in this journal are of how I have put these principles into practice, rather than simply reporting on research findings and theories.

Social Psychology as a field of study has a focus on the impact and influence that our social arrangements and environment (i.e. our social groups, social norms, cultures and sub-cultures; our interactions, dependence, independence, interdependence; our language, and the symbols, shapes and sounds of our communication) have on our decisions and judgments. Such social arrangements and constructs play a critical, yet often overlooked, role in how we make decisions and judgments. And in relation to our discussion in this book, these social arrangements and constructs also have a critical role in our decisions and judgements in risk , while still addressing the effect of our interaction with hazards (objects)?

So what is it about Social Psychology that can support us to move away from an 'obedience to rule' approach to dealing with risk?

Social psychology has a long history of exploring and understanding the dehumanizing approaches that are focused on obedience and control. There are many case studies, including the well-known work of Milgram (1961) and Zimbardo (1971) that help us understand the trajectory of obedience to rule (and authority), the impact of social arrangements and control.

Further, there are the real life stories of the power of obedience such as The Peoples Temple (Jonestown, mass suicide), the control of people through Scientology and more recently the events at Abu Ghraib and the treatment of Child detention centres in Australia, that inform us how influential social arrangements and constructs can be on how people live their lives, and importantly on the decisions they make.

So how may an approach (that considers Social Psychology) support an organisation and its leaders in their approach to risk and safety?

Firstly, it could help people who work the risk and safety field extend their current focus from one that is predominately on systems and objects (as hazards), to better understanding people and how we make decisions about, and interact with, such objects. Secondly, it will understand the critical role of the unconscious in our decision making and move to an approach that recognises that not all decisions are logical, rational and well thought out (see Chapter 4). Thirdly, it will understand that as 'social beings', we learn and make sense of things together with others and not in isolation, which is the typical approach adopted in traditional approaches.

The thing that most traditional approaches to risk and safety seem to preclude, ignore or fail to understand is: an understanding of social arrangements, an acceptance of human fallibility and critically, of the social nature of learning, development, growth and of course sensemaking. The current mechanistic and engineering centred paradigms of risk and safety just don't allow for, or consider these things, hence not much really changes.

Additionally, the challenge with these approaches is that invariably they don't match up with how people make decisions and judgments. We could easily (mistakenly)

think that all decisions and judgments are fully considered; they are made consciously, rationally and logically based on all the information available.

Why do I say mistakenly?

Social Psychology helps us understand that people are not machines or robots and we cannot measure their utility through outputs (reductionism). People have emotions, we act in ways that are often hard to make sense of, at least individually, and we are very heavily influenced by what happens in our unconscious and non-conscious minds.

Further still, we resist being programmed (i.e. to be obedient). And even when we are programmed to think and behave in certain ways, this does not make us immune from making mistakes, or from doing things that others may not expect or be prepared for. Human beings are fallible.

People often make decisions based on how we feel or on our intuitive, unconscious intelligence, as referred to by Gigerenzer as our 'Gut Feelings' (2007). But what else is it about Social Psychology that is critical to a better understanding of risk and safety?

Humans have a rich desire and craving for connection, to love and be loved, and to share in community with others (McKay, 2013). Programming and controlling people, even when it is in the name of 'care' or 'protection', seems anti-human to me.

When our approach is *anti-human* what can we really expect from the people in organisations?

This book is an attempt to explore and muse over these factors. The aim in writing this book is not to specifically criticise individuals working in risk and safety. Instead, it offers a critique of the traditional approaches and encourages further discussion and dialogue about how people working in these fields may best support others to discern and deal with risk for themselves. It does not offer a silver bullet or 'the next best thing' to dealing with risk and safety. Rather, it is to share some of what I have learnt through communing with others over a relatively short period of time.

This book has come about through reflections that have been recorded throughout the 'learning adventure'. Reflecting through journaling has become an important way for me to 'make sense' of things and to continue to contribute to my learning long after formal studies have been completed.

These reflections have often turned into Blogs, which are posted on my good friend Dave Collins' website[6]. I've found the process of both writing the blogs and reading the feedback, questions, and critiques, an important part of my learning. And to all those people who have taken the time and effort to read and comment on the blog, I am grateful. So it is the reflection on these blogs that form the basis of this book.

Front cover, drawings and photos

One of the key things that I've come to understand about Social Psychology and risk, it is the role, importance and influence of the unconscious to our communication.

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6. http://www.safetyrisk.net/

In particular, the significance of symbols and semiotics and how these, almost unknowingly impact on how we make sense of risk. With this in mind, the many images, photos and in particular the front cover of this book, have all been deliberately designed, and included, to convey the various key messages and learnings in the book in ways that move beyond text. Many of the images are hand drawn by the talents of Melinda Holme and Justin Huehn in order to keep with the spirit and nature of the book being a reflective journal.

Of course, in the spirit conveyed in the book, these items were not developed in isolation; *Social Sensemaking* was the method of choice in the design. One story in particular that I'd like to share is the design of the front cover.

The cover started as a conversation with Melinda and I, where we shared stories and ideas about what *Social Sensemaking* meant for us. This turned into several draft covers that were then shared with a group of close friends, Max, James, and Aaron who then came together to share thoughts and feedback on the covers that Melinda and I had drafted. I am grateful to those who participated in this exercise and for this experience, and example of *Social Sensemaking*.

Who is the book intended for?

I've heard from many people working in the risk, safety and 'people' (e.g. Human Resources) fields, who are looking for a different approach to the current methods used. In the 'traditional' approaches in these areas, the focus is usually on: legislation, regulation, systems, processes, engineering (solutions), law, objects and what seems to be a never-ending quest in trying to control behaviours and to instill obedience.

While many of these elements are important, if our aim is to better understand '*why we do what we do*', and if we truly want to better understand and support people in their work. It is critical that we better understand what this 'systems only' approach is doing to us in terms of how it influences our thinking, and discerning and management of risk. It is time to move on to a more holistic and humanising approach.

An approach to dealing with risk, that understands the *Social Psychology of Risk,* does recognise that systems and process are needed. However, it also understands that systems come with trade-offs and generate by-products (see Section 2), most of which we won't be aware of if we don't value reflection and critical thinking.

So how have the risk, safety and people functions come to act in this way?

These functionaries seem focused on reductionism (as put forward originally by Descartes and Newton) and control, rather than taking the time to understand people. By focusing mainly on objects as hazards, on compliance with laws and with engineering controls for risk, the by-product is that we create environments that limit thinking, that foster obedience and that focus on a numerical understanding of risk rather than accepting its relationship to people and the subjectivity and fallibility of humans.

We can see evidence of this through the number of organisations which encourage and seem to thrive on what Professor Patrick Hudson (1999) describes as a 'calculative

culture'. If your organisation thinks that safety is measured by the number of incidents that occur, this may be you.

To support people to better deal with risk, we need to encourage more critical thinking, a better understanding of people and more conversations where the agenda is about others, and not just us as individuals. We are after all social beings, there is no such thing as *I* without *Thou* (Buber, 1969).

The people who will find this book most useful are those who are looking to further explore how people make decisions and judgments about risk and who are wanting to understand how the non-conscious part of our mind is responsible for most of the decisions that we make; and most importantly, what this has to do with risk and safety. People may also find the book useful if they are looking for practical tips and thoughts on how they might be able to better support people to deal with risk more effectively.

Why has this book been written?

I've worked in risk, safety and human resources since the mid '90s. During this time, I have come to know a lot of people and I've heard the views of many who have become frustrated with how these functions are perceived.

Many of the people I know that work in the safety field got into it because they care about people. They are nurturing and well-intentioned people and they are often engaging and passionate. Yet, the realities of their role means that they rarely get to work with people and share this passion and kindness. Instead the focus of their work often turns to numbers, process and verification (aka 'arse covering'). They become known in their organisations as internal regulators (fun police), and people take a different view of them.

For example, a friend wrote to me recently and shared this story:

> When I introduce myself to people they usually ask the standard question; "So what do you do?" When I tell them I'm a Safety Advisor, it's really not often that I get a positive response. Most of the time people's faces change, and not in a good way. Their eyes scan me as though I am a different breed of a person. Sometimes they even step back slightly as if I've got some sort of highly communicable disease. Often they'll say something like "oh, you're one of those people." Or "And you seriously enjoy that?" Or "That has got to be one of the worst jobs in the world" or "How do you enjoy all of that paperwork?"
>
> Safety Advisor from an International Organisation (2014)

I also speak with Managers who argue that Safety demands that they must do everything they can to control people so that they do not hurt themselves at work. These people are known to say: *"I can't let dangerous things go untouched"; "I can't let people make choices that may lead to them being injured"* and *"doing everything that is reasonably practical means that I have to have systems, and people have to follow them"*.

These conversations typically end with something like: *"the law says that I need to provide a safe workplace, I'm not going to jail and risking my house just because someone*

doesn't follow a rule. All your fluffy stuff about motivation and decision making sounds fine, but I've got to follow the law, so I'll stick with implementing procedures, thanks anyway."

I find this sad and disappointing, but not surprising.

The question that I've learnt to ask when I hear this type of talk is: "*Where is this approach taking us;* that is *what is the trajectory of this language?*"

If being 'safe' is all about controlling people in our workplaces, we need to be aware of the trade-offs of controlling people's behaviour and actions (e.g. obedience and to rule and non-thinking). We also need to be aware of the by-products that these trade-offs create including stifling learning, innovation and flexibility. We need to understand the demotivating impact of these by-products and trade-offs for people who no longer have control over the decisions they make (Deci, 1995).

I know, and understand, that it is hard when you are in a traditional role in risk and safety to get away from the all-consuming systems, processes, controls, numerics and endless statistics and reports. It is expected of you, and even when you second-guess the value of this approach, it's often easier to continue, than to try to break the nexus and change thinking. Mavericks are not treated well in traditional environments.

You might think, so what?

I acknowledge at this point, that there may be some people reading this who feel that Mavericks should be removed, and that they have no place in society.

After all, it is normal, easier and an expectation that we conform in society. We are taught this from a very early age.

Consider our schooling for instance. As Paulo Freire writes about in the *Pedagogy of the Oppressed* (2015, Foreword): "*...in our own technologically advanced society, which to our detriment acts to program the individual – especially the disadvantaged – to a rigid conformity*".

We are expected to, and coerced into conforming. We often don't even know this is happening to us, with much of the 'coercing' done within the 'hidden curriculum' of our education 'system'.

Mavericks challenge the conformity espoused by many in society, and they can be disruptive. They often ask perplexing questions, they can generate tension and they may contest the status quo.

Some may do this because they are oppositionist ('look at me') or entrepreneurial ('there's money in this'), however for others, and I would consider myself in this category, it is because they believe that there is a better way. If 'Safety' is to be 'done', without a fixation on control, it may be that the best way to do this is to ditch the term 'Safety' altogether. If it is significant and drastic change (disruption) that the people working in risk and safety are seeking, could ditching the term accelerate such change? Perhaps this point is worthy of further reflection by those working in risk and safety.

For me, to disrupt by being a Maverick, is done with the intention of encouraging greater dialogue and critical thinking. You may be challenged by some of the ideas put

forward through the reflections in this book. If this causes you to reflect for yourself, then the intention of the book has been met.

If, however, this upsets you to the point where you cannot read on, that's ok too. As Ayann Hirsi Ali writes in her book *Heretic* (2015, p.18): *"They are not the intended audience for this book. They are the reason for writing it."*

So how do you deal with your own challenges and tensions?

That is the main purpose of this book; to support people who are interested in thinking about people and risk in a way that better considers what it means to 'be' as a human engaged in risk. It implores the reader to develop further understanding by learning to ask better questions; questions that may not have neat and tidy answers, but that do explore what it means to 'be' as a human engaged in risk.

The book offers lessons learnt through formal study, through reflection and through conversation and through *Social Sensemaking*.

It aims to promote critical thinking; to raise questions for us to ponder, and to ultimately encourage further *Social Sensemaking* in the risk and safety industry.

It is my hope that this book provides some incentive as well as space for you to consider how *Social Sensemaking* may work for you.

How to navigate through this book

The book is deliberately written in the style of a reflective journal and narrative rather than an academic study. The aim is to provide examples of experiences and thoughts on select key topics that you may find most useful in broadening your understanding of how humans go about making decisions and judgments about risk.

This is done by breaking the book into Sections with each including a number of Chapters. Each Chapter is devoted to one key topic. Academic referencing and style has been kept to a minimum, however a comprehensive bibliography is included, as is a suggested reading list to assist the reader to commence on a learning adventure of their own.

Typically, each chapter introduces key Social Psychological ideas or concepts, along with real life, and practical, examples of how you might identify the topic, that is, what you might see or hear. It then considers some practical tips and thoughts that the reader might find useful when further exploring the topic for themselves.

The book aims to delve into four key questions:

- What do we know about people, decisions and judgments?
- What do we know about risk?
- What influences our decision making and judgments about risk?
- How can we put *Social Sensemaking* into practice?

It is not necessary to read the book from 'cover to cover', rather it may be best to choose the chapters and topics that you are most interested in. The chapters have been deliberately kept brief to cater for those who struggle with time. If you are up for more reading, there are plenty of references included throughout the book.

Finally, each Chapter includes a short summary and suggestions for "*Further growing and developing the ideas in this Chapter*". You will be able to easily identify these sections with this symbol:

What this book is not — my apologetic

This book is not intended to be a 'textbook' on the science of the *Social Psychology of Risk*. Nor is it intended to be an exhaustive taxonomy of all learning that comes with a study of that topic. This book is also not intended to be an academic style text. It does not suggest answers to complex problems. Rather it shares ideas and learnings for the reader to consider and contemplate – ideally in a social setting, where *Social Sensemaking* can take place.

This book is introductory in nature and is a shared reflection of a learning 'adventure', at this point in time. It is a look back on what I have learnt to date, and I know (and hope) that even in the time it will take between writing and publishing the book that my views and understanding will further develop and mature.

I also expect that at some point in the future, I will second guess and contradict myself on some of the ideas included here. Not only do I find this quite liberating, I look forward to it; I know that this means that I will continue to learn, grow and mature as a person.

Let me reinforce, this book does not profess to be the 'next best thing', or the 'solution'. The ideas proposed in the many stories in this book are not a 'right' approach; they are not 'guaranteed'; nor 'perfect'. The pursuit of 'perfect' is seductive and dangerous; and I see that as witness to an approach to risk that understands that humans are full of contradiction and paradoxical ideas; and that our decisions and judgments are influenced by many factors, most of which we are blissfully unaware of.

Finally, a word about 'Safety'. While I acknowledge that for much of my working life I have been associated with Safety, you will note my intentional framing away from it and instead reference to words such as 'risk' and 'wellbeing' throughout this book.

While the reason for this may become obvious as you read on, the argument to make at this point, is that I feel the idea of Safety, in this day and age, brings with it a trajectory of control and policing. These are not ideas that I want to be associated with when I think of the wellbeing of people.

This book won't be for everyone. It may challenge some; others will dismiss it. But for some, it may create enough cognitive dissonance that their need to change becomes inevitable; it is especially for these people that this book has been written.

I'm no expert!

Finally, I want to be clear up front that I am not an expert in Social Psychology or risk. In fact, if you read Malcolm Gladwell's book, Outliers (2011, p.35), you'll glean from him that in order to become 'expert' in anything; one must practice the 'thing' for 10,000 hours. While there is much written about this idea, and some argue that Gladwell's idea is a fallacy, the key learning that I take from this is not from a scientific perspective, that is the numbers, but rather a more philosophical interpretation which is that to become 'expert' (or to want to be considered 'expert') at anything, hard work, over an extended period, is required. Gladwell makes this point well in framing up the Chapter on the '10,000 Hour Rule', by asking the question, *"is there such a thing as innate talent"?* (2011, p.38)

I recognise that I am part way into my learning adventure and still have many more hours of practice to go before I can be considered an 'expert'! To be explicit, I am not a Social Psychologist in the true sense of the academic model.

In saying that, I have completed the first stage (Post-Graduate Diploma) of my post graduate studies in *Social Psychology and Risk* and over the past three years I have read something like 200+ books, academic articles, reference documents and research papers. And I've watched numerous videos and spent many hours listening to Podcasts on specific topics that are covered in this book. I have also spent countless days sitting together *communing with others*; thinking, asking, challenging, learning, and making sense of things together, in the practice of *Social Sensemaking*.

Through all of this, the most important thing that I have learnt is that I now realise how much that I don't know and I find this quite liberating!

Finally, there is a level of risk and a sense of fear and of vulnerability in writing and publishing a book at such an early stage of my learning adventure and life. However, I also know that with the risk and associated fear will come still more learning.

I look forward to the conversations and further *Social Sensemaking* that may be created through the engagement of other 'learners' with this book.

Section 2

UNDERSTANDING PEOPLE, ORGANISATIONS & OUR DECISIONS
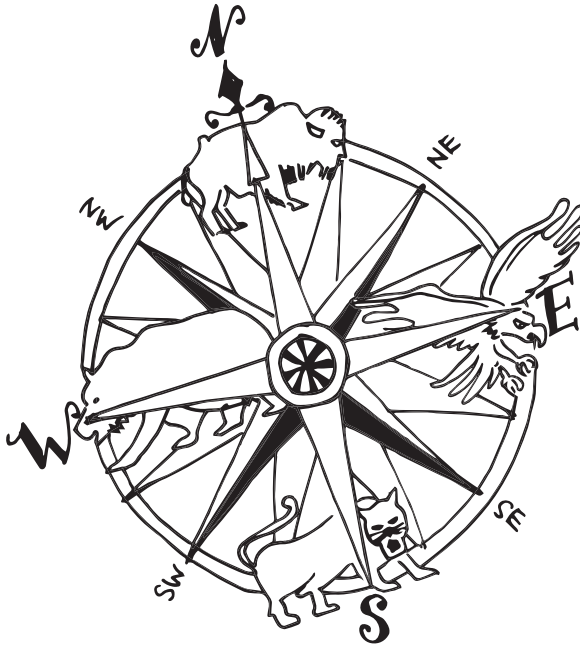
Chapter 3 – Understanding People & Seeking the 'Truth'

By Robert Sams

> "If I want to understand an individual human being, I must lay aside all scientific knowledge of the average man and discard all theories in order to adopt a completely new and unprejudiced attitude. I can only approach the tasks of *understanding* (sic) with a free and open mind, whereas *knowledge* (sic) of a man, or insight into human character, presupposes all sorts of knowledge about mankind in general."
>
> Jung (1990, p. 6)

Firstly, beware of the trap!

In order to gain a better understanding of people, let's begin with the fairly straightforward question that has been posed already in this book: *'Why we do what we do'?*

It would seem that if only we knew the answer to this question, life may be easier; less grey and less messy. We may also have greater clarity on our 'reason for being'. However, what does it mean to come to a simple understanding of why we do what we do?

So what do I mean by this, and why raise this question so early in the book?

One of the key dilemmas in seeking to better understand people, is that the very process of pondering such a question as why we do what we do brings with it, the seduction of trying to reduce people down to their composite parts (reductionism). It seems much easier to understand 'bits' than the 'whole', as the 'whole' is more convoluted, challenging and complex.

While my aim will be to resist doing that throughout the journal (as best, and where I can), and instead focus my reflection on searching and exploring (rather than 'solving'), I also know that it is in our nature as humans to want to break things down in order to understand (solve). It's very seductive.

To further assist in understanding this predicament, I offer a quote from Alexander Dru's writings about the Danish Philosopher and Theologian, Søren Kierkegaard:

> **"The truth is a trap. You cannot get it without it getting you; you cannot get the truth by capturing it, only by its capturing you"**.
>
> (Dru, 1996)[7]

What does this mean? Let's explore this a little before continuing.

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7. Søren Kierkegaard: Papers and Journals (1996) Source: http://enq.translatum.gr/wiki/S%C3%B8ren_Kierkegaard accessed on 29 June 2016

Questions that immediately spring to mind for me are: what is the 'truth'? And, how may it 'capture you'? Also, what can we learn from a search for the truth? How do we come to an understanding of the truth?

These are important questions to reflect on in order to better understand people.

Perhaps Kierkegaard is cautioning us not to get 'trapped' in binary (black and white) thinking; something that we can all easily be entrapped by.

These may be pertinent questions and considerations to keep in mind as you conduct your own exploration through the journal. There are many tough and challenging questions to consider as we reflect and better understand people; perhaps it is a search for the 'truth'.

While I ponder such questions in a relatively simplistic way here, there is no getting away from the complexity of paradox[8] when it comes to understanding why we do what we do. The paradox occurs when we feel that we have come to the 'truth' and then subsequently cease our exploring, reflecting and learning. This in turn may mean that we may never truly learn what the 'truth' is, as seeking the truth may require a continued reflection and re-examination (with others), rather than it being a fixed answer or idea.

With this in mind, I offer a caution before you proceed any further. That is, to be mindful of when you may succumb to the seductive nature of reductionism and view people individually (and as parts), rather than socially and holistically (i.e. as body, mind and spirit). Perhaps it is only when we come to accept the paradoxical nature of human beings that we can begin to contemplate 'truth'. Thus beware of the trap of simplistic reductionist thinking, when it comes to understanding people and risk.

A better understanding of people

Succumbing to the 'trap' (of *answers,* through reductionism) is something that can happen to us all. However, if we accept the paradoxical nature of human beings, this should not stop us from further exploring, thinking about, and studying the questions we have.

Understanding the presence of paradox is a key learning of the 'adventure' of the past few years.

If we are mindful of how we go about our search for the 'truth' and answers, we open ourselves up for a world of learning and discovery and perhaps it is only then that we can begin to discover *why we do what we do* or *what makes us tick*.

However, I suspect that it's not only these questions that drive our intrigue; it is also understanding how people can share such different views, ideas and feelings from one another, yet co-exist, and in many ways thrive, through these differences. How can we all be so different, yet still live together, on the whole, so cooperatively?

This is at the heart of the concept of dialectic, where the aim is to seek to understand

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8. That is, where two things (beliefs for example) seemingly are not able to co-exist, yet do.

different views and ideas through the process of questioning with others, and where the aim is not to convince the other of our 'rightness', rather to better understand a 'truth' by a process of exploring and 'synthesising' and for this process to continue.

So with this point made, let's explore some insights that may help us in our exploration in better understanding people.

Learning about our 'type' and preferences

One of the most discerning ways to learn more about people, is to gain a greater understanding of Archetype or 'Type'. Based on the underlying work of Carl Jung, Type provides a good introduction for understanding the different 'preferences' that we have as humans.[9]

Jung was an 'Analytical Psychologist', and a significant pioneer in our learning about the unconscious. Crowley (1999, p.10)[10] provides us with a useful insight into Jung's life and work when he writes:

> From his study of himself, his patients, and many spiritual traditions, Jung found that the personality we acquire through our upbringing and social conditioning is only part of what makes us what and who we are. Within us is a deeper and wiser being – the eternal Self, a unique center, a center for consciousness and an archetype of order. This is who we become when all the complex aspects of our personality integrate.

In Jung's own work in *The Undiscovered Self* (1990, p.5), he notes (on the subject of learning more about ourselves):

> Most people confuse "self-knowledge" with knowledge of the conscious ego-personalities. Anyone who has any ego-consciousness at all takes it for granted that he knows himself. But the ego knows only its own contents, not the unconscious and its contents. People measure their self-knowledge by what the average person in their social environment knows of himself, but not by the real psychic facts which, are for the most part hidden from them.

He goes on to say: "*In this broad belt of unconsciousness, which is immune to conscious criticism and control, we stand defenceless, open to all kinds of influences and psychic infections*". (1990, p.5)

There are many Philosophers, Psychologists and Psychoanalysts who have grappled with the question about the role of the unconscious in our decision making and thinking, however it is Jung's work in particular that I find a very useful foundation. In particular, it is Jung's link to 'Archetypes' (Collective Unconscious, Jung, 1969) that I feel is particularly relevant.

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9. It is important at this point to refer to the quote by Jung at the commencement of this Chapter, where he reminds us that; "*I can only approach the tasks of understanding with a free and open mind, whereas knowledge of a man, or insight into human character, presupposes all sorts of knowledge about mankind in general.*" When considering this point, along with the observations made already about 'truth', there is further caution not to consider 'Type' as anything other than a tool to assist in understanding, rather than an answer in itself.

10. Crowley's (1999) introductory text is a very useful starting point in better understanding the work and purpose of Jung. During the 'adventure' of the last few years, I have often found it useful to read books about Authors as a precursor to reading their work directly. For the more challenging authors, you may also find this a useful technique.

So why is an understanding of unconscious and 'Type' critical in managing risk?

Firstly, an understanding of the unconscious in our decision making is central to the Body of Knowledge[11] which is the foundation of *the Social Psychology of Risk*. While this will be further explored in more detail in Section Three, the point to make here is that it is the vast array of activity that occurs in the unconscious that impacts on so many of the decisions that we make, including about risk.

What this means for those who aim to support others in discerning and dealing with risk, is that our focus ought to be on influencing others to better consider risk for themselves, rather than managing it on their behalf (through the strict application of process for example). This can be done through creating greater space for thinking and reflecting, and resisting the urge to 'dumb down' how people think in our organisations and in society.

So how does learning more about ourselves help us to better understand and influence others in dealing with risk? And, how can an understanding of 'Type' better inform us with this?

What I have learnt about my own 'Type'

I will now explore the concept of learning more about 'self' in order to better understand and influence others by sharing stories of my own experiences.

People have described me as a 'doer' and 'Action Jackson', a person who likes to get things done. I like to organise and see things through to completion. For anyone familiar with the Myers Briggs Type Indicator (MBTI)[12], my personality and type is ENFJ[13]. Although during recent testing, it has become apparent that my 'I' ('introversion') is rapidly developing.

At this point, I appreciate that there may be some people reading this who are not familiar with the Myers Briggs indicator and who may be seeking further information on how MBTI works and how the various 'Types' relate to one another. While this book doesn't allow for the space for a detailed explanation of Type (MBTI), in order to provide a brief understanding, I will outline four critical questions that are at the heart of MBTI which are:

1. What is the direction and focus of your personal energy? It may be either inward (I = introversion) or outward (E = extroversion).

2. How do you prefer to gather information? This can be either focusing on what is experienced through the senses (S = sensing) or through a focus on patterns and meaning behind ideas (N = intuition).

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11. As noted in the 'Map' on page 14.

12. Mary McGuiness in her introductory book on Type called; *You've Got Personality* (2004, p.3), provides a short and useful summary of Type; *"The personality theory is based on the work of Swiss Psychiatrist Carl Jung (1875-1961). Jung noticed that much human behaviour that appears random actually follows clear and predictable patterns related to a few basic personality differences. In his book, The Psychological Types, Jung described some of the personality differences in normal healthy people. These differences indicates our natural gifts and strengths. They influence the way we behave, communicate and interact in many daily situations in the workplace and at home".*

13. This means that I 'get my energy' from being with others (E), that I prefer to 'gather information' through intuition (N), that I prefer to 'make decisions' through feeling (F) and that I 'deal with the outer' world through judging (J).

3. How do you prefer to make decisions? You may do this by either using logic, laws and principles (T = thinking) or through values and what is important for people (F = feeling).
4. How do you deal with the outer world? Do you prefer to be planned, organised and seek closure (J = judging) or spontaneous, flexible and ready to explore new options (P = Perceiving).

For readers who are interested in learning more about MBTI, I recommend Mary McGuiness' book or the Myers Briggs organisation website[14].

For people who know me only through my blog posts, they may be surprised when reading the description above. Based on the feedback that I receive, people may take from what I write, that I appear to be 'anti-organising'. I do ask a lot of questions on this subject.

However, my natural preference is to 'organise', to 'plan' and to 'make things happen'. I make 'to-do lists', I set agendas for meetings and generally I'm an action orientated person. Mostly this works well and it is certainly useful in running a consultancy.

Like most things in life however, I have learned that there are trade-offs and by-products. I have become particularly aware of these trade-offs over the past few years as I have come to know myself better. In particular, how my actions and preferences impact on others. I learn a lot when I am able to *Socially Sensemake* with others. So lets explore some examples.

A recent experience with a dear friend caused me to pause and reflect on this. It had me considering the effect that my preference for organising and action had on my friend.

The specific example I am thinking about is when we had agreed to do a couple of things before a meeting we were about to have. This was on a Thursday and by the Monday my friend hadn't done what we spoke about. I thought that my friend may have been tied up with other things, or had not considered the actions as important as I did. So because of my need for closure and action, I just went ahead and did the thing that my friend was supposed to do. I wanted to see it 'done and dusted', it made me feel more in control.

Some people might be thinking great, you're a good friend you made things easier for the other person, well done! Sure, but this doesn't consider the impact of my actions on my friend? How did this make them feel? What did 'me taking control' mean for how they felt about things?

The good news is that my friend values good conversation and feedback. They called me to let me know that they had done what we agreed, and were just about to send an e-mail to confirm this. However, I had beaten them to it.

I thought of my friend and how this may have made them feel. Would they think that I thought they weren't worthy or capable of doing the task? I know that my friend is not slack, nor complacent, so by me taking control by being a 'doer' could really have

14. http://www.myersbriggs.org/my-mbti-personality-type/mbti-basics/ (accessed on 29 July 2016).

impacted on how they felt about themselves, particularly on their motivation. This was clearly not my intention, I would not want to hurt my friend, but I recognise that this is how taking control can impact on others.

So how may this type of event effect motivation?

Motivation

Motivation is at the heart of '*why we do what we do*'. Edward Deci's research, outlined in his book (by that title), provides a key insight when he postulates:

> Perhaps there is an innate or intrinsic need to feel a sense of personal autonomy or self-determination – to feel a sense of what deCharms had called personal causation. That would imply that people need to feel that their behaviour is truly chosen by them rather than impact by some external source. (Deci, 1995, p. 30)

If our aim is to influence others so that they are self-motivated, we need to understand the concept of supporting them to be autonomous in their decisions. That is, being free to make decisions for themselves.

But is this possible if our goal is to simultaneously control risk?

Perhaps this one of the key challenges we face in managing risk. That is, we have to weigh up situations and decide whether we are willing to let go of control for ourselves, and allow others to be free to make decisions. When we can move to a position to allowing this in risk and safety, then we may be closer to people feeling more motivated in what they do.

But is motivation just about 'autonomy support' (Deci, 1995)?

The answer is no. Motivation is much more than supporting others to be free to make decisions. To further understand motivation, we can turn to one of the best researchers and authors that I have read on the subject, Tori Higgins. His work is well described in *Beyond Pleasure and Pain, How Motivation Works*; and he states:

> Thus, I believe that the best answer to the question of what it is that people want is they <u>want to be effective</u> (their emphasis). People want to be effective at having desired outcomes (value), but they also want to be effective in establishing what's real (truth) and at managing what happens (control). (Higgins, p.14. 2014)

It is these concepts of *value*, *truth*, and *control* that help us understand that motivation is more complex than the way it is referred to and thought of in risk and safety. In these fields it is not uncommon to hear motivation spoken of in a way that can be described as 'Hedonic'.

As is common in risk and safety, the thinking and discussion is binary in nature. Motivation is far too often simply thought of in terms of 'carrot and stick' which is about avoiding pain and maximising pleasure. This is why Higgins (2014) proposed to move 'beyond' this simplistic binary approach, because as with most things, when trying to gain a better understanding of people, we are far more complex than being considered either one thing or the other (binary).

Reflections of a 'doer'

The incident with my friend was a relatively minor 'event'; there were no serious consequences and our friendship remains strong. However, things could have been different; particularly if it had occurred with someone with whom I don't have such a good relationship, or with someone who doesn't value feedback.

My reflections didn't stop there. I thought back through the many times in my career (and in life) where my focus was on 'just getting the job done'. While the people I was reporting to may have been full of praise and 'well dones', my reflections now are on what this meant for others.

In risk and safety (like in life), being a 'doer' can be good. However, if our preference is to 'do', finding the time to stop and consider what this means for others (through reflection) is critical. Finally, if our focus is on 'doing' we shouldn't be surprised when others just sit back and let us 'do our thing'.

I think back to my relationship with Beavo too. I suspect he was an ESTP, the 'SP' being the dominant feature. People with such a preference like to have fun, they are often the life of the party. With this in mind and on reflection, it is not that surprising that Beavo would be testing the boundaries and seeking to be 'free', not bound by rules and controls, which was his unconscious preference.

Be wary of putting people in buckets!

At this point, and before moving on from the topic of Type and motivation, I feel it is important to pause for a moment to make an important comment. The point that I make at the start of this Chapter about being aware of the 'trap' is critical.

In my use of Type to explore a better understanding of people, I try to be conscious of not using the model as a way to put people into neat little buckets so that I can label them[15]. Of course, we are all very different as individuals and understanding our preferences can help us understand these differences. The seduction of the 'trap' of labelling people in this way is profound, and should be resisted as best as possible.

When we better understand ourselves, our preferences and the unconscious biases associated with our personalities, we may be better able to understand what these may mean for others.

Now that I have provided an introductory understanding of Motivation and Type, both of which require an understanding and acceptance of the 'unconscious' (Chapter 4), I will end this Chapter with a short explanation about the symbol that appears at the beginning of this Section of the book and is repeated below.

A special note about the drawing for this section

While the text in this Chapter may assist you in better understanding people, this semiotic image is also designed to convey many things about people, 'Type' and decision making.

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15. While at the same time I do acknowledge the irony of 'Type' providing 'labels' for the various different preferences.

As Jung explains in *Man and His Symbols*:

> "Thus a word or an image is symbolic when it implies something more than its obvious and immediate meaning. It has a wider 'unconscious' aspect that is never precisely defined or fully explained. Nor can one hope to define or explain it. As the mind explores the symbol, it is lead to ideas that lie beyond the grasp of reason."
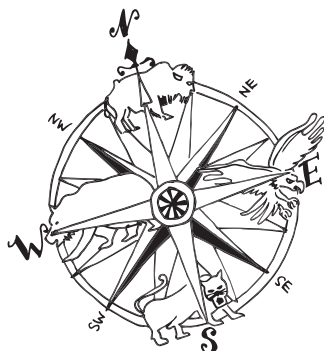
<div align="right">(Jung, 1964, p. 4)</div>

The points of the compass included above are included to remind us that there are many directions in which our decisions may go, and while it is useful to have a compass to provide direction, the multiple points of the compass are intended to depict that the direction is more than just a choice of one way or the other.

The animals in the image also have significance. As noted in a website dedicated to this topic, the animals are often used to symbolize Archetypes:

> Animal symbols are found in the earliest of cave drawings. Not only were they hunted, they were revered, if not worshiped. Each animal symbolizes something in terms of its strength and weakness. The weakness is its shadow.

> Animals also symbolize our instinctual sides. In itself a particular animal is neither good nor bad. It is part of nature, just as our instincts are part of our nature. As such, they often symbolize our shadow sides.

<div align="right">Source:http://www.horses-helping-troubled-teens.com/Jungian-archetypes-symbols.html
accessed on 10 June 2016</div>

In the case of the compass image, the four animals represent the animals on the Native American Indian Medicine Wheel. The wheel includes four animals that also depict four winds or spirits as noted here:

> In the case of the Directions or Four Winds of the Medicine Wheel the Chief animal totem is actually called a Spirit Keeper because the totem of the Directions is a power totem, if you will. These Spirit Keepers are Beings responsible for teaching us about the power of the direction of the wind they represent. When we are born we are given one of these Spirit Keepers by the Great Spirit. These power totems from the Four Winds are much like a Guardian Angel, if you will. They are given to us to guide us, teach us, and protect us.

> Although we have one Direction and Spirit Keeper who particularly watches over us, we can always learn much from each of the Four Winds.

<div align="right">Source: http://native-american-totems.com/four-winds/totems-of-the-four-winds/
accessed on 10 June 2016</div>

The inclusion of this image is aimed at providing an active example of how images are significant and impactful on our unconscious. You may like to further reflect on what this symbol may mean and why it is included in this book.

My key reflections

One of my key learnings during the past few years, is the value of reflection. This provides me the space to slow down and learn more about both myself and others. In writing this part of the book, my first working title was '*confessions of a doer*'. However, after sitting back and thinking about this for a while, I decided that it wasn't about confessing or apologising for whom I am, rather a reflection on what being a 'doer' meant for me and others. It is the reflection, and resultant learning, that I find critical in maturing as a person.

When we are honest with ourselves about who we are, when we understand our own 'type', 'preference' and motivation, we begin to understand how this in turn impacts on our relationships with others.

If this reflection resonates with you and if you too have a bias for action, what does this mean for the people you are aiming to lead or influence? What are some of the things that you can do to mature your relationships with others with the aim of influencing rather than controlling?

Further growing and developing the ideas in this Chapter

For all the 'Action Jacksons' out there in risk and safety, I wonder if the list below might be useful if we want to focus more on influencing than 'doing'?

- Perhaps we could think about the 'cues' that may mean we are 'taking action', ahead of considering others. Perhaps as we look at our 'to do lists' and agendas we could take some time to pause, and before heading into action, consider what impact the action may have on others.
- Consider whether we need 'to do'. Perhaps 'influencing' and 'supporting' may be more appropriate in some situations and contexts?
- Consider the value of conversations in person rather than e-mail so that we can get a feel for how others are feeling about the conversation. E-mails tend to be about doing and actioning, conversations allow us to 'check in' with others and consider their perspective.

If you too are a 'doer', these are perhaps good questions to help with your own reflection:

- Would stopping and reflecting more often allow us time to consider the impact which our 'doing' has on others?
- Could it be that our personality type is the force behind our preference for 'control'?
- Does 'control' make us feel good because things get done?
- What impact does this have on others and their motivation?
- Could taking the time out to consider this in the context of ourselves in turn help us to understand and better influence others?

Of course, there will be many readers who are not 'doers' and 'Action Jacksons'. Perhaps you are more introverted, perhaps you prefer to sit back and contemplate before leaping into action. For those of you who prefer this approach, these questions may be useful for you:

- How do you cope with, and maintain relationships the 'Action Jackson' types? For example, like with the interaction with my friend, how would you cope with this situation where I to come in and 'take control'?
- How do you support others who are also more contemplative and reserved?
- What can you do to demonstrate that you are 'doing', even though others may not see things this way?

Segue to the next chapter

Now we have commenced an exploration of some of the differences between people, and have begun to understand the messiness and complexities of human beings, let's consider how this may play out in how we make decisions and judgments about risk.

Chapter 4 – Decision Making and Risk

By Robert Sams

> "We do not first see, then define, we define first and then see."
>
> Walter Lippmann (cited in Plous, 1993, p. 15)

To understand and discern risk, we make decisions and judgments about uncertainty[16]. We are often required to do this *without* the benefit of unlimited time, and most likely *without* using our deliberate, analytical and logical 'thinking' conscious mind. This is in part because understanding risk is a subjective activity and decisions often need to be made quickly.

While we do make some decisions and judgments using our conscious mind, Norretranders (1998, p.131) notes the research of Miller who found that the capacity of our conscious mind is limited to keeping only around seven things consciously active at any one time.

When we think in our conscious mind it is (relatively) slow at 16-40 bits per second (Norretranders, 1998), it takes time and can feel exhausting. It requires us to analyse and work through matters in some detail. The unconscious meanwhile is much faster and capable of calculating information and decision making at 10 billion bits per second.

So why is it so difficult for some people to understand that we make most of our decisions in our unconscious?

I wonder whether one of the reasons is that there have been varying views, opinions and studies done throughout the years, about the role of the unconscious?

When it comes to understanding the unconscious John Bargh is one of the academic guru's and he notes about the unconscious that:

> Contemporary perspectives on the unconscious mind are remarkably varied. In cognitive psychology, unconscious information processing has been equated with subliminal information processing. ... Social psychology has approached the unconscious from a different angle. (2008, p.73)

It is the perspective of Social Psychology that I am most interested in. Social psychology is concerned with our social arrangements, culture, the spaces and places we live in, and importantly how the unconscious impacts on our decision making. So how does Social Psychology help us understand the importance of 'thinking' in the conscious and unconscious?

A useful reference and a good beginners read on the subject is Daniel Kahneman in his book *Thinking Fast and Slow* (2011) in which he introduces the concept of System 1 (unconscious – the 'fast') and System 2 (conscious – the 'slow') thinking. Kahneman argues that most of our thinking is done in System 1; and it is fast, intuitive and emotionally based.

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16. Risk, as defined in AS/NZS ISO 31000:2009, Risk management - Principles and guidelines is: "the effect of uncertainty on objectives".

While this model is a useful introduction, one of the challenges is that in many ways our thinking is not either fast or slow (binary), but often *'flows'* (Csikszentmihalyi, 1992) between fast and slow and the many areas in between.

To further extend this thinking about conscious and non-conscious 'thinking', Long in *Risk Makes Sense* (2012 p.96) introduces his *One Brain, Three Minds*© Model (Figure 2). This model defines the types of decisions that we make in the conscious (Mind 1) and the unconscious (Minds 2 and 3).

One example of how we may use the three minds to make a decision is to consider the purchase of a house, where we would use all three minds in a constant state of '*Flow*' as noted above.

Mind 1 may work through a mental 'checklist' for the type of home to look for (single story, number of bedrooms, bathrooms, car spaces, suburb etc.). You make these type of 'decisions' in a slow, rational and methodical way. Mind 2 is where we use heuristics to make decisions. Heuristics are 'rules of thumb' we develop over time and through trial and error. Mind 3 encompasses our emotions, gut feelings and intuition; and to the surprise of many, may actually be the 'mind' that is used most often when making the decision of which house to buy.

I know when De and I bought our house, we had our 'Mind 1' checklist' for the suburb, we'd thought about that long and hard. We both decided through our experience (heuristics – Mind 2) with other houses that we had lived in, that single story was best for us. However, it was the 'feeling' of security and comfort that we felt when we walked into the house (emotions and gut feelings in Mind 3) that was the real decision maker. We couldn't name or describe the feeling of security, we couldn't tell a real estate agent about the type of house where we felt most comfortable and safe, it was just a feeling that we had when we walked in the door. Indeed many real estate experts will say that we decide within 10-15 seconds of entering a house what our decision will be.

So what it is that made us feel this way? How could we make such a big decision and commitment as buying a house by using 'thinking' in our unconscious mind? It is these type of questions that I find useful when I reflect on how I make decisions and judgments in my own life.
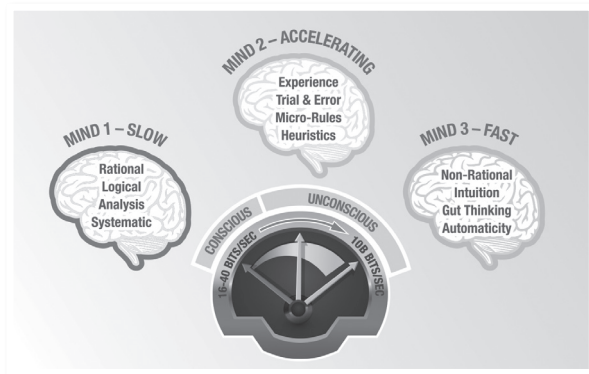
Figure 2
One Brain Three Minds©
model. Long (2012)
used with permission Dr. Long

A deeper look into decision making

It is often the things that aren't so obvious that inform our unconscious mind. Things like the colour of the walls, the way that light passes through the house, the floor plan and the noises that we may hear, or may not hear, all impact on our decisions.

While De and I may be busy analysing the house in our conscious mind by looking for cracks in the wall, signs of disrepair or water leaks in the roof, all things that we may work through rationally when buying a house, it can be those things that we 'look at', but don't see, or hear but don't analyse, that can be the biggest determinants of decisions we make.

The idea that such a significant decision, as buying a house, may have been made 'unconsciously', can be difficult to grasp. Surely all such significant decisions must be made rationally and logically, and in our conscious mind?

While Long's model helps us understand the differing nature of both conscious and unconscious decisions, a further and deeper exploration into the factors that may impact on our unconscious is useful here.

For example, my most recent reflections on heuristics[17] lead me to believe that they may be very hard to understand, and in particular articulate. I suspect that heuristics are deeply seeded in our unconscious thoughts, and are hard even to name and think of examples.

Couple this with the myriad of factors that impact on our unconscious and we can begin to understand just how complex and challenging decision making is.

To assist with an understanding of this, I have developed a semiotic reflection (a model) of how I see this deeper layer of understanding on decision making.

The Model (on the following page) is based on the 'tree of life'[18]. The model is meant to firstly symbolically differentiate between the factors relating to our decisions and judgments that occur in our non-conscious (non-exposed or symbolically 'under the ground') and then to highlight the things that we do as we make decisions (the branches) and then afterwards as we reflect and learn (open to view or 'above the ground' as in the exposed structure of the tree). The roots of the tree include the factors that relate to us as individuals and they are surrounded by the earth (soil) which is meant to symbolise the more social factors that impact on our decisions. They are depicted in the 'messiness' of the soil as a way to demonstrate that, not only are they often hidden from us (under the ground), but may be challenging to understanding being in the mix of the soil (dirt, rocks, humus, worms and subterranean bugs etc.) and the entanglement of the roots.

While it is difficult to explain and articulate the metaphor fully here in text, it is hoped that, in addition to the descriptions provided above, as well as the explanation of the One Brain Three Minds© model developed by Long (2012), that by combining all of this information will provide you with a better insight into the complexity of human decision making and judgment.

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17. Rules of thumb in decision making.

18. While the "Tree of Life" has a long and significant history, particularly in religion, it was through the work and art of William Blake that the idea for using the Tree of Life in this model was created.

THE DECISION TREE
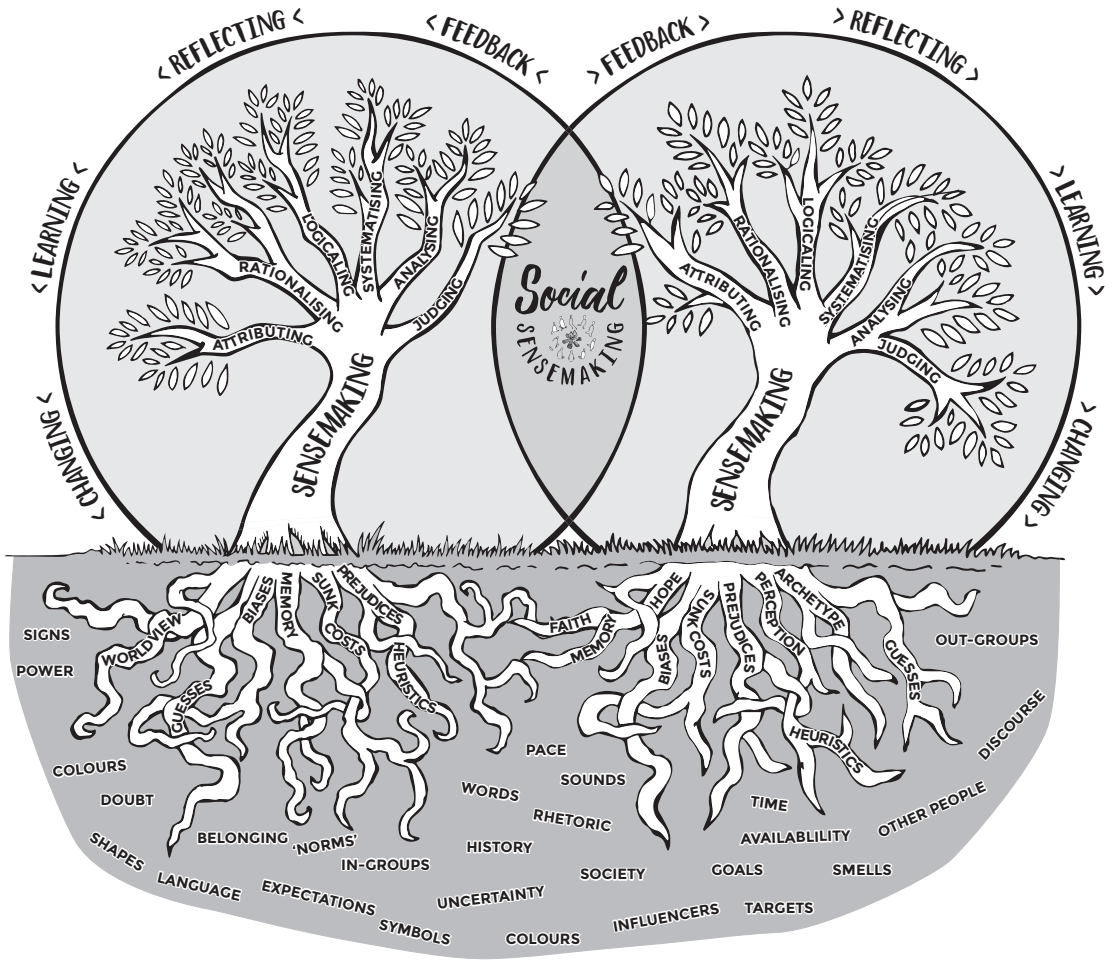
Figure 3 The Decision Tree (Sams, 2016)

Further Growing and Developing the Ideas in This Chapter

So if we accept that there are many factors that may inform our unconscious mind and therefore affect so many of the decisions that we make, what can we do about that? Here are some tips you may find useful:

- First, just recognising that there are things that impact on and inform our unconscious can be useful. This does not mean that we will necessarily be any more aware of them when we make decisions ourselves (they impact the unconscious after all), however, we can be aware of them when we are looking around our worksites and consider how they may impact thinking

- Perhaps you might try walking around your site with a different 'lens'. Ditch your next hazard inspection, and wander around your site looking out for things that you think may play on our unconscious mind. Things like the words used in communication, signage, the colour of walls, the location of work stations and offices. Ask yourself how these things may impact on the unconscious?

- Maybe you could stop and think about how the space you are in makes you feel. What is it about the space that makes you feel this way?

- Consider practicing *Social Sensemaking*. That is share ideas and talk with others about your decisions. Ask questions, seeking to understand, explore, play and challenge. Critically as we go about this, we need to be aware of our own agenda and be prepared to 'suspend' it, along with our own thinking and ideas, in order to be open to new ideas, to make a different sense of things and to learn.

- Finally, as my good friend James Ellis is known to say when contemplating challenging decisions, 'buy time'. Maybe defer if needed, and remember that making no decision, is in fact a decision in itself.

Segue to the next chapter

If we accept that we make decisions both consciously and non-consciously, and that we all think differently as people, it is possibly no surprise then that the way we perceive the world, and our perception of risk is also different. In the next Chapter we will explore this further.

Chapter 5 – Risk is About People, Not Just Objects

By Robert Sams

> "We humans have an irresistible urge to explain behavior, (sic) to attribute it to some cause, and therefore to make it seem orderly, predictable, and controllable. You and I may react differently to a situation because we think differently. How we react to a friend's insult depends on whether we attribute it to hostility or to a bad day."
>
> David Myers in:
> *Essentials of Social Psychology* (2010, p.5)

The focus of so much of our attention today in risk and safety is on *'risk assessment'*. Walk into any workplace and talk about Safety and it is likely that someone will pull out a 'JSA", a 'SWMS', a 'JSEA' or some other similar document that people will invariably refer to as their *'risk assessment'*.

Risk assessment is a daily routine for many people working in risk and safety. We lead risk assessment teams, write up risk assessment processes, 'teach' people how to do risk assessments or report on the outcomes of risk assessments. *'Risk assessment'* is also a cornerstone of modern health and safety legislation in Australia, New Zealand and many other countries; it is enshrined in so much of what we do in health and safety.

But I wonder if our approach to *'risk assessment'* is all that effective[19]? What does the approach mean for how people discern risk in the workplace?

There have been times in the past where our approach to 'risk assessment' has troubled me, and I wonder if other people feel the same?

For example, I remember working in manufacturing where we had well established and detailed processes in place for commissioning new equipment. We considered hazards and risks at all different stages; during plant design, manufacture, install, commissioning, and we continued to consider 'risk' as equipment became operational. We used checklists to help remind us of all sorts of hazards and risks; machine guarding, electrical and chemical (for cleaning), plus many others. Of course we did all this while consulting with our team.

This process seemed textbook perfect at the time, and compliant with Regulator guidelines. So why did I feel troubled? What was it about the process that caused such tension in my thinking?

It has only recently become clear that the main cause for my concern was that I considered risk primarily in an objective way. That is, I was concerned with risks associated with objects: plant, structures, equipment and the like. Sure, we had columns in our checklist that looked at 'human factors', things like fatigue, heat stress

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19. I acknowledge here that the term effective is in itself subjective and requires interpretation and understanding between different people who are determining 'effectiveness'. The position that I take in this book is that in order for an approach to 'risk assessment' to be effective, it requires an understanding of how people make decisions and judgments about risk. This provides a more holistic understanding of risk rather than just a mechanistic perspective.

and anthropometric data, but we had no appreciation at the time about the subjectivity of risk (despite 6 years of 'Safety' study at University!). We could pick where a guard needed to cover a hole without a problem, however what we couldn't pick was: who, when and why a person may put their hand in that hole. As I reflect, I recognise that was the cause of most of my tension.

To really understand how this 'object' could injury a person, requires us to understand how the person may make decisions and judgments about risk. Further, we need to better understand how people *feel about the risk* including their own experiences and values. I've learnt that risk is not, and can't be *only* objective, risk must be considered in the context of the environment and *most importantly* in the social setting in which it appears.

This has me reflecting also on how I may have approached 'risk assessment', had I been working in Speno Rail at the time of Beavo's accident, prior to my understanding of the *Social Psychology of Risk*.

According to the court judgment[20], Speno had considered a reasonable number of physical hazards including that of climbing on top of the train whilst it was in motion. There were also reportedly 'controls' in place including: induction, training, 'Toolbox' communication, signage and barriers; none of which stopped Beavo heading up for a 'ciggy' on that fateful day.

I wonder whether the 'risk assessment' process considered factors such as: where the power sat in the organisation, a consideration of the organisations' 'competing values'[21] or, how over-confidence may impact on decisions? These are factors that organisations would seek to better understand if the *Social Psychology of Risk* were part of their lens for reviewing organisational incidents.

So what are the challenges with the current paradigms for risk management and why may it be difficult to comprehend the *Social Psychology of Risk* Body of Knowledge (Chapter 4)?

Partly this is because organisations, and people, have adopted the far too simplistic view that 'risk assessment' is as simple as choosing a likelihood and consequence from a matrix. How can this be valid when we don't all share the same thoughts, experiences, values and importantly feelings about risk? How could such a numerical attribution of risk mean the same thing to all people? If it doesn't, what purpose does it serve? In our attempt to make risk assessment objective, are we in fact making it counterproductive and even detrimental?

How could we have 'ranked' the risk of Beavo being on top of that train in February 2001, by using a matrix? The risk factors associated with his injury are far more complicated than understanding likelihood and consequence.

This reminds me of a recent conversation I had with an experienced risk and safety person ('John') who did not agree with me about this point. John was adamant that *risk assessment* is a valid *scientific* process. He told me, *"consequence is usually pretty*

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20. Inspector Marshall v Speno Rail Maintenance Australia Pty Ltd [2004] NSWIRComm 1. File Number. IRC 441 of 2003.

21. See Cameron, K., and Quinn, R., (1999) *Competing Values Framework*.

obvious, and you can either cut your arm off or not." He went on to say *"Likelihood on the other hand is a little more difficult. Likelihood is a little more subjective, but the key to overcoming this is to make sure that the group work together and come to 'consensus'."* I asked him how he did this, and he gave some great examples of how he helps teams work together and no matter how long it takes, they eventually come to an agreement about the likelihood[22]. He told me his organisation strongly supported safety and as part of their commitment, if teams needed extra time to complete a risk assessment, i.e. come to a 'consensus', then that was ok. What this approach also does not take into consideration is our 'Bounded Rationality' (Simon, 1982).

Imagine trying to understand Beavo's accident without an understanding of who he was as a person and how he went about making decisions and judgments. I'm sure there are plenty of people who would either site a myriads of compliance breaches or, alternatively have written him off as a 'stupid idiot', in order to make sense of his death. *But what would we have learnt from those approaches?* Understanding Beavo's accident is much messier and grey than suggesting a breach of regulation. Perhaps it can't be understood at all? Maybe investigations carried out with the methodology of reductionism are akin to Kierkegaard's search for the 'truth'. What do we trade-off when this is our approach?

The conversation that I recall above with John is typical of many discussions I have with people working in risk and safety. The problem with this approach is that it does not consider how humans make decisions about risk. This requires an understanding of key social psychological factors, two of which are:

- **'Group Think'**[23] the approach that John takes when a conducting a risk assessment, in terms of consensus, is not wrong. In fact, if you read through most risk and safety textbooks and literature published on the Safe Work Australia website (http://www.safeworkaustralia.gov.au/sites/swa) it encourages this approach. Consultation with all 'workers' is a key focus of legislation. Most health and safety literature and training however does not consider 'group think'. Have you ever considered this when you have been part of a risk assessment team? When we consider 'group think' we know that the 'consensus' of the group is not likely to be a 'consensus' at all. As stated in the YouTube clip, *"social penalties dished out to those that disagree by confirming perpetuate majorities that may not really exist".*

Have you been part of a risk assessment where Group Think was present; when people just 'agreed' and 'conformed' in order to get things done and to move on?

- **'Sunk Cost'**[24] – John also told me that it was important to make sure the right people are on the team. You need to bring together engineers, operators, cleaners and anyone else who will be involved in the task. Once all of these people agree on

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22. With these points made, I would like to share with readers the feedback on this point provided by Ron Gantt, after he read and subsequently provided a critique for this book; *"the irony of John's comment is that frequency is the most objective part of risk assessment. I can quantitatively determine frequencies for many events, which allows me to pretty accurately predict likelihood. But it is the consequence where the subjectivity is irreducible. Yes, losing an arm is not very subjective, but how "severe" is that? Is that more or less severe than having a debilitating back injury? What about a fatality? And who gets to make these determinations and at what point in time (before or after the event)? These are value judgments that are extraordinarily subjective."* (Gantt, 2016)

23. http://www.youtube.com/watch?v=TrNIuFrso8I

24. http://youarenotsosmart.com/2011/03/25/the-sunk-co

the risk score, then we know we have done a thorough job. What John didn't know was the effect that 'sunk cost' would have on some of the individuals in the group. As David McRaney[25] explains so well on his website:

> The Misconception: You make rational decisions based on the future value of objects, investments and experiences. The Truth: Your decisions are tainted by the emotional investments you accumulate, and the more you invest in something the harder it becomes to abandon it.

Do you have 'sunk cost' as one of the items on your risk assessment checklist?

In a world that is crying out for simple answers (did someone say three word slogans…) and solutions to often complicated and even unsolvable problems, it takes a brave person to contest the current paradigm in risk assessment. As noted previously, Mavericks are not treated well in most organisations.

The challenge for risk and safety people is to consider whether their current processes for risk assessment are focused mainly on objects, and if they are, if this is the most effective way to deal with risk.

So if we accept that making sense of risk requires an understanding of people as 'subjects', not objects, what are some examples of situations that may help us understand this?

I recall one such example from a recent holiday.

What we can learn from a Gympie Gympie Stinging Tree

The holiday was in Far North Queensland, Australia, where there is a warm climate that provided a great way to welcome Spring and all that comes with a change in season.

De and I were fortunate enough to spend time exploring the Daintree Rainforest. It was there that we visited the Mossman Gorge and experienced one of their Ngadiku (Nar-di-gul) Dreamtime Walks that are conducted by the local Indigenous people. Ngadiku, in the local Kuku Yalanji language, means stories and legends from a long time ago.

During our visit, our welcoming host was Rodney.

As we meandered through the rainforest, I could not help but feel welcomed, valued and respected. Rodney was showing us around an area that his family and ancestors have inhabited for many thousands of years. Rodney shared stories, knowledge and experiences. He guided us through what he described as "our backyard", referring not only 'our' being his people, but also 'our' as being the people who were sharing the journey today, it was a very welcoming experience.

Whilst Rodney enjoyed pointing out various artefacts along the way and demonstrating some of the history and practices of his people, he was equally as interested in our stories and what we knew. He asked lots of questions and while he was the host for our walk, you couldn't help but be left with the impression that Rodney was keen to develop his own learning as much as he was interested in sharing his own stories.

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25. Source: http://youarenotsosmart.com/2011/03/25/the-sunk-co as accessed on 18 May 2016.

As we started our walk, Rodney, who can best be described as a 'top bloke', warmly greeted us. He started by referring to us as his family and said we were welcome into his backyard, a place we shared. He said he hoped to share with us some of the knowledge that had been passed down to him, but also wanted to make sure that we were able to share our own experiences, ideas and questions.

One of the first things that we came across, as we commenced our walk, was one of Australia's most dangerous plants the *Gympie Gympie Stinging Tree*[26].

This tree, that doesn't look at all out of place in a rainforest, and certainly had no obvious signs of danger, is rated up there alongside some of Australia's most dangerous animals and plants in terms of the effect that it can have on people who are exposed to it.

I'm told that if you come into contact with a tree, the pain is almost unbearable. You scratch like crazy as tiny 'nettles' from the plant are imbedded in your skin. Worst still, while the initial pain can be treated, one of the horrible things about this plant is that the sensation of pain comes back regularly, even after the nettles have been removed. This return of pain I've learnt can last for many years. It's sound bloody awful!

So, I picture how something this dangerous might be treated in the workplace. There would of course be the obligatory 'this toaster is hot' style signage, there'd have to be guards around it, there would be instructions, rules, procedures and the list would go on. Danger it seems just can't be tolerated in today's workplaces. Now, there has been plenty written about how crazy the safety industry is getting and how our abundance of 'control' is quite possibly creating just the opposite of what it may set out to achieve. In this piece however, I want to share the ideas and experiences that I learned from Rodney that day and spark some discussion about what we in risk and safety may learn from his approach. So what was Rodney's approach to dealing with one of Australia's most dangerous plants?

To begin, it started with questions about what we already knew. As we came up to the plant, Rodney stopped and asked what we could see. He listened intently as we all rattled off a list of what was in front of us, and not surprisingly, not one of us mentioned the Gympie Gympie Stinging Tree. I couldn't help but think that if this was 'safety', Rodney's next move would have been to say to us all 'good try', but you're missing something very obvious and we all need to 'listen up'. You know the style of safety person, they seem to enjoy asking questions that they suspect (almost hope) most won't be able to answer, and seem to enjoy even more watching people as they almost beg them to share their knowledge. This was not Rodney's style.

Rodney moved next to asking what dangers we thought we might be exposed to in the rainforest. There was a long list of snakes, spiders, uneven surfaces, sunburn and a few others. Rodney listened and engaged with the group as we shared our stories and thoughts. It was a great conversation with many people sharing stories about how they have been exposed to these things and how they dealt with them. I learned a thing or two.

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26. See http://www.australiangeographic.com.au/topics/science-environment/2009/06/gympie-gympie-once-stung,-never-forgotten/

Rodney then asked if anyone knew of any dangerous plants. A few of us vaguely answered 'yeah sorta' but no one really had any specific knowledge that we could share. Rodney pointed out an example of a Gympie Gympie Sting Tree and highlighted its distinctive features that include the 'nettles' in the leaves and a bright red berry. Rodney shared stories of its dangers and of some of his own experiences, but there was something different about Rodney's story and style than what we typically see in risk and safety.

In our industry Rodney would have been sharing 'war stories' and using these to make sure everyone knew of the dangers and consequences. Not Rodney, no instead it was a 'yarn' (a conversation) where he encouraged questions and shared his knowledge, but not in a way where I walked away feeling silly for not knowing. Instead, I walked away feeling part of a conversation and story where everyone involved shared learning (*Social Sensemaking*). It felt great.

Of course there will be some from a traditional safety background reading this who will probably suggest it would have been far more efficient and appropriate for Rodney to just come out and tell us about the dangers of the Gympie Gympie Stinging Tree up front. That would have been his 'duty of care' and would be the responsible approach. Not for Rodney though, he didn't seem interested in sprouting how smart he was or how much more he knew, instead for the two or so hours that we shared a walk through the rainforest, he facilitated some great discussions where I'm sure we all learnt a thing or two, least of all about the dangers of the Gympie Gympie Stinging Tree.

The Gympie Gympie Stinging Tree

I wonder if there something we can learn in risk and safety, from Rodney and his approach to sharing experiences and facilitating conversations? Do we welcome people into our backyards? I wonder if we compared this approach to how traditional organisational inductions are carried out, how might people who complete such inductions feel afterwards? I wonder if they would feel as welcome as we did with Rodney?

Rodney made De feel very welcome in his 'backyard'

Speaking of how we feel about risk – Paul Slovic reports on his research in his book *The Feeling of Risk* (2010); and finds that how we '*deal*' with risk is affected by how we '*feel*' about it. So let's now explore the significance of 'feeling' as a factor when making decisions about risk.

How I feel about risk

Slovic notes for example:

> The earliest studies of risk perception also found that, whereas risk and benefit tend to be positively correlated in the world, they are negatively correlated in people's minds... If their feelings toward an activity are <u>favorable</u>, they are moved toward judging the risks as low and the benefits as high; if their feelings towards it are <u>unfavorable</u>, they tend to judge the opposite – high risk and low benefit. (2010, p. 26)

When we accept that risk is subjective, that it is connected to feelings and emotions, and that many of our decisions and judgments about risk are not always made in a rational, analytical and logical way, we may be better able to understand and support people to deal with and engage with risk.

An experience that I recently shared with a good friend is typical of '*how my feelings about risk*' may impact on decisions that I make about it.

To begin this story, I should point out that I'm a car fan; this dates back to my childhood. I love to drive in, and experience, different cars; I find them fun and enjoyable. In particular, I like fast cars.

De knows this, so of course a choice Christmas present for me was a voucher for a one-hour drive in a Lamborghini.

I was on a high leading up to that weekend when I would use the voucher and share the drive with my great mate Macca. We'd been talking for months about how fun the drive would be. One might say we were pumped and feeling favourable about the activity.

So on that Saturday afternoon we arrived at the place where the Lamborghini was parked, ready for our adventure. We were instructed to arrive 20 minutes before our departure time so we could run through the required safety briefings and induction.

This part was pretty painless, it involved me being breath tested (tick!), a basic run down of the features of the car including how the gears work (tick!) and a little bit of planning for the route we were going to take (tick!).

Of course, there were also the six pages of paperwork (disclaimer) that I signed (without reading thoroughly of course, goodness knows what I signed up to!), and then I had to pay a $2,000 bond that I was not expecting. Then came an important moment.

Macca and I about to take the 'Lambo' for a spin

Just before I hopped into the car, I was reminded that I was about to step into a car that cost $500,000 when purchased new. I was told that the car was in pristine condition and that there had been no accidents from people hiring the car in the two years that the business had been running.

Primed with this information, while at the same time still pumped for the drive, I was then asked to sign the insurance 'waiver form' which basically meant that I was responsible for payment of the excess (or 'deductible') for the insurance of the car if I was the 'at fault' person in an accident. The potential damage to my bank account if I had an incident, $10,000! I signed the form, headed over to the car and prepared to 'take off'. I was feeling pretty good about this drive, I'd been waiting for months, my great mate was by my side, and this car was a cracker. I then paused and thought for a moment.

I'm about to drive a car that I have never driven before and it goes from 0 to 100km/h in 3.8 seconds. This thing is a beast to drive, and I'm going to have to cough up $10,000 if I have an accident. I became a little nervous, one might say a little less favourable about the activity.

The guy that owned the business was quick to usher me into the car, and start the engine. The sound of the exhaust was like music to my ears; this was going to be a fun ride. But what about the $10,000 if I crashed?

I must admit that this did concern me as I drove off in the car. I was worried about what might happen if I were to have an accident. For the first 15-20 minutes of the drive, I drove very cautiously until I got a 'feel' for the car. I then started to feel more relaxed. We hit a 100km/hr zone and I was able to 'give it a bit', I was cruising in that beast and loved it. By the time I got half way through the one hour drive, the thought of the $10,000 excess wasn't as relevant anymore; I was enjoying the drive, another thing off my bucket list; I was feeling favourable about the activity. Perhaps 'hubris' was kicking in?

It's interesting to reflect back now about how I feel about risk. In the weeks leading up to, and as I arrived for the drive, my feelings for the activity were very favourable,

and I reckon if you had asked me about the risks associated with the drive, I suspect I could name very few. This was (initially) a low risk and high benefit feeling for me.

However, as I signed that form and got in the car, my feelings about the activity were less favourable, at least for a little while. I started to worry as I changed lanes, I was asking Macca to check over my shoulder and I was very cautious. My feeling about risk at this time was intensified.

As I became more comfortable with the car, I started to feel more favourable about the activity, in fact as the vehicle arrived at 100km/hr after I 'put the foot down' I was feeling very favourable indeed and on an emotional high. Combine this with the fact that Macca was sitting beside me with a grin on his face a mile wide, and I know it was extremely favourable. The potential $10,000 forfeit wasn't even on my mind.

When I am aware that 'how I feel' about an activity may impact on how I assess risks, perhaps I am better able to discern the risk. My awareness of how I was feeling about risk did impact on how I considered risk throughout the drive. I'm conscious that it changed; I can reflect now and think about this. As I was going through the emotions (in my non-conscious mind) of the drive however it was very hard for me to consider the risk in a rational and logical way, as I did just before I started to drive. My feelings about the activity definitely shaped the way that I considered the risks (and my behaviour) associated with it.

Does how we view an activity (favourably or not) impact on how we feel about risk? Are there activities that we feel favourable about that might be impacting on how we think about risk?

Or, should we ignore our feelings and continue to hold the view that risk is objective and has nothing to do with 'feeling'?

Further growing and developing the ideas in this Chapter

So if we accept that there are many factors that may inform our unconscious mind and therefore affect so many of the decisions that we make, what can we do about this?

Here are some tips you may find useful:

- Perhaps consider, are we in risk and safety too easily seduced into looking at things only as 'objects'? Do we use all of our senses, our hearts, our minds, and tap into our spirituality (or our gut) when we are experiencing our world? Or do we limit our views by using only our eyes to make decisions and judgments.

- If we are to support people to understand and deal with risk, do we need to better understand spirituality and beliefs? Are we prepared to open up our bodies and minds to experience things more deeply and aim to understand, or are we satisfied to see something as fact and make assumptions because that's simple, and then move onto the next challenge?

Segue to the next chapter

Now that we have explored the idea that risk is subjective and subject to our feelings and experiences; and that it is not just about objects, we will now turn to a reflection of how we can deal with things when our dealing with risk doesn't go as we may have planned. How do we deal with the pain, suffering and loss where an interaction with risk brings about an unfavourable result and harm is the outcome?

Chapter 6 – Organisations, Their Decisions About Risk and Trade-offs

By Robert Sams

> "I think much organizational research is uninformative and pedestrian partly because people have tried to make it general *and* accurate *and* simple. In trying to accommodate all three of these aims, none have been realized vigorously; the result has been bland assertions."

<div align="right">

Karl Weick in:
The Social Psychology of Organising (1979, p. 41)

</div>

Acknowledge 'trade-offs' to make better inquiries

In March 2016, I attended the Society of Australasian Social Psychologists (SASP) Conference in Brisbane, Australia, where I had the privilege of both listening to, and then reflecting on, some great presentations. I also presented a short paper myself[27].

It struck me as I sat listening to the many presentations over three days that, not surprisingly, some interested me more than others. There were academics and students at all levels presenting their thoughts and research on a broad range of social psychological topics. There are some that I've decided to follow up in more detail than others. In doing so, I know that this means that I might be missing out on some useful information and knowledge. The fact is that I cannot follow through on everything, as much as I do love to learn!

This reminded me that when we choose a certain path to follow, we must accept that we are trading-off one or more other methods of inquiry. What do I mean by this?

In this Chapter, I thought it would be useful to explore this idea of trading-off when making inquiries, by considering a model outlined by Karl Weick in his book *The Social Psychology of Organising* (1979), and then presenting my own model.

In a section titled *Acknowledge Tradeoffs* (p.25), Weick provides a useful discussion on the topic in the context of making inquiries in relation to theories of social behaviour. Weick notes in relation to Thorngate's (1976) postulate of commensurate complexity: *'This postulate states that it is impossible for a theory of social behaviour to be simultaneously general, accurate and simple'*.

If you have not read Weick, you may by this point, be confused and wondering what I am on about, please let me explain. To begin, Weick's explains that such 'inquiries' may be either general, or accurate, or simple.

Firstly Weick suggests that *general* inquiries lead us to have perhaps an *overall* understanding, rather than a deep understanding of the topic of the inquiry. This may mean that we read a few articles, maybe a book, or talk with a subject matter expert in seeking to understand a particular topic.

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27. If you're interested in reading my paper, you can access it here (http://dolphyn.com.au/wp-content/uploads/2016/04/Robert-Sams-Essay-Why-is-the-mental-health-of-workers-so-poorly-dealt-with-by-organisations-11.04.20162016.pdf).

Secondly, he suggests we may seek an *accurate* understanding. It may be useful to think of this in a philosophical way, as a search for the 'truth' (Chapter 3). This is bound to require extensive inquiries in many different directions and through many different sources. It may be an 'up and down' journey as one path may lead to another as the truth is chased down.

The third line of inquiry that Weick suggests is *simple*. That is, we may accept something on face value without delving too deeply at all. This might be accepting new information such as a newspaper article or media report, or someone's opinion and not much else. We are likely to have no real deep interest in the topic, which in turn causes us to make no further inquiries.

Of course, like all things in life, making inquiries is not such a simple process; there will be many variations of each of the three models. That is, we may make a decision that is somewhere between *general* and *accurate*, or likewise between *accurate* and *simple*. In his book, Weick uses the metaphor of a clock face as a way to visually depict this, I've attempted to reproduce this below.

If you consider the clock metaphor, you may think of decisions made at 2 o'clock as being somewhere between *general* and *accurate*, and likewise decisions at six o'clock as somewhere between *accurate* and *simple*.

General

Simple   Accurate
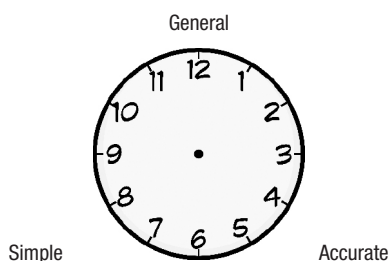
Figure 4 The Trade Off Clock (Weick, 1979)

So what has this got to do with risk, safety and people?

We often hear criticism of 'dumb-down' thinking in risk and safety and I agree that there is a tendency to 'dumb-things down' in the industry. It seems that the approach is often somewhere closer to simple and general, rather than accurate in the context as described by Weick. We see this play out when we hear; '*safety is just common sense*'.

I know, retrospectively, that as I sat through the Conference that I made (mostly unconscious) decisions to follow information through using all of the ways described by Weick. I am limited by time and I have a thirst to continue to learn, so I know that I cannot follow all information through in an accurate way, there will be some inquiries made that are simple and general, and that's ok. I understand the 'trade-offs' in these decisions.

It would be silly of us to think that we can make good inquiries without 'trading-off' one or more of the other methods and as Weick notes; "*if you try to secure any two of the virtues of generality, accuracy and simplicity, you automatically sacrifice the third*".

If we are to move away from 'dumb-down thinking' in risk and safety, I wonder if considering Weick's model might be a useful way for us to move out of this mode of inquiring? Do we need to think more of trade-offs rather that *rights* and *wrongs* (binary)?

If we are to think more in this way, we might take advantage of the Competing Values Framework (CVF) developed by Cameron and Quinn (2011) as a useful model to assist us develop that thinking.

The Competing Values Framework

The Competing Values Framework allows for an understanding of organisational culture by considering it through the lens of competing views and dimensions within an organisation (trade-offs). Developed by Kim Cameron and Robert Quinn, the: *"Competing Values Framework was developed initially from research conducted by University of Michigan faculty members on the major indicators of effective organisational performance."* (2011, p. 2)

A key to the framework is the four different perspectives in the quadrants (see Figure 5.). As Cameron and Quinn state:

> What is notable about these four core values is that they represent opposite or competing assumptions. Each continuum highlights a core value that is opposite from the value on the other end of the continuum – flexibility versus stability, internal verse external. The dimensions therefore produce quadrants that are also contradictory or competing on the diagonal. (2011, p. 40)

The important point to note about the CVF is that it is not an assessment of 'good' or 'bad'. The tool does not focus on compliance or a rating for the purpose of 'pass'/ 'fail'. Instead the CVF tool provides a method for organisations to better understand both the current state of their culture, and as a tool to provide the grammar to consider the future state.

The diagram included below (Figure 5) is taken from a short summary document developed by Kim Cameron that introduces the key aspects of the CVF and it provides an overview of the four quadrants.

It should be noted that the quadrants opposite each other in the framework effectively 'compete' with each other. For example, the 'collaborate' quadrant focuses on people working together, engaging people and long term development. Diagonally opposing this is the 'compete' quadrant that is focused on short-term performance, and getting things to 'market' quickly.

On another side of the quadrant is the 'create' or ad-hoc quadrant that is focused on being the first to do something and innovation. Activities observed in this quadrant will focus on taking risk, working outside of, or at the least pushing boundaries and being creative. Diagonally opposing this is the quadrant that is focused on 'system', 'rule' and 'control'.

There are times and situations where organisations need to adopt all four of the styles outlined in the CVF, and those organisations, which understand their current and

ongoing situation, are best placed to adapt and develop in areas where they may face challenges. It is not unusual for some organisational cultures to present as having a strong bias in only one of the four quadrants; although most will also exhibit an influence from the others to a greater or lesser degree.

	Long Term Change		Individuality Flexibility		New Change
	Culture Type: CLAN		**Culture Type:** ADHOCRACY		
	Orientation: COLLABORATE		**Orientation:** CREATE		
	Leader Type: Facilitator, Mentor, Team builder		**Leader Type:** Innovator, Entrepreneur, Visionary		
	Values Drivers: Commitment, Communication, Development		**Values Drivers:** Innovative outputs, Transformation, Agility		
Internal Maintenance	**Theory of Effectiveness:** Human development and high commitment produce effectiveness		**Theory of Effectiveness:** Innovativeness, vision and constant change produce effectiveness		External Positioning
	Culture Type: HIERARCHY		**Culture Type:** MARKET		
	Orientation: CONTROL		**Orientation:** COMPETE		
	Leader Type: Coordinator, Monitor, Organizer		**Leader Type:** Hard-driver, Competitor, Producer		
	Values Drivers: Efficiency, Timeliness, Consistency & Uniformity		**Values Drivers:** Market Share, Goal Achievement, Profitability		
	Theory of Effectiveness: Control and efficiency with capable process produce effectiveness		**Theory of Effectiveness:** Aggressively competing and customer focus produce effectiveness		
	Stability Control		Incremental Change		Fast Change

Figure 5 The above diagram is taken from the document 'An Introduction to the Competing Values Framework' by Kim Cameron, PhD

Source: (http://www.thercfgroup.com/files/resources/an_introduction_to_the_competing_values_framework.pdf) accessed on 25.07.2015

A model to understand trade-offs using the CVF

Now that we have an introductory understanding of trade-offs and have reviewed a tool that can assist us in understanding where organisations may focus their attention, we will now bring this together into one new model designed to assist in understanding how trade-offs are made in our decisions about risk. The new model, outlined in Figure 6, uses the key concepts of the Competing Values Framework as its basis to depict the four 'competing' quadrants of; *Control*, *Compete*, *Collaborate* and *Create* (the Four C's)".

While these quadrants demonstrate four different focuses that an organisation may have in dealing with risk[28], in reality, organisations need to have some level of focus in all four of the quadrants in order to be sustainable as an organisation and deal with risk.

Another critical point to note before I introduce you to the model itself, is that it is based on the idea of a 'mandala' which Fincher (2009) notes is;

> "Sanskrit for "magic wheel" and, in the most basic sense, a mandala is simply a circle. Since ancient times in many cultures the mandala has had a powerful role in depicting, containing, and expressing the sacred" (2009, p. 1)

So why use a mandala as a way to symbolically explain 'trade-offs' in risk?

A point we make several times throughout this book (for example in Chapter 9), to date is of the importance of 'communicating with the unconscious' (Jung). Fincher refers to Jung and the importance of symbols and the unconscious in *The Mandala Workbook*. Specifically, she quotes Jung (2009, p.23) as suggesting; *"The Mandala is the center* (sic). *It is the exponent of all paths. It is the path to the center* (sic), *to individualisation"*. Fincher (2009) further notes:

> Just as a wheel must have a hub in order to turn, the journey of a lifetime requires a centering point as well. Mandala's can connect us to our center (sic) even when the turning of the wheel pulls us into a busy lifestyle. Through time we can come to trust the centering force that is the Self, as Jung did. (2009, p.23)

As you consider the mandala offered below to explain 'trade-offs' in risk and safety, it may be help to reflect on how developing such a model in the form of a mandala relates to "connecting us to our centre". What do you notice at the centre of this model and why is it placed there?

The intention of demonstrating trade-offs through a mandala is to highlight that the more that an organisation 'pulls' in one direction, they potentially trade-off a focus in another. It is not for me to suggest here that there is a 'right' nor 'wrong' direction in which to focus, instead, the mandala is provided to assist your own reflections on the trade-offs that you may be making and how 'centred' you believe you and your organisation are (or want to be). Importantly at the centre of this mandala is the symbol for 'hope' (the 8 pointed star). This symbolically aims to depict how much of our decision making around what we 'trade-off' across the different quadrants is based on what we 'hope' will happen. This in turn accepts the role of chance (uncertainty) and in many ways 'trust'. The concept of 'hope' being at the centre of a mandala representing trade-offs in risk is not what you would expect to hear and see, in the grammar of traditional risk and safety, where such a concept (of 'hope') would be frowned upon.

Explicitly, this model is not intended as a checklist or 'audit' mechanism for an organisation to 'test' against. It is a model provided to assist with reflection, discussion and subsequently *Social Sensemaking*.

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28. It is important to note that in reality, there are many more competing demands, and this model, as most models do, provides a simple demonstration of this.
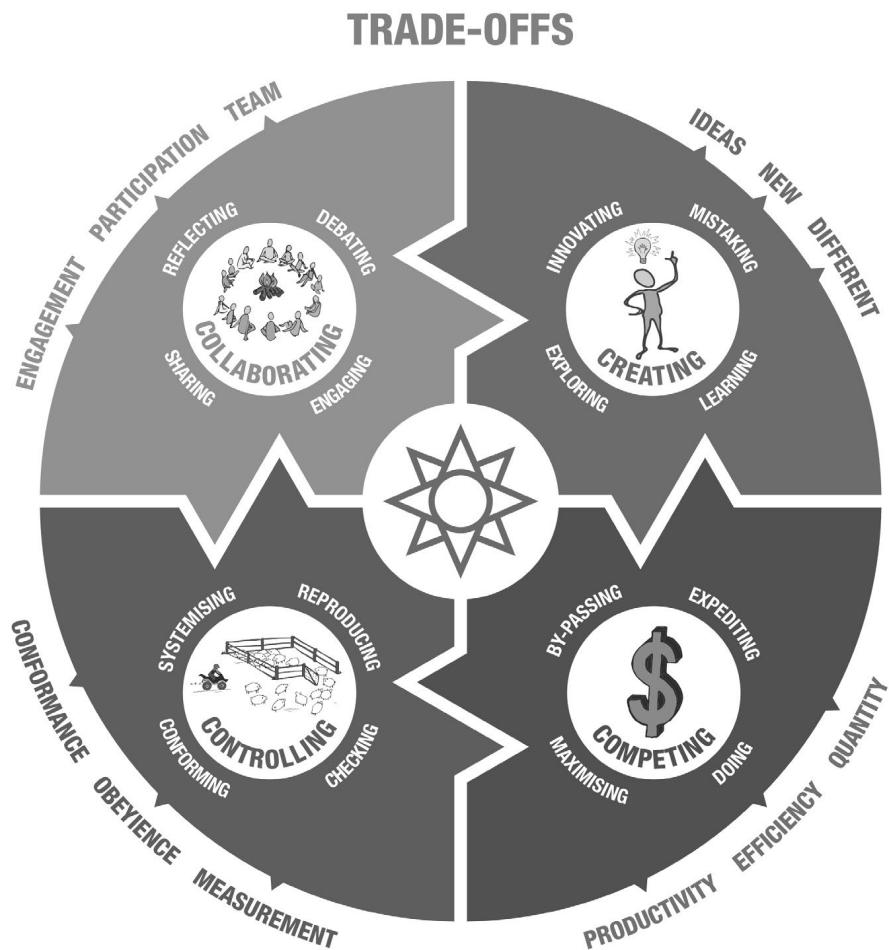
Figure 6 Trade-offs Model©

Further growing and developing the ideas in this Chapter

Understanding trade-offs in our decisions is critical if our aim is to deal with risk. If this is your aim, here are some reflection questions that you may find helpful:

- Is the focus of an organisation static? Is an assessment of CVF the same this month as it was last month?
- How might you go about understanding an organisation's focus using the CVF? What things would you listen and look for?
- If organisations focus too much in the direction of 'Control', what factors may they be trading-off?

Segue to the next chapter

The Competing Values Framework and the 'Trade-offs'© model provided in this Chapter above, are included in order to encourage and help us to look, and listen into organisations differently, in order to better understand how they make decisions about risk. We will now further explore this idea of looking at things differently through a specific case study related to Uluru, the iconic and spiritual landmark in the centre of Australia.

Chapter 7 – Looking at Objects Differently

By Robert Sams

> "Many of us live one-eyed lives. We rely largely on the eye of the mind to form our image of reality. But today more and more of us are opening the other eye, the eye of the heart, looking for realities to which the mind's eye is blind. Either eye alone is not enough. We need 'wholesight,' a vision of the world in which mind and heart unite 'as my two eyes make one in sight.' Our seeing shapes our being. Only as we see whole can we and our world be whole."

> Parker J. Palmer in
> *To Know as we are Known* (1983, p. xxiii)

What Safety can learn from a rock?

I live in Australia, a country inhabited by people from many cultures; a country with a strong indigenous history and a country with a geography that is well summed up by poet Dorothea Mackellar in her poem My Country[29]:

> I love a sunburnt country, a land of sweeping plains, of ragged mountain ranges, of droughts and flooding rains. I love her far horizons, I love her jewel-sea, her beauty and her terror - The wide brown land for me!

Australia is a beautiful land with a rich geography and short but colourful (Europeanised) history. We have much to see, to explore and to understand. But if we limit our view of the world, and if we were to explore our 'wide brown land' by looking at our many wondrous features only as 'objects' and one dimensionally by relying only on our sight, we would miss so much.

When we don't use all of our senses, including our hearts and minds to explore and understand our world, we limit our learning, our understanding and most importantly our living. When we take a more holistic view of the world; when we open our eyes to look at things as more than objects; when we use all of our senses to feel, taste, hear and smell we risk opening ourselves up to an experience which just might enhance our lives.

I recently had the privilege of visiting Uluru (also known as Ayers Rock), which is right in the heart of Australia. I'd wanted to visit there for many years (it was on the bucket list) to see, feel, hear and discover for myself the many wonderful things that I had read and heard about 'The Rock'.

For some, visiting Uluru is considered a holiday, a visit to a tourist destination, which of course it is. More than 400,000 people visit Uluru each year and it is one of Australia's most well know tourist attractions. It's also a significant geographical landmark, some 348 meters high, 3.6 kilometres long and 1.9 kilometres wide. It is approximately 10 kilometres to walk around the rock.

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29. Source: http://www.dorotheamackellar.com.au/archive/mycountry.htm as accessed on 14 April 2016

But what makes Uluru really special is its history and its place in Australian indigenous culture. And as such it occupies a place that means that it is much more than just an 'object'; it is part of the 'land'.

To look at Uluru as simply a rock, or geographical phenomenon would be like looking at your husband or wife just as a human body, or looking at your home just as a building. If we really want to understand 'The Rock', we would be wise to use more than just our eyes to 'see it'; in doing so we might elect to see it through its history and significance for our indigenous brothers and sisters.

Uluru

> To understand our law, our culture and our relationship to the physical and spiritual world, you must begin with land. Everything about aboriginal society is inextricably woven with, and connected to, land. Culture is the land, the land and spirituality of aboriginal people, our cultural beliefs or reason for existence is the land. You take that away and you take away our reason for existence. We have grown that land up. We are dancing, singing, and painting for the land. We are celebrating the land. *Removed from our lands, we are literally removed from ourselves.*

Mick Dodson
(former Aboriginal and Torres Strait Islander Justice Commissioner)[30]

The Aboriginal people don't just see a rock. Instead, they see, feel and 'be with'; 'the land'. They don't just look at Uluru's amazing change of colours, at its many and varied textures or at its incredibly overwhelming size as an 'object'. To them it has far greater meaning. To them Uluru is a place of spirituality, of history, of culture and a place that is sacred. Uluru is not just a rock to be understood as a piece of geography.

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30. Source: http://www.aboriginalartonline.com/culture/land.php accessed on 05 May 2016

So why am I writing about this in a book dedicated to making sense of risk?

I wonder whether our workplaces are also places of spirituality and of culture, and instead of understanding this, are we too easily seduced into seeing things in our workplaces just as 'objects'. Whether at work (plant, structures, equipment, tools), at home (furniture, paintings, buildings) or in our community (parks, vehicles, structures), it can be easy to view things as 'objects', but is there more to them than they are just 'things' before our eyes?

When we use all of our senses, as well as our hearts and minds to explore, to understand, to listen, to touch, to feel, to taste, to live with such 'objects' we are open to experience so much more.

I suspect it's easy to look at 'objects' and think only of their purpose, rather than considering: who uses them, what 'objects' mean to the user, and how they are interacted with. Looking at a tool solely as an object means that we don't even need to 'know' about the user, it's just the 'object' that is our concern. Imagine if the Aboriginals of Central Australia looked at Uluru simply as a rock? They would discount all of their history, their spirituality and the feeling for 'land'.

So what lessons might we take from those Aboriginal people in how they experience objects?

One example might be to consider Kapi Mutitjulu (which means Listen to Country), a beautiful and quite waterhole tucked away on the eastern side of Uluru. It is a place where the Aboriginals gathered for water, but was also a great place to capture animals that also went there for water.

De and I took the 50 metre or so walking track into the hole from the main track and just stood there in silence. We saw the sign below:
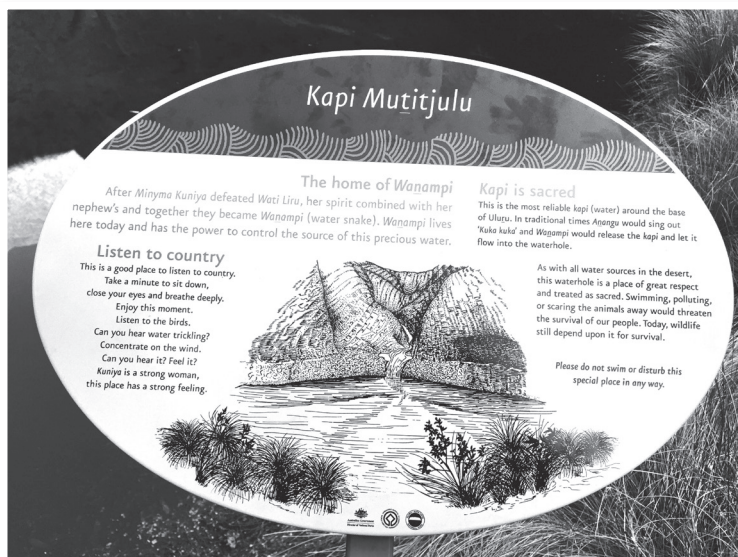
The words that struck us most were:

> "This is a good place to listen to country. Take a minute to sit down, close your eyes and breathe deeply. Enjoy this moment. Listen to the birds. Can you hear the water trickling? Concentrate on the wind. Can you hear it? Feel it? Kuniya is a strong woman, this place has a strong feeling."

I do wonder whether we should take the advice from this sign more often in risk and safety. Should we just sit and listen? Should we concentrate on what is happening around us and experience our world with more than just sight? Should we tune in more to our feelings and emotions rather than falling for the seduction of just looking at objects and things? Dealing with feelings and emotions can be difficult – maybe too difficult?

Even if we are just to use our eyes and sight to look at an object, should we believe what we see when we first look? Another amazing feature of Uluru is that it looks so different depending on how and when you see it and where you see it from. From almost every angle we looked at Uluru, we saw something different. Whether that be from a distance where it looks smooth and peaceful, from the air where you could see all of the crevices and rough textures or while standing right in front of it and looking up in awe, this rock sure is more than an 'object'.

Perhaps we can learn a lot if we are prepared to look differently at objects. So how else may we apply this principle of looking differently at things?

The same principle applies to art which is often the subject of much conjecture and discussion about what is good or bad. I suspect that if we adopt the same approach as outlined above in relation to Uluru, our appreciation of art may improve.

This reminds me of a time that I visited an art gallery with De, Max and Sylvia and where we learnt a lot about art and had some great discussions about '*what is ugly*'. Intrigued? Then read on.

Who decides what is ugly?

The way I go about my work has changed significantly over the past few years. When I think back to before 2010, my work could best be described as mechanistic and routine. I worked in '*health and safety*' and that mostly meant developing, and then assessing systems and processes which, when I reflect on them honestly, were designed mainly as an attempt to control how people behaved.

When life, and work, is focused on systems and process (control), people are not 'free'. Not free to think, not free to make choice, and not free to be creative. That is how a system works; most systems have little flex, they are structured and rigid, that's how control is achieved.

In a world focused on control there seems no time, nor space to admire the beauty of what is being created; instead, control is about efficiency. When we focus on control we miss out on so much because our view of the world is limited, as it is governed by the boundaries of many systems.

So why have I titled this part of the book *Who Decides What is Ugly*, and what has this got to do with risk, safety, control and systems?

The answer lays in a great experience that I shared recently when we visited our local art gallery. We saw the latest exhibition by Melbourne artist Patricia Piccinni which was called *Like Us*.

The visit was De's idea; she loves art and takes any opportunity to see an exhibition. Me on the other hand, historically I didn't mind attending exhibitions but I was 'give or take'. I think this is partly because I didn't allow myself to fully see and 'feel' the beauty that is art. I suspect my thinking, and hence view of the world, and art, was governed in many ways by the social construct of the environment that I worked in. I could see the great colours and detail in art, and I could admire the work that went into it, but I didn't always see and importantly *feel* the beauty. I look back now and realize I was missing out on so much.

When I viewed art as just paint on a canvas, I could not see and feel what the artist was trying to portray. I liken this to how we can often 'look' and 'observe' in risk and safety. When we only look through the lens of a checklist or legislation, we also don't 'see and feel' what is happening. We simply can't because 'Safety' is not about 'feeling', it's about right and wrong, that's what the system dictates.

So you may still be wondering what 'ugly' has to do with things?

One of the things I enjoyed about our visit was walking around and chatting with Max. We are both learning about Social Psychology together; I enjoyed the conversation we had and the questions we asked each other. Questions like: "why do you think the artist used leather next to that image?"; "what do you think was the significance of the peacock next to the child?"; and "what is this all doing to us, how do we feel?" These were great conversations that had us both thinking a lot.

These conversations were not the type that could have been prompted with a checklist or process, they happened because Max and I have a relationship, we have a shared interest and we enjoy discovering, because we know that is how we learn. The conversations weren't part of a system; they were about feelings and emotion, something systems are not interested in.

But still I hear you ask, what's ugly got to do with things?

One of the beautiful things about Piccinni's work[31] is her mix of animal, nature and people melded together into various different sculptures and pieces. The sculptures could be described as unusual; they are not simply recreations of animals or people from real life.

They are a creation based on Piccinni's worldview of her subject at the time and the key theme of the *Like Us* exhibition which is empathy and connection. To achieve this, she has pieces where animals nurture a childlike figure (*Big Mother*), where animals protect people (*Undivided*) and one piece called *Bottom Feeder*.

For some people, I imagine these pieces could be considered 'weird', 'strange', 'odd' 'confronting', or perhaps 'ugly'. I understand this, because if I looked at these pieces four years ago through the lens of my 'checklist thinking', I may have appreciated the detail and workmanship, but I know I wouldn't have interrogated the work by asking questions like the ones that Max and I asked each other.

As we continued looking at one particular piece where animal and human were as one, we noticed that mounted on a wall next to it was something that looked like a bassinet that was made of leather. We noticed this and discussed it with the gallery Guide; sharing our thoughts and questions. The Guide explained a little about the unusual looking sculpture (perhaps 'ugly') and told us that this contrasted with the beauty of the leather.

The Guide then asked us a very poignant question, *who decides what is ugly*? This made us stop and think. Max and I looked at each other and had a real 'aha moment'. We had a great discussion about this and explored the question. We wondered why some people might look at the sculptures and think that they are ugly. How could a person who has animals coming out of part of its body be considered beautiful? How could an oversized animal nurturing a child feeding on a breast be gorgeous?

The answer, when you think through the lens of 'checklist' thinking, is that you cannot. When it is your 'system' that describes what you should and need to see, how can you possibly see beauty in things?

Further growing and developing the ideas in this Chapter

I wish that I had come into risk and safety through either (or preferably both!) art and/ or education. Both callings encourage creativity and imagination. Both also encourage me to look at art honestly in order to see the beauty, not the process or technique.

For anyone in risk and safety who wants to view the world outside of a 'checklist lens', a visit to an art gallery, accompanied by some reflective thinking may help you enjoy what you discover and open your mind to a different way of looking at things. Perhaps share in the experience with others so that you may practice *Social Sensemaking* as a way to explore and understand what the artist had in mind; and what it may mean to you.

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31. http://www.patriciapiccinini.net/

Why not do this in your workplace too! Have you ever wandered around your worksite (checklist free) and observed the 'space and place'? What do you notice? How does the space make you feel? What things do you see differently when you look beyond items as objects? What impact do you think, what you see and feel, is having on others in the workplace? Is it the same? If you don't know, how could you find out?

Segue to the next chapter

It is when we are receptive to new ways of looking at things and new ways of exploring and understanding, that we really open ourselves up for learning. Learning is about change; and if we allow ourselves to be humble and ready for new ideas, change and learning can be rapid.

Let's now explore the idea of learning in more detail.

Chapter 8 – An Introduction to Critical Thinking and Learning (& Why it Matters)

By Robert Sams

> "Human knowing, rightly understood, has paradoxical roots – mind and heart, hard data and soft intuition, individual insight and communal sifting and winnowing – the roots novelist Vladamir Nabokov pointed to when he told his Cornell University students that they must do their work "with the passion of the scientist and precision of a poet.[32]"

<div align="right">

Cited in Parker J. Palmer's
The Heart of Higher Education (2010, p. 22)

</div>

Critical thinking and learning — the connection as I know it

I claim no real knowledge of 'critical thinking' rather a 'beginners interest', along with an intrigue and a desire to further understand and explore. While much of my learning of the past few years has been through the study of Social Psychology and risk, this has morphed in recent times to reading books and sharing in *Social Sensemaking* with close friends on more critical questions such as;

- What is a 'good life'?
- How do I 'know'?
- What is free will?
- What is truth?
- What is a sane society[33]?

The list goes on. As noted earlier in this journal, it is the questions, and not the answers that I find most useful in my quest for learning and understanding.

An introduction to critical thinking has also taught me about the value and importance of 'Socratic questioning' (originating from Socrates) where a shared search for the truth is the fountain of real learning. This concept is based on '*dialectic discussion*' which is about discovery through exploring the idea from one person's thesis, against another's 'antithesis', with the aim of creating 'synthesis'.

While I can understand that this concept may be considered deep, and for some, new, while for others; 'over my head', I think it is important for us to think more deeply and critically in risk and safety. There is enough 'dumb down' already! For this reason, I encourage more reflection on this topic. If our aim is to learn, we should be open to be challenged and to see, and to understand and appreciate the views of others.

Further, a study and understanding of the philosophical topics of 'ontology' (our

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32. Stephen H. Blackwell, *The Quill and the Scalpel* (Columbus, OH: The Ohio State University Press, 2009), p.xxii

33. See Fromm's *The Sane Society* (1991)

reason for being), 'epistemology' (how we learn) and our 'methodology'[34] (worldview) really are critical if our aim is to better understand people and how we make decisions. It is also critical if our aim is to support others in their learning. These topics are not part of the existing curriculum in risk and safety but in my view are must haves if we are to move these fields to a more 'humanising' approach. While I could continue here with my reflections on critical thinking, this journal is introductory in nature, and now that an introduction has been made, I will leave it to you to further reflect on how you may go about developing a deeper and more critical way of thinking in risk and safety.

I will now reflect on what I have learnt about learning.

Learning is a Social Activity

As noted previously, the 'adventure' described in this journal has taken me in many directions, there's been more than 200 books, countless articles and research papers, formal university activities, essays and conference presentations, all of which I am grateful for, and which I have found valuable.

However, as I reflect on the last few years, what I recognise as being most valuable, in fact the single most critical facet of my learning, is that is has been done through communing with others.

I've come to realise that if we are to better understand what it means to learn and understand 'why', our attention needs to shift away from focusing on *how* we gather and process information and data ('techniques'), and move towards recognising that learning is a social activity. That is, one that is most effective when we share, discover and search for the truth together with others. Humans are communal beings and learning is a communal (social) activity.

To begin an understanding of learning as a social activity, I turn to one of my favourite authors who I have been introduced to over the past few years, Parker J. Palmer.

In his book *To Know as we are Known*, Palmer explains that Scholars:

> ...now understand that knowing is a profoundly communal act. Nothing could possibly be known by the solitary self, since the self is inherently communal in nature. In order to know something, we depend on the consensus of the community in which are rooted – a consensus so deep that we are often drawn upon it unconsciously. (1983, p. xv)

Extending this, Palmer, in his short video on the '*Myth of the Individual*'[35], refers to the paradox of co-existing as an individual in a communal world.

I suspect this, along with the paradox of 'messiness' co-existing in a world where equivocality is the 'enemy', are the reasons why social learning is not better understood in risk and safety; an industry that is so dominated by binary 'methods' and 'techniques', and one that does not seem to cope well with paradox.

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34. 'Methodology' as referred to here should not be confused with how it is most commonly used (in risk and safety), i.e.. where people and organisations often talk of the 'methodology' used to assess, inspect or audit. When used in this way to describe such activities, the term methodology is actually referring to 'method', which is the technique or the way we do things. Methodology, when used in this journal, refers to a much deeper understanding than a 'technique'. 'Methodology' is more closely aligned to a worldview or ideology.

35. See: https://www.youtube.com/watch?v=dI4KIos7tuU accessed 10 June 2016

Moving on from Palmer, another critical point that I have learnt is of the importance and power of *Dialectic* in learning and knowing (another messy and 'un-binary' topic). I had not heard of the term dialectic three years ago, let alone understood its importance in learning. To seek to establish 'truth' with others, who hold different worldviews to me, through the practice of reasonable argument and while being aware of my own agenda and biases, is essential if I want to grow, mature and develop (learn).

In my career to date in risk and safety, I've not experienced much of a 'dialectic' approach in learning. Instead the 'debates about truth' usually begin (and end!) with "*section 123 of the xyz Act states that… [insert instruction here]*". So no discussion or *debate*; just do as I say!

While I'm still coming to grips with the concept of dialectic, what I am discovering is that if I am prepared to accept my own ignorance and vulnerabilities, and if I sincerely seek to understand the truth, rather than think in fact, data and evidence (binary) I will continue to live, grow and develop, rather than just exist. It might be messy, confusing and at times confronting, but that's ok with me.

Do we recognise and accept that learning is a social activity in risk and safety?

I'm not so sure we do if a recent promotion on how to do site inductions, as promoted by the safety regulator in the State of NSW[36] in Australia, is anything to go by. In this promotion, the Regulator suggests that there are 10 Steps to an Effective Site Induction.

These '10 Steps' relate to 'methods', instruction and indoctrination. There appears to be no understanding of the social nature of learning and there is no thought of curriculum, scaffolded development or readiness. No! Instead, the Regulator is focused on the transfer of information. This is not learning; instead, this is what Paulo Freire describes as 'banking education'[37].

While I don't intend to further critique the advice of the Regulator, my question is: "how do we move away from this approach of indoctrination and oppression adopted by the Regulator[38] and better support our industry to realise that real learning is a social activity?" It appears that the Regulator is not going to go down this path anytime soon.

I'm interested in understanding how we can 'search for the truth' through communing in risk and safety. As you reflect on your own learning and education in safety, what role do you see indoctrination playing? What may this 'do to people'? How does this work in with what we have already discussed here about motivation? These are questions that may assist in your own reflections and learning adventure.

So how else may this play out in life?

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36. https://safeworkwrap.com/2015/12/21/10-steps-to-an-effective-site-induction/

37. The term 'banking education' was first used by Paulo Freire in his highly influential book Pedagogy of the Oppressed. Freire describes this form of education as "fundamentally narrative (in) character" with the teacher as the Subject (that is, the active participant) and the students as passive objects. Instead of communicating, the teacher issues communiqués and makes deposits which the students patiently receive, memorize, and repeat. This is the "banking" concept of education, in which the scope of action allowed to students extends only as far as receiving, filing, and storing the deposits. (Freire, 2015, pp. 71-86)

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38. and hence so many others in risk and safety

Learning through play, adventure and taking risks

Being a Dad to Laura is one of the greatest joys of my life. However that role brings with it some of my most important responsibilities and also greatest challenges.

My role as a Dad is not one of controller, nor is it of friend. Instead, I see my role as educator; as someone who guides learning and most importantly as someone who encourages discovery in learning. One might say 'adventure'.

While I could share my love for Laura through several pages within this journal, there is one story that I feel gets to the heart of how I feel about her learning adventure and how I deal with it.

At the time of writing this, Laura is nearing the age of 13. She is in her first year of High School, and despite some challenging times in the first few years after her Mum and I separated, we have a close relationship now.

Laura lives with her Mum most of the time, however, we communicate most days, and my time spent in person with Laura is amongst my most treasured times. Some of this communication is via social media, mainly messaging Apps, with the occasional phone calls, plus my participating in her other social media pages including Twitter and Instagram.

Now, at this point, some of you may be thinking, what? Your (currently) 12-year-old daughter is on social media. Well, not only is she on it, on one of her Instagram accounts, where she posts photos of mainly her plastic toys, she has, (at the time of writing), more than 37,000 followers! So what has this go to do with learning in risk and safety?

Firstly, I know that a young child is easy prey for the not so desirable people who frequent social media. To be frank, I understand that Paedophiles for example, use social media in an attempt to engage with and trap kids. This could happen to Laura. So why do I *allow* this?

Firstly, if we understand trade-offs in considering risk (Chapter 6), and if our thinking is not binary (in this case right/ wrong), then we will be able to see that there is much learning that Laura (and I) can take from such (perceived) risk. What do I mean by this?

It is through our regular conversations that I know that Laura is able to discern the risks. We talk about how she deals with 'strange people' and requests. We chat about some of the comments that appear, and most importantly, Laura asks questions, when she is not sure. I'd much rather this as an approach to learning, than pretend that banning her would have any impact. While I could write a Chapter on social media[39], the point to take here is that at this point in Laura's life it is part of her own learning adventure.

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39. Although if you are interested in reading a good and relevant book on the topic of social media, Andrew Keen's, The Cult of the Amateur is highly recommended

Laura and her friends have a great time, and learn so much when they are at play

Further growing and developing the ideas in this Chapter

The following questions may support you in reflecting further about both your own learning and the learning of those you support.

How do we create forums where we can commune and 'search for the truth' through reasonable argument, rather than demonstrate and foster the 'one-upmanship' that is so rife in existing forums such as social media sites like LinkedIn?

What can we do to support others to realise the essential nature of communality in understanding learning as a social activity?

Segue to the next Section

As we pause and reflect on the previous two Sections of this book, we have travelled some distance in our learning about people, our motivation, how we make decisions and critically, the powerful role of the unconscious. In the next Section, we will explore how this knowledge that we have gained to date, is vital in further understanding risk and how we communicate about it.

Section 3

RISK AND COMMUNICATION
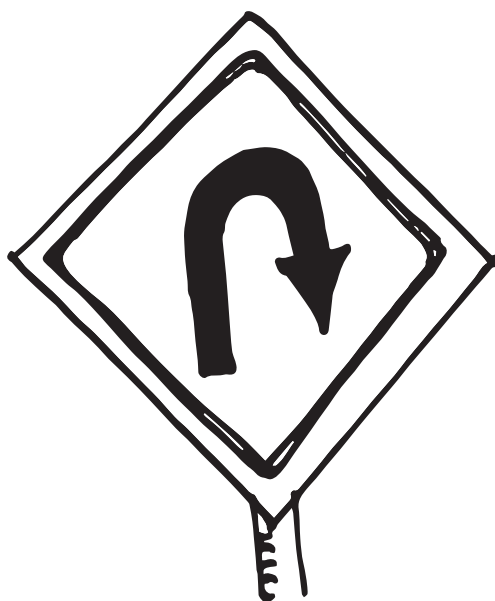
Chapter 9 – The Unconscious in Communication

By Max Geyer

> "Man, as we realize if we reflect for a moment, never perceives anything fully or comprehends anything completely."
>
> Jung (1964, p. 21)

Introduction

While we have explored the importance of understanding the role that our unconscious plays in both decision making and understanding risk, in this Section, we explore this further in the context of the role that the unconscious plays in our communication.

To begin this Section, we have this Chapter from Max Geyer who shares his reflections on the role of the unconscious in communication. I'm sure you'll enjoy Max's perspective[40].

Max's story

Norretranders (1998) provides ample evidence that the unconscious plays a major role in communication. This Chapter looks at the critical nature of unconscious communication in relation to understanding and managing risk. It uses the example of a road sign as a symbol which is used to unconsciously transmit to us a large amount of information related to a high risk, everyday activity and so enable us to quickly and efficiently recognise and manage the risks associated with driving. It concludes that if we fail to acknowledge the role of unconscious communication we risk overloading our conscious mind and drastically reducing our ability to manage risk.

Making sense of the world around us is facilitated through the recognition and understanding of the meaning of the images, sounds, words, smells, tastes, symbols, actions and objects which make up our surroundings. Although these factors may have the same or different meanings, depending on the standard adopted and how individuals filter them to form their particular model of the world (Chomsky cited in Charvet, 1995, p. 4), they are collectively studied under the discipline of semiotics and are identified as the signs which enable us to think (Chandler, 2007, p. 13).

When dealing with risk, it is often critical that we make very rapid decisions. This is what Gigerenzer (1999, p. 75) calls 'fast and frugal' decision making. Humans create heuristics (micro rules based on experience) to make these quick decisions. Being able to quickly identify and absorb the signs of danger enables us to prepare for and take action, hopefully in time to avoid the danger.

So what does all this mean in 'the real world'.

Consider for example, a person driving along a Tasmanian mountain road who is faced with a road sign. The sign meets the Australian road sign standard, it is coloured

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40. Author's note: This "story" is adapted by Max from a paper submitted as part of his Post Graduate studies in The *Social Psychology of Risk* with Dr. Rob Long

yellow, is equal sided, two dimensional, has a diamond shape and displays in its centre, a black arrow curved sharply to the right to form a "U" shape.

The sign has been placed by the road builder as a communication device; a graphic symbol of the designed and built shape of the road immediately ahead. It highlights to a driver a series of risks associated with continuing to drive that particular stretch of road, particularly at high speed.

For those of us who are adept at driving on Australian mountain roads we recognise the need to be cautious (yellow with black indicates caution) in that we are shortly to be faced with a sharp switchback to our right. It also tells us that we may need to slow down using the vehicle's brakes and gears, and prepare to turn the vehicle in the direction of the arrow taking care to not turn too sharply that we go off the road, or too shallowly that we fail to take the turn.

We know to assign that meaning based on our driver training and our conditioning from experience on similar roads with similar signs. The message contained in the symbol is the result of a great deal of information which, in the interests of brevity, has been discarded. This discarded information is referred to by Norretranders (1998, p.92) as 'exformation'.

The alternative to discarding the information would be to replace the symbol with a sign, large enough for the driver to read while potentially travelling at speed, containing all of the information related to the sign and its purpose, plus reference to the road design conditions, the reasons the designer believed we needed warning, the meaning assigned to the sign's colours and arrow, and what our reaction should be to the sign. The evidence indicates that such a sign would 'flood' the conscious and the message would likely be lost (Long & Long, 2012, p.xi). Obviously such a sign would be completely impractical.

Our unconscious mind plays a critical role in managing our understanding of the symbol and also in managing our response to it. The risks identified by the engineer and encoded in the sign are very quickly (heuristically) recognised and an appropriate response can be managed equally quickly.

At the time we see the sign we are not knowledgeable of the process used to develop the exformation, and we also don't *consciously* consider the entirety of its meaning. We notice the sign and we react. We slow the vehicle and manoeuvre it around the bend. The mechanism which triggers our automatic response to the symbol, without having to recall all of the exformation, is itself *unconscious* (Bargh & Chartrand 1999, p, 463). Further, as experienced drivers, we don't *consciously* operate the controls to manage the vehicle's progress; we operate in 'automaticity' (Bargh cited in Kazdin, 2000, p.348). But it is the *unconscious* message behind the engineer's symbol that triggers these responses.

If this discernment of the risks, indicated by the symbol, did not occur in our unconscious we would be required to keep all of the exformation, related to the sign, in our conscious mind. Further, all other communication signs, and navigation information related to our journey, would have to be similarly treated. Together this

would amount to having to keep a vast amount of information continuously in our conscious mind just to manage all of the risks along our journey.

Miller (cited in Charvet 1995, p. 4, and in Norretranders 1998, pp. 130-132) tells us that it is virtually impossible to keep more than seven items in our conscious mind at any one time. However, while it is possible to bundle some information into logical groups and apply a symbol to the bundles (e.g. a road sign) as a smart way to remember things (Norretranders 1998, p. 132) we still can't hold any more than seven bundles in our conscious. We are in constant danger of being flooded with information, thus rendering it almost impossible to discern any associated risks.

This is what Herbert Simon (1982) called 'Bounded Rationality' which has as its central principle, that when making decisions we are 'bounded' by many constraints (e.g. time), that in turn, mean that we are regularly (some might suggest always), making decisions without all of the available information and time required to analyse things in the way that we wish we could. We regularly 'satisfice' in our decision making.

Without our unconscious and the unconscious communication of symbols we would not be capable of holding all the risk information that the road builder wants to communicate with us such that we can successfully negotiate the road. The road builder's use of symbols, as a means to unconsciously communicate with us the risks associated with the road's design, reduces the flood of information and enables an efficient method to manage those risks. It clearly demonstrates the critical nature of unconscious communication in understanding and management of risk.

Further growing and developing the ideas in this Chapter

So if we accept that there are many factors, which may inform our unconscious mind and therefore affect so many of the decisions that we make, what can we do about that? Here are some questions you might want to ponder:

- Have you critically considered the messages that the signs in your workplace send?
- Do the messages from those signs mean what you actually want them to mean?
- Have you considered what it might mean to remove some of the signs that are in place? What message might that send to your people?
- Have you thought critically about the other symbols in your workplace such as:
    - defined or specifically allocated car parking spaces?
    - defined or specifically allocated toilet and meal areas?
    - the emphasis placed on the artefacts related to the business (logos, awards, photos of people, connections to supported causes, etc.)?
- What messages are conveyed by these signs and symbols; what reactions do they drive; and critically, are these what is intended?

Segue to the next chapter

Consider for a moment what happens when someone asks a question; no not that one where we just get a 'yes' or 'no'; the one where we are called upon to think about possibilities, about options, about different courses of action, and about what we know and what we don't know about the subject.

Now consider what happens when someone (particularly if that someone is a person in authority) gives a defined answer to that question. Where do all the possibilities, options, etc. go when we are 'told' the answer? In particular, what happens to our learning when 'telling happens'?

In this next Chapter we look at 'telling' and explore the potential impact that it might have on our communication and learning.

Chapter 10 – Reflective Listening

By Robert Sams

> "… the art of questioning becomes more difficult as status increases. Our culture emphasizes that leaders must be wiser, set direction, and articulate values, all of which predisposes them to tell rather than ask."
>
> Schein (2013, p. 5)

Piggy in the middle

In my very first blog post (http://www.safetyrisk.net/safety-professionalspiggy-in-the-middle/), I wrote about the role of the modern day risk and safety professional and how at times it can feel like we are 'stuck in the middle'. It's a tough gig being in risk and safety in today's environment if we follow the path of traditional safety, which can easily focus on *telling* rather than listening and having effective dialogue .

So what do I mean that we focus on 'telling'? Think about a typical 'day in the life' of a risk and safety person. It's audits, risk assessments, training, toolbox talks, inspections and the list goes on. All 'telling' right?

We 'tell' people what's wrong via audits; 'tell' people what may hurt them through 'doing' risk assessments; 'tell' people what procedures to follow when we train and do toolbox talks; and then do inspections to find, and ultimately tell, all about faults. Telling, telling and more telling. Is it any wonder that at times when we walk into a room, a workshop or a site that people turn off, or worse run?

Have you ever been in that situation where you've just delivered a training session on the latest procedure you've written, then thought, *"that was great, I told them exactly what they needed to know. I used real examples, my training was interactive, I did some small group sessions and they did a short fun quiz at the end"*. Maybe you thought: that was contemporary training right? Only to have a feeling of frustration two weeks later when doing an incident investigation and you find that one of those employees who "passed the test" didn't follow the procedure.

What were they thinking? They knew what to do. You told them very clearly, they said they understood. What went wrong?

If we focus all of our attention on 'telling' people *"what they need to know"*, I wonder how we will ever get others to own risk and safety.

It reminds me of a story from a while ago when I was driving with my daughter and her young cousins. At the time she was ten and her cousins were around the same age. They were telling their stories - what happened during the week, what games they played during their lunch break, what they did on sports day, and there was something about One Direction, Justin Bieber. The list goes on....

I listened with interest. I learnt a lot. Problem was... I found it hard work to listen. Why? Because they were all talking at once! Each story of *"I did this......"* was met with a *"Yep, I did that....."* followed by *"Yeah, I did this and that...."* You probably know the

situation, kids talking over each other, telling their 'war stories', with the main goal seeming to be .... *"My story is better than yours......"*

We can probably all relate to this with kids; it's quite innocent at that age, full of enthusiasm and passion. Funny that I've also heard the same thing said about a lot of safety people. In fact I've heard that said about me! *"You're so passionate about safety Rob, you really feel it; you tell such good stories and get our attention."* It was quite a boost to my ego hearing this.

But! It has its down side too.....

The most inspirational boss I ever had gave me the most significant piece of advice that sticks with me to this day. It goes something like this.... *"Rob, your presentations are great, you have presence, passion and people really listen to you. The way you tell a story really gets people thinking."*

Great feedback, it felt good. Then came the BUT..... *"But, my question to you is.... "What legacy do you leave people when you go? When you are not here, when you are not delivering your passionate story, what happens then? Why is safety all about you, and what impact does that have when you're not there?"*

What a question I thought. So you are saying I'm good, I'm passionate, people listen to what I say. That's good right? This makes me think of my daughter and her cousins. I wonder whether people were really listening to me, I wonder whether I really had an impact on people? I wonder whether it really made a difference, all this talking and telling? Was I just telling my story and trumping them because they didn't have a better story, and did this mean they weren't really listening? Or maybe I was just entertaining them and what I was saying or 'telling', didn't really have an impact at all. Maybe the message I was delivering was *"My story is better than yours...?"*

With my daughter's discussion with her cousins, she didn't know; probably didn't even really mind, if they weren't listening. I wonder whether I was the same. Did I really think about whether people were listening; whether they really understood what I was saying; whether they would do anything different based on what I was saying? Or, was I more concerned about the response from the audience? Did they like it; did they find it interesting; even entertaining? Did they think I was a good bloke sharing a story - 'passionate'. If they liked what I was saying, that meant that they were serious about safety right?

When I look back now at what I've learnt through my career, and by listening to my daughter and her cousins, and through other feedback, I can realise that my approach to 'doing' Safety may have been very similar; lots of telling with little time for listening and understanding. I recognise that it did not matter whether people thought my stories were interesting, passionate or entertaining, what really mattered was that people were engaged and that they translated the story into their own actions. However, what I now wonder is, can this really be done at all by 'telling', no matter how entertaining the story is?

Is it our job, as a risk and safety professional, to tell people through the medium of *"my story is better than yours"*? Or, is it about asking people questions and engaging in effective dialogue so that they own their own safety? Is our job really about moving

people from unconscious thinking (sometimes referred to as autopilot) to conscious thinking? People don't need, in fact generally don't appreciate, being 'told' what's dangerous or not. It may be better for them to realise it for themselves for them to truly 'own' it. How can I expect someone to own something if they don't discover it themselves, and how can people discover things themselves if all I do is tell, tell, tell?

Possibly the best thing we can do for people, to help discover things for themselves, is to ask open questions, create a dialogue, practice dialectic and have more *effective* conversations. That is, to do more 'asking' than 'telling', to pull back from instructing and telling war stories, and instead make humble enquiries. It appears to me that this is the fundamental challenge we have in our field; to move away from a position where we are expected to have all the answers (which after all has never been possible) to a situation where we feel ok to be the facilitator, rather than the 'teller'.

I wonder how we ever think we will drive Safety ownership if we are the ones doing all the thinking and talking. I also wonder whether we need to spend more time having conversations and consider the impact that conversations can have on risk and safety performance.

Further growing and developing the ideas in this Chapter

Maybe we have to challenge ourselves to ask more and not tell. Effective conversations can, and do, make a difference. They help bring safety, and a lot of other things for that matter, from our unconscious to the conscious mind. This is what leads to people 'owning' their own health and safety. People don't usually do unsafe things because they are stupid, they do them because they are running on autopilot, or distracted, or rushing or over-confident. All of those things happen because of what is happening in our unconscious. Through effective dialogue, we can stop for a moment and move out of autopilot, stop the distraction or slow down and not rush; and we can challenge our level of confidence; we can 'entertain doubt'.(Long, 2012) . All of these are things that can prevent an incident from occurring, and they don't require expensive processes or engineering solutions. They require effective dialogue.

Perhaps we shouldn't worry so much about who's story is better, just as long as we are engaging in effective dialogue which brings our unconscious thinking into the conscious?

Some questions for further reflection:

- How do you feel about silence in your life?
- Do you create time and space for silence, meditation and reflection?
- If you do find yourself 'telling', what 'cues' might you have to become more mindful that you are in this mode?

Segue to the next chapter

In the next Chapter, Gabrielle Carlton will explore these ideas further by providing a basic introduction in the practice of 'Humble Inquiry', a term coined by Edgar Schein in his book of the same name.

As you will see throughout the journal, there have been many ways (methods) that I have reflected on the learning adventure of the past few years. Before we move from this Chapter, I would like to share another method of reflection that has been helpful; reading poetry. Included on the next page is a short poem by one of my favourite authors, Parker J Palmer, that I found useful in my reflections on the important role of silence in reflection.

Reflecting on this Chapter Through Poetry

The Importance of Shared Silence

Within each of us there is a silence
—a silence as vast as a universe.
We are afraid of it…and we long for it.
When we experience that silence, we remember
who we are: creatures of the stars, created
from the cooling of this planet, created
from dust and gas, created
from the elements, created
from time and space…created
from silence.
In our present culture,
silence is something like an endangered species…
an endangered fundamental.
The experience of silence is now so rare
that we must cultivate it and treasure it.
This is especially true for shared silence.
Sharing silence is, in fact, a political act.
When we can stand aside from the usual and
perceive the fundamental, change begins to happen.
Our lives align with deeper values
and the lives of others are touched and influenced.
Silence brings us back to basics, to our senses,
to our selves. It locates us. Without that return
we can go so far away from our true natures
that we end up, quite literally, beside ourselves.
We live blindly and act thoughtlessly.
We endanger the delicate balance which sustains
our lives, our communities, and our planet.
Each of us can make a difference.
Politicians and visionaries will not return us
to the sacredness of life.
That will be done by ordinary men and women
who together or alone can say,
"Remember to breathe, remember to feel,
remember to care,
let us do this for our children and ourselves
and our children's children.
Let us practice for life's sake."

Source:
http://www.onbeing.org/blog/parker-palmer-the-importance-of-shared-silence/8348

Chapter 11 – The Art of Humble Inquiry

By Gabrielle Carlton

> "Ultimately the purpose of Humble Inquiry is to build relationships that lead to trust which, in turn, leads to better communication and collaboration."

> Edgar Schein in:
> *Humble Inquiry* (2013, p. 21)

Chatting with a good friend

I was chatting with a good friend and fellow colleague, let's just call him 'Brett'. Our discussion was on the importance of effective conversation leading to engaging workers. Brett stated that it was easy, he just 'has a chat with the guys' about what's going on and then he 'tells them what he wants done'. Brett is a safety manager in a large corporation.

This is not the first conversation I have had like this in my many years as a risk and safety consultant. Yet after my conversation with Brett I questioned whether this was indicative of our industry or society as a whole. Schein (2013) eludes to this in his book Humble Inquiry.

Schein (2013, p.10) explains that; that our culture is "biased toward telling". We value the art of 'knowing' and fixing problems rather than understanding and focusing on relationships. We see 'asking' as a 'weakness' or being 'ignorant' so we avoid it.

We only have to go so far as a Google search on 'safety management'[41] to see the fixation on solutions focused on systems and processes. One of the links leads us to the *Safe Work Australia Code of Practice: How to Manage Work Health and Safety* (2011).

This code (2011, p. 4) details 'a step-by-step process' for managing risk. According to this document it's a four-step process; identify, assess, control and review.

Let's turn to the textbook for *Work Health and Safety Certificate IV and Diploma* (2014). A 368-page book on the 'process' and 'law' of risk and safety management, which focuses on 'telling' the safety student how to 'do' risk and safety in the workplace and on the 'telling' of the law. Even the safety culture section details a process on how to integrate a 'safety culture'. All about 'telling' and the 'how' of risk and safety and no mention of people focused safety, relationship building or collaboration!

As a person in the risk and safety field myself I find this a concern. This is the standard textbook for risk and safety education. It has nothing on social engagement, relationship building, engaging people or collaboration. Most of the focus is on legislation and restating the Safety Act. It amazes me that in order to 'learn' about safety I need to learn about the 'safety law'. But, when I 'learn' about how to be an *educator* I learn about pedagogy, curriculum, human motivation but nothing about 'education law'. Even an engineering degree focuses on maths, physics, mechanics, design etc.., but certainly not a large focus on the law.

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41. (https://www.google.com.au/webhp?sourceid=chrome-instant&ion=1&espv=2&ie=UTF-8#q=safety%20management accessed 11 April 2016)

My safety degree was no better than the diploma or certificate. The focus was on how to interpret the law, compliance, systems and 'telling'. I did one year of law! So why is it that I must learn the law when it comes to safety? This suggests the focus is only on 'telling' not 'knowing'!

It is no wonder that my good friend Brett (who also has the same degree under his belt) thought that his way of 'effective' risk and safety management was all about 'telling'.

In my view what this industry needs more of is a focus on how to engage workers, how to build relationships and collaborate more. There is no simple and easy formula for that either. We need to accept that 'asking' is not about being 'ignorant' but that it is essential in relationship building. Schein outlines this here:

> If I don't care about communicating or building a relationship with the other person, then telling is fine. But if part of the goal of the conversation is to improve communication and build a relationship, then telling is more risky than asking. (2013, p.9)

In order to build a relationship, we need to develop trust. We can develop trust by 'empowering' the other person and just as quickly destroy it by stamping all over people. Schein calls the method of 'upbuilding' others through conversation as 'Humble Inquiry'. Schein (2013, p. 10) further states that there is growing evidence that we can achieve better 'safe' work tasks through the art of 'Humble Inquiry'.

Possibly the safety curriculum could do better by starting with a year focusing on the 'art of humble inquiry' instead of a year focusing on law and compliant systems!

Further growing and developing the ideas in this Chapter

Learning about, Humble Inquiry is not part of the standard curriculum in risk and safety. Nor does it seem to be part of the regular practice in these professions where the standard approach is of telling, controlling and policing.

If you would like to build 'humble inquiry' into your approach and practice, these questions may be useful to consider and reflect on:

- When are times where you are focused on 'self'', rather than others?
- How do you go about asking open questions and seeking understanding rather than solutions and answers?
- What 'cues' can you listen out for in yourself to identify when your approach is focused on 'getting to the bottom of things', rather than 'seeking to understand'?

Segue to the next chapter

So far, we have reflected on an understanding of people, of how we make decisions and of what it means to learn, and the critical part that our social arrangements play in this learning. Yet, we know that even with this greater understanding, things will still happen that we don't expect; things will still not always to go according to the way we plan; and we will get things wrong. Let's now reflect on what happens when things don't go to plan.

Section 4

WHEN THINGS DON'T GO TO PLAN?

A short note about the image used in this Section. Like the introduction to all Sections, we have used images and drawings as a means of conveying messages. In this particular image, on the left, you will note an 'incident' with the coconut falling on the man's head. Contrastingly, the image on the right depicts the same man drinking from the same coconut. This prompts the question; if we were to better understand paradox in risk and safety, would we view incidents differently? Do all unplanned events (incidents) have a 'bad' outcome? What other possibilities are there?

The questions are provided for you to further consider for your own reflection.

Chapter 12 – Why We Make Mistakes

By Robert Sams

"In many cases, our mistakes are not our fault, at least not entirely."

Hallinan in:
Why we Make Mistakes (2009, p. 2)

A simple error...

Recently I stayed in a hotel room with De where the bathroom was pretty small and we had our stuff everywhere! It came time to brush my teeth and thankfully De came into the room just as I was putting what I thought was toothpaste on my brush; it wasn't! I was just about to brush my teeth with her hand cream! I'd made a mistake, it wasn't life threatening, and we both had a good laugh about how moist and soft my teeth may have become. So, how could I make such a mistake?

I've brushed my teeth thousands of times, in fact I couldn't tell you the number of times that I've put toothpaste on a tooth brush, and every other time I have done so without making a mistake. Why did I nearly get it wrong this time?

It can be frustrating when mistakes are made. If we make mistakes ourselves, we are often left thinking '*why did I do that?*' or '*I hadn't noticed that before*'. When others make mistakes, particularly in the context of safety and work, we can become easily frustrated and think '*but I've told them a number of times how to do that*' or '*they've been trained, why don't they just do what they've been trained to do?*'

The truth, and reality is, that we all make mistakes. We do things that we don't mean to do because of systemic biases in the way we see, remember and perceive the world around us.

Hallinan (2009), in *Why We Make Mistakes* explores this topic and looks at: how we look without seeing, forget things in a second and are all pretty sure we are way above average. Hallinan explains that we are all biased; we just don't all recognise that we are. So what of these biases?

To start, the biases can be very helpful in the way we go about our daily life. As Hallinan (p. 3) confirms, we can be very quick to size up a situation. Within a tenth of a second after looking at a scene, we are usually able to extract its meaning. However, the price we pay for this rapid review is that we often miss a lot of details. He says "where the problem comes in is that we don't think we've missed anything, we think we've seen it all" (p. 4).

A classic case in the safety and risk industry, where this bias comes into play, is when we conduct incident investigations. Hallinan (2009, p.5) again, provides some useful thought on this when he says:

> If the mistake is big enough, it will be analysed by investigators who are presumed to be impartial. But they are plagued by a bias of their own; they know what

happened. And knowing what happened alters our perception of why it happened – often in dramatic ways.

We call this effect 'hindsight bias' and this often leads to us overlooking details and things that we ought to have seen, another mistake we can all make.

There are many reasons why we make mistakes and in my career in safety and risk I have heard a lot of commentary on this. I often hear views from people about others who make mistakes, such as:

- not being intelligent;
- not listening;
- not following instructions;
- not following training and even:
- people <u>not caring</u> about their own safety.

All of these comments, and there are many more, are not helpful in generating understanding. What is perhaps more useful is to consider and understanding of Hallinan's work. He provides a much better perspective on why people make mistakes; here are some examples:

- **Overconfidence** – or otherwise known as, '*hubris*'. When we perform a task or a job over and over, we can become very good at it. When we do a job well for a long time, it stands to reason that we become confident in doing that task. When we get this feeling, we may think things like "all's good here, nothing could go wrong with this job" and "I've done this job so many times before, what could go wrong?". When we are observing and listening well in the workplace, it pays to be looking out and listening for signs of overconfidence. Where we hear, or observe people showing signs of overconfidence, our response is important. One option is to interject immediately and *tell* the person what you've seen, but this approach may not help the person to learn, they may just follow your instruction (or question your credentials to be telling them, followed by an argument). Another, and certainly a much more effective option, may be to engage in a conversation with that person; perhaps starting with asking an open question. In this conversation the aim is for the person to recognise their own over confidence. This approach is far more likely to lead to the person recognising an issue and learning (as opposed to just being told) and therefore mean they may be better prepared in the future.

- **Our seeing isn't always effective** – we only see a fraction of what we think we see (indeed, scientists tell us that our vision only runs at 40 bits a second). Hallinan (p. 12) explains that '*the eye is not a camera. It doesn't take pictures of events and it doesn't see everything*'. The eye moves and adjusts all the time to the environment it is in and what the eye sees depends on who is doing the seeing. Hallinan notes for example that '*women tend to notice details of a woman whose purse is snatched; men notice the thief*' (p. 12). In safety and risk, we see examples of this all the time. When talking with people about hazards and incidents, it can be amazing the number of different ways different people see things.

- **Change Blindness** – that is, we notice things on a need to know basis. When we are focused on one, or a few particular tasks, we will often overlook or not see something that might be obvious to others. British mentalist and illusionist Derren Brown (http://en.wikipedia.org/wiki/Derren_Brown) conducted a classic experiment about this in central London. In his experiment, Brown shows people asking for directions to various sites in London. As the person is asking for directions, they are interrupted by a large sign that passes between the person asking, and the person receiving the directions. As the sign passes by, the person asking for the directions changes and the other person seems none the wiser. The reason that this happens, is that the person giving the directions is focused more on the map and the task at hand than the other person. The results may surprise you. You can see the experiment for yourself on this video – (https://www.youtube.com/watch?v=vBPG_OBgTWg). From this it is easy to imagine how change blindness might play out so often when it comes to safety and risk; and why this might be the cause of someone making a mistake.

Further growing and developing the ideas in this Chapter

So we can all make mistakes; some quite innocent like nearly brushing your teeth with hand cream, and of course others with far greater consequences.

One of our constant frustrations in safety and risk can be failing to understanding why people make mistakes. Hopefully you will now have a better appreciation of just some of the reasons why this is so.

You may also like to reflect yourself and consider:

- What 'mistakes' have you made? Did you learn from them? What did you learn from them?
- How can you better understand 'paradox' when it comes to incidents and mistakes? That is, how can we focus on learning opportunities rather than just errors?
- How do you support others in your organisation to understand learning in incidents? What language could you use when talking about incidents, to support such learning?

If you'd like to learn more, I can recommend you read Hallinan's book, it has great insights on this common cause of frustration. Each of the contributors to this book would see Hallinans' '*Why We Make Mistakes*' and Decis' '*Why We Do What We Do*' as compulsory early stage reading when attempting to understand human decision making.

Segue to the next chapter

Now that we have a basic appreciation of '*why we make mistakes*', let's explore the ways in which some organisations and people react when faced with a situation that they were not expecting. How do people and organisations react when things don't go as planned? What are the social expectations in this situation? How might these social expectations influence how we respond?

Chapter 13 – Just Get to the Bottom of It!

By Robert Sams

> "When something goes wrong, the cause is overwhelmingly attributed to human error: airplane crashes (70 percent), car wrecks (90 percent), workplace accidents (also 90 percent). You name it, humans are usually to blame. And once a human is blamed, the inquiry usually stops there."

> Hallinan in:
> *Why we Make Mistakes* (2009, p. 2)

There's been an accident, all systems go!

An incident occurs at work, the well entrenched procedures quickly kick into play - first aid provided, forms filled in, reports to management, find the cause (sometimes causes), change operating procedures (they must have been wrong), issue Safety Alert and conduct Toolbox Talk, include information on monthly report, then file[42].

Our systems and standard processes, some argue even the legislation, often dictate that this is what I should do, so I just do it. Sound familiar?

The question is, if following this type of systematic approach is the way I go about things following an incident, do I limit the opportunity I have to learn from the incident? Could it be that the more programmed and mechanistic our response, the less I 'think' and reflect humanly about what has happened?

Traditional approaches used within the safety field following an incident typically use a mechanistic method of review.

For example *Taproot[43]*, *ICAM[44]*, *Ishikawa or Fishbone Diagrams[45]* and *5 Why's[46]* are all popular tools used by the profession to guide incident investigations.

These tools differ in a number of ways, but the one thing they have in common is that they demand a systematic and mechanistic approach to investigation. What is more, all these approaches to investigation seem to assume that social-psychological factors are 'human factors' (that is, humans in support of a system, rather than a system in support of a human). Perhaps those who developed the tools assume that social-psychological factors are so simple to understand and detect, that the 'investigator' will already consider them in their analysis and therefore don't require consideration in the tool itself?

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42. I acknowledge that this is a far too simplistic view of how events are responded to in organisations, however, I include this description to highlight the point that our reaction to events is often far too simplistic and mechanic, which doesn't allow for ideas and thoughts to 'emerge' as the process continues. This is one of the challenges that occurs when our thinking is limited to 'systems' and process.

43. http://www.taproot.com

44. http://www.mirmgate.com/index.php?articleId=32

45. http://en.wikipedia.org/wiki/Ishikawa_diagram

46. http://www.isixsigma.com/tools-templates/cause-effect/determine-root-cause-5-whys/

Each of these systems of investigation not only proposes a 'method' but has its own underlying methodology a bias that typically does not understand, nor accept the unpredictability or fallibility of humans. The majority of incident investigation approaches understand the human as a rational being and have no factor in their mechanistic structure to understand the way social psychological factors shape judgment. This has the effect of priming users to focus on 'things' and the quest to find 'root causes' as if incidents are solely an engineering process. Mechanistic and systematic approaches are useful and necessary to assess engineering and forensic factors, but do really expect such approaches to understand the nature of human decision making associated with an incident? Imagine the outcome if we applied such an approach to Beavo's incident, what would we have learnt?

While some of the tools listed above include elements of 'human factors', they typically focus on how humans made 'errors', 'mistakes', 'lapses' and 'violations'. While there is much written about 'Human Factors', notably by people such as James Reason (1990) who came up with the 'Swiss Cheese Model'[47], the attribution that people (aka humans) involved in an incident made an 'error', 'mistake', 'lapse' or 'violation' primes those who investigate the circumstances of the incident to think negatively about the incident and about the human. Indeed we often hear that people '*committed*' the error or mistake; which brings with it the associated implications of guilt, blame and penance (punishment).

The term 'Swiss Cheese' has become folk law in risk and safety. It is used so unquestioningly and blindly by so many that there does not seem to be any critical thinking in reference to it. Many people roll out the model during induction and in most standard training in 'Safety'. However, like most simple models developed to explain complex tasks, it is sometimes useful, but generally wrong.

Reason himself has made this point and raised concern about the model's use and simplistic explanations. In a paper developed with colleagues Hollnagel and Paries (2006), they note in the Abstract of their paper about the Swiss Cheese Model:

> Accidents in complex system occur through the accumulation of multiple factors and failures. J. Reason has famously developed a model based on the Swiss Cheese Metaphor that suggests multiple contributors (the holes in cheese slices) must be aligned for any adverse events to occur. Barriers in a system (the slices themselves) are intended to prevent errors that result in these adverse events. This Swiss cheese model is not without drawbacks, and is not accepted uncritically. With use over time even the author has acknowledged its limitations. (Emphasis added)

I understand the desire and seduction to explain away complex subjects such as the 'reason for incidents' with simple to understand models; in fact I do this myself, including the models developed for this book. However, we must be cautious and considerate of what we are 'trading-off' (Chapter 6) when we take this approach.

So why is this important if we are to better learn from incidents and events in our organisation?

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47. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1117770/

The key thing is, the mechanistic approaches, to incident review, adopted by most organisations assume a rational and logical human. This means that they don't include the non-rational or the a-rational factors that influence human decision making; they don't include for example, the importance of the unconscious in decision making.

The rational assumption thinks that any mistake or error has an element of intent or 'fault'. It assumes something must have gone 'wrong'; someone didn't do what was expected of them; we must find fault. Once we have found fault, we can come up with recommendations and controls, job done, right?

This point has me wondering how would an organisation cope if the investigation found no fault? What if the outcome could not easily be pin-pointed back to one or two simple contributing factors? Organisations, (as with people) don't deal well with ambiguity. Does this drive our behaviour after an incident occurs?

The effect of this is that the outcomes of many incident investigations become predictable and often inappropriate or at least lacking. A little while ago I wrote about heuristics[48] and in particular the 'availability heuristic' and the impact that this can have on risk assessment. The same effects can occur with incident investigation. Have you ever been in a situation where you have been investigating an incident and a familiar pattern becomes obvious to you, something like… the person didn't follow the procedure, they hadn't been trained, the machine wasn't serviced, the list goes on.

What impact did the availability heuristic have when you were conducting your investigation? Did it limit your thinking? Did it do what a heuristic is designed to do (make life easy) and take you on a 'mental short-cut' that lead you to a premature conclusion; limit your exploration and your thinking and with that (and most importantly), limit your opportunity to learn?

Unfortunately, a mechanistic approach to investigating incidents constrains investigative thinking because factors such as the availability heuristic mean I must 'just get to the bottom of it' (Chapter 13). Organisational pressures often insist that we find root causes, *as quickly as possible*.

Why is it then that we continue to adopt predominately pre-programmed, mechanistic approaches when reviewing incidents?

Perhaps one of the reasons that the person did not follow the procedure was that they were distracted - by a noise, because they were thinking about their favourite sport, because they were bored in their job, stressed, anxious about their sick child in hospital, or running on autopilot. The list could go on.

How could we discover these things if we only ask mechanistic (and often closed) questions about procedures, training, maintenance, and errors linked to process or human failure[49]?

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48. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1117770/

49. Again, I turn to feedback received from Ron Gantt through the process of compiling my thoughts for this book. Ron offered the following thoughts that are appropriate of inclusion here and which may assist the reader in their own reflection; *"regarding the models that assume a "rational and logical human", I'd argue that their problem is that they assume a hyper rational/logical human, or perfectly rational/logical. People's decisions are rational and logical when considered in the broader context of an uncertain world with scarce resources. Biases can be logical in such an environment. It's only in hindsight when many of these biases appear to be illogical."* Gantt (2016)

Imagine (for a moment) the information we could learn if, in addition to looking at systemic processes, we had an open conversation with the person, or persons, involved in an incident. What if we didn't focus just on asking questions such as 'five why's', 'six when's', 'four how's', or whatever the programmed process is that is in place.

What if we talked less, and *listened* more *with* people?

Maybe one of the outcomes of such an approach would be that they would open up; they would not feel like they are being interrogated (blamed); they would not become defensive, and they may tell us what was really going on, rather than tell the investigator what they want to hear. Of course, this might not occur, but wouldn't it be a more humanistic approach?

Of course to take such an approach requires courage and imagination. The focus would be on the conversation not just the system.

We may need to overcome some fears of our own first though. What if we are talking with a young person following an incident and they tell us that they were thinking about the date they have planned for Saturday night, maybe that's *one* of the reasons why they didn't hit the right button. How do we respond to that? To the rationalist assumption, this is hard to explain, so we then find fault (blame) that they 'didn't have their mind on the job'.

I have talked to many safety and HR people who say *"just don't go there"*. I've had union officials say *"you can't ask about that; what happens outside of work has nothing to do with what happens here"*. Concerns and apprehensions about the response we get, when we engage in open dialogue, can limit our opportunity to learn.

Further growing and developing the ideas in this Chapter

Systems can play a role when trying to understand the factors that contributed to an incident, but we need to recognise their limitations. The standard approach to gathering facts, reviewing procedures, training records and maintenance documents are all useful in helping to understand some of the contributing factors.

However, if we continue to use only programmed, mechanistic methods when reviewing incidents, we will continue to limit our learning. Instead, we may be best advised to suspend our own agenda's, be aware of our own biases, and recognise the impact of heuristics. Perhaps we need to talk more with people, engage in conversation and most importantly listen to what people are saying. A dialogue with people will encourage them to tell us what really went on, without fear that they will be seen to have failed, or be 'at fault'. If we follow this approach, perhaps the less obvious contributing factors will become more obvious to us; but better still, to the person, or persons involved in the incident, and perhaps we will all share in learning in the spirit of *Social Sensemaking*.

Questions to consider for further reflection:

- How can we go about discovering our agenda and then trying to suspend that agenda when conversing with others?
- What factors get in the way of you suspending your agenda?
- What factors may be at play unconsciously that may drive your agenda?
- What role can *Social Sensemaking* play in incident investigation?

Segue to the next chapter

So we know that, despite our desire to 'get to the bottom of it' that sometimes we just can't explain things, and we have to accept that we 'satisfice[50]' in decision making; that sometimes we just can't get to the bottom of things. Okay so, what do we do when we want to share information and learnings about incidents? Most often the simple solution is to 'just toolbox it'. Let's now reflect on how this plays out in risk and safety.

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50. Satisficing is a form of "making do"; it is '… a decision-making strategy or cognitive heuristic that entails searching through the available alternatives until an acceptability threshold is met. The term satisficing, a combination of satisfy and suffice, was introduced by Herbert A. Simon in 1956. Source: https://en.wikipedia.org/wiki/Satisficing, accessed 28th June 2016.

Chapter 14 – Just Toolbox It!

By Robert Sams

> "By *technique*, (sic) ... he means far more than machine technology. Technique refers to any complex of standardized means for attaining a predetermined result. Thus, it converts spontaneous and unreflective behavior (sic) into behavior (sic) that is deliberate and rationalized. The Technical Man is fascinated by results, by the immediate consequences of setting standardized devices into motion."
>
> Robert K. Merton
> referring to the writings of Jacques Ellul in:
> *The Technological Society* (1964, p. vi)

"We'll cover that off in the next Toolbox Talk!"

... how often have you heard this in risk and safety, particularly after we have conducted an 'attribution exercise' (i.e. incident investigation, see Chapter 13)? 'Toolbox Talk' seems to be one of the most popular tools of choice available in risk and safety to address 'concerns' including incidents, inspection results and hazards, similar methods are 'safety alerts', 'safety shares' or 'safety moments'.

The Toolbox Talk (and other tools mentioned) are '*Technique*', and as we are informed through the writings of Jacques Ellul as noted in the quote at the start of this Chapter, we understand that: "*The Technical Man* (someone who's focus is 'Technique') *is fascinated by results, the immediate consequences of setting standardized devices into motion.*"

We can be easily seduced into action through the temptation of results and outcomes. But what might this mean for others, and what might this mean for learning? These are the topics that we will explore in this Chapter.

As the name suggests, the 'Toolbox Talk' (also known as the 'pre-start meeting', the 'huddle', the 'first five minutes', 'Team Talk', etc...) unsurprisingly has its origins with people hanging about, chatting, while waiting by their toolboxes for the day's work instructions. Like a lot of things in risk and safety, I'm sure it started as a good idea, a way of sharing key information, ideas and planning for the day ahead. However since 'Safety' took it over, there seems less focus on conversation, and more on 'telling'.

When we only communicate in a one dimensional way, through 'telling' rather than engaging, we limit the opportunity to understand the views of others and whether people discern risks themselves.

So why has the 'Toolbox Talk' turned into the 'Telling Talk'?

Perhaps one of the reasons is that the 'Toolbox Talk' has become one of the only ways that 'safety' is communicated. It's often the place for rolling out the new procedure, warning about the dangers of a particular hazard or laying down the law on new safety 'standards'. There were Toolbox Talks conducted at Beavo's workplace, what impact do you think that they may have had? If they were the typical type, where 'telling' trumps 'inquiry', that wouldn't have played out well for a bloke like Beavo I suspect, that is. If our focus is on 'telling' what may this mean for learning?

Rarely are 'Toolbox Talks' genuinely interactive. While there may be superficial questions such as '*does anyone have any questions?*' (where the hope is that people don't!), or '*does anyone have anything to add*?' (I've lost count of the times I've heard people say yes, only for the manager to say '*let's take that offline*'), the reality is that Toolbox Talks are controlled by managers, and the agenda is predominately that of the manager.

Toolbox Talks are also often limited in time, and conducted at the start of the day or shift when work has to begin. 'Safety' is an extra. There is rarely time to engage with people, so 'telling' becomes the order of the day.

Have your Toolbox Talks become 'technique'? Are they about 'driving outcomes' or are they a genuine attempt at dialogue; to engage, listen and understand?

So what can be done if your organisation has fallen into the trap of the 'Toolbox Talk' being the most significant way you communicate with your team?

Here are a few tips and ideas to think through which may make your safety communication program more effective:

- Allow, organise and prioritise specific time for training where it is needed. Try to not cram important training into a time limited meeting like a Toolbox Talk.
- Share information at a time that is appropriate. If the news is important enough to share, why wait until the next 'Toolbox Talk'? Sharing information, at a time that will help people make sense of it, will make it more effective.
- Consider developing conversation skills. Instead of the superficial 'does that make sense to everyone?' at the end of a Toolbox Talk when people are keen to start work, allow time to have better conversations with people while they are working. This may be the best way to understand whether they understand, and are able to deal with risk.
- When having these conversations, think about the questions you ask. While talking with one safety team a while ago, we spoke about 'asking' ('humble inquiry') rather than 'telling'. We talked about open questions, i.e., those that aim to understand the views of others. They told me that they asked these type of questions all the time, sighting examples such as 'why are you doing things that way?' or 'have you been trained to do that job?'. Unfortunately for them these are not examples of open questions, and the people asking these questions have a clear agenda, it's often about control. Instead, the key is to engage in conversation (see - 'Humble Inquiry' in Chapter 11) focusing on listening for cues to help you understand whether the person recognizes the hazards.

This book has been made possible through the act of reflection. While being an 'Action Jackson' (Chapter 3) may bring with it many positive outcomes in our lives, if we don't take the time and if we don't value reflection, we miss the opportunity of learning from our actions. We may also be less aware of our biases and how these impact on our decisions and on our relationships with others.

Reflection is a valuable tool in learning more about ourselves, more about others, and is critical if we are to find the 'truth' to the question of 'why we do what we do'. Educationalists have been aware of this for many years when they talk of 'double-loop' and 'triple-loop' learning modes (Argyris and Schon, 1996). While I don't pretend to be an expert in education, what we can take from these educationalists is that if our goal is learning, we need to move beyond the simplistic data dumping methods of 'teaching' (single-loop), and consider how we can better 'educate' the people we aim to support. So what may this mean for risk and safety?

If our goal is to truly support people to learn, grow and develop, we would do well to focus more on 'facilitating experiences', rather than falling for the seduction of 'dumping data'. Reflecting on such experiences is a significant, yet often overlooked (or unknown) method that supports us to learn. Simply regurgitating and remembering information is one way to learn new 'things', however, real learning is not just about knowing more, it is about change.

How do we support people to change rather than simply learn new things? How do we reflect on our own actions and behaviours so that we too can grow and learn? Perhaps these are the questions that should be discussed in risk and safety when the conversation turns to how to 'disrupt' our current thinking?

Further growing and developing the ideas in this Chapter

Are you interested in making the most of your Toolbox Talks? Here are some questions for further reflection that may assist in achieving this:

- Are your Toolbox Talks predominately 'one way' and directive? If they are, what impact does this have on engagement?
- In your Toolbox Talks, do you 'tell' and share information that people are likely to already know? Could you share new information, ask more questions, all with the aim of gaining a better understanding?
- Are your Toolbox Talks 'mechanistic' structure or have they become a 'technique'? What can you do about this?
- How could you engage in some *Social Sensemaking* of your own to assist your Toolbox Talks?

Segue to the next chapter

Now that we have considered a brief review of incidents and why we make mistakes, and we have outlined ways in which we may be able to adopt a more 'humanistic' approach, let's now consider how we can further reflect on events and incidents in order to make sense of things.

Chapter 15 – Reflection Makes Sense

By Robert Sams

> "This process is called reflective thought; it alone is truly educating in value…."
>
> <div align="right">(Dewey 1997, p. 2)</div>

Typically, humans like to hear and see things in black and white. Making sense of numbers and facts can be easier than feelings, imagination and possibilities. With black and white there is often less reasoning to do and we can get onto things without the bother of analysing and critical thinking. However, when we begin to understand that the world is rarely black and white; that grey and messy is real and present, we can begin to think about how we deal with, make sense of, and tackle risk.

In risk and safety, dealing with grey and messy is something we often try to avoid. Our attention is usually focused on 'control' in order to achieve black and white, either through planning, acting or reacting.

Planning often takes place through risk assessment, safety management plans, and standard operating procedures; all done in an attempt to control how work is done. Acting is 'doing' the things that we plan. Reacting can take place through investigations, audits and 'Safety Alerts' after an incident.

Many people I observe and talk to in risk and safety are 'Action Jackson' types, busy being busy, going from one situation to another ensuring that there is a plan, action or reaction to every possible situation. When I reflect on my career, I see a person who often only got attention when something went wrong; I became 'Mr. Fixit'.

At times I still struggle with this, trying to balance my desire to 'fix and control', against what I know now is the approach required in order to 'meet and support' people (see Chapter 16).

Being in risk and safety can be hard and tiring work. The demands on the modern day risk and safety practitioner can make us feel like a ping bong ball at times.

There seems to me to be a constant seduction in risk and safety (and in life) to spend most of our time planning, acting/ doing, and some time reacting BUT it seems we have hardly any time, or see any real value in reflecting.

So why is this?

I look back now and realise that you can't plan for uncertainty and that acting and reacting, whilst important, don't provide space for reflection and I realise that this may be a key if we want to make sense of the grey and messy that is risk. Weick (1995, p.78), sums this up well when he asks: *"How can I know what I've made until I see how it's sewn?"*

In Weick's model of 'sensemaking' he outlines seven key factors to how we make sense of things. These are:

- Sense is made of things through our *identity*; it is who we understand ourselves to be in relation to the world around us.

- Sensemaking is *retrospective*: we shape experience into meaningful patterns according to our memory and experiences. That is we often make sense of things after they occur.

- Sensemaking is a process of '*enactment*', that is, we make sense of things by playing them out and experiencing them.

- We make sense of things depending on the *social* context in which we experience them.

- Sensemaking is a *continuous* flow; it is ongoing and our understanding of our world is constantly changing.

- Sensemaking builds on '*extracted cues*' that we capture through our senses and perception. Cognition is the meaningful internal embellishment of these cues. We articulate these embellishments through speaking and writing in what Weick refers to as our 'consensually validated grammar'.

- Sensemaking is not so much about accuracy and completeness; rather it is about what is *plausible*. We simply have neither the perceptual nor cognitive resources to know everything exhaustively, so we have to move forward as best as we can.

So perhaps one of the critical challenges facing the modern day risk and safety professional is in not trying to understand the latest laws; not searching for the latest engineering controls; not searching for the latest technological solution to make our systems easier; perhaps it's to find the time to 'sense-make' through the model prescribed by Weick and Sutcliffe. We cannot do this if we do not value reflection as part of our 'sensemaking' process. Given that sensemaking is a 'social' activity (in that we make sense of things in relation to others); it makes sense that we might advance our understanding of risk through 'Social Sensemaking'.

Further growing and developing the ideas in this Chapter

So how can we put this into practice? Here are some practical tips to make reflection part of the way you do things:

- Consider keeping your own journal – take time out to regularly consider the day or the week that has passed and write things down. Think about the good, the bad and the things that you have discovered. Then take time to read through and consider what you have learnt.

- Maybe take a walk – the combination of moving and fresh air can help us clear our mind of 'busyness' and allow us to reflect and make sense of things.

- Be careful to not try too hard – if we try to force reflection, it may not happen. Further, a lot of reflection can happen in our non-conscious mind, so the key is clearing your mind to allowing critical thinking. Often you may not be conscious of your reflection and learning, however if you create the space, it will happen.

- Talk to others – perhaps form a Thinking Group (see Chapter 31), they are a great way to get away from the being 'Action Jackson' to share stories, ideas and thinking with others, this can help our own, and others reflection and learning.

- Seek out a coach or someone who you can talk to. Caution here again; this person is not there to solve your problems or 'fix you', their role is to listen, and to help you trawl through your thoughts. This person need not be a risk and safety expert; the skills that make a good coach are 'effective listening' and critical thinking.

Segue to the next chapter

Many of the topics we have covered in this Section of the journal to this point may have helped in your own reflection of the 'techniques' and methods commonly used both by people and organisations in reviewing incidents. In the next two Chapters we extend this exploration to a more personal level and examine how we often treat and deal with people following pain and loss, and when they experience grief.

Chapter 16 – Please Don't Try & Fix Me, I'm Not a Machine

By Robert Sams

> "At The Wayside, we tell people they are not 'problems' to be solved but rather 'people' to be met. We know we have had a good day if someone walks out our front door feeling 'met', rather than 'worked on'."

<div align="right">

Graham Long in:
Love Over Hate (2013, p. 14)

</div>

Brian the tinkerer

My friend Brian is a 'tinkerer', a very good one. If there's work to be done on a machine Brian's your 'go to man'. He can analyse, adjust, maintain or fix most things mechanical. For example, I recently bought a second hand lawnmower that wasn't quite running right. After a few hours with Brian that machine was humming like a new one. Brian sure is talented.

I appreciate having Brian around to help me fix machines when they break, but I would never want, or expect, Brian try to 'fix' me when I'm not quite running right. Why?

I'm human and need to experience pain and failure in order to learn. I also have feelings and emotions (unlike machines) that at times I don't understand myself until I take time out to reflect.

If you were to ever feel that I'm not quite running right, then I would appreciate your time, empathy and conversation but, '*Please Don't Try to Fix Me – I'm Not a Machine*'.

People aren't objects to be fixed and tinkered with like lawnmowers; we're 'beings' to be understood and 'meet'.

Resisting the seduction to fix people

In our modern world, and in particularly in risk and safety, it can be tempting to want to fix people when things are not quite running right. We can struggle to deal with pain and suffering as part of a normal life as we constantly hear messages focused on 'fixing', 'helping' and 'preventing', all of which have their place. But so too do pain, suffering and grief.

Pain and suffering, while difficult at the time we experience them, are a part of what it means to grow, mature and develop as a human. But try telling that to a mother who has just lost a child or someone recently diagnosed with cancer.

Of course, life is rarely as simple as one thing or another (good or bad) so we need to be cautious not to get caught in the trap of binary thinking. The point to be made here is that pain and suffering are just as essential for human development and growth as good times, success and happiness, and rather than being good or bad, they can be a 'messy' proposition to comprehend.

So why is the desire to 'fix' so tempting? Explicitly why are we drawn to fixing and trying to eliminate pain and suffering, rather than accepting that it is part of developing and growing?

This question is not an easy one to answer, and perhaps there is no absolute answer for it, however Kushner (2007, p.55) suggests that:

> It may be that instead of giving us a friendly world that would never challenge us and therefore never make us strong, God gave us a world that would inevitably break our hearts, and compensated for that by planting in our souls the gift of resilience.

This may provide some insight as to why we struggle to find a positive side to pain and suffering. When one is in the midst of pain and suffering and experiencing all of the feelings and emotions that go with that, it may be difficult to understand that such pain may spawn "the gift of resilience". So this is one explanation for why we may be easily tempted to move to 'fixing', that is, we can't or don't see it as a gift. But are there other explanations?

The role of pain and suffering in 'being'

I'm reminded of a friend who has recently started in the role of a mentor in a program that supports women, who have been victims of severe domestic violence, to work their way back into society. Part of the training for this role is the *Accidental Counsellor* program.

My friend was sharing some of the details of this training with me and the thing that stood out clearly was that the role of the 'counsellor' *is not to fix people*.

If we do try to fix people, she told me, we often unintentionally create more pain and suffering. The role of the counsellor is to accept the other person's pain and suffering, not to try to eradicate it. Listening and being present are the key things. It all sounded logical and to be honest, quite easy (the way that she described it).

Of course, reality is much harder than theory (a point that I'm constantly reminded of as I pen this reflective journal). Sitting with someone, hearing of their pain, their suffering and often pleas for help must be one of the most challenging things that we can face as a human being. To be confronted with someone else's pain and resist the urge to 'fix' can seem counter intuitive. In these situations though, we need to be very mindful and aware of our own 'agenda'; is it to 'fix' or is it to 'support'?

It is the idea of 'suspending our own agenda' that is critical if our goal is to support others. As my friend reminded me, while we may have all good intentions when we attempt to 'fix', the very act 'fixing', may create more challenges for the person you are trying to help as they may feel more helpless and broken (in need of fixing).

Such are the challenges of understanding the paradox of being human. If it is our goal to support, rather than fix, we are most helpful when we resist the urge of our 'reductionist' tendencies (solving and fixing), and instead see the person as a whole. Let's now explore this idea of reductionism a little further; why is it important to understand?

Why does reductionism tempt us so easily?

Sidney Dekker in *Drift Into Failure* (2011) provides a useful outline of how the reductionist approach is enacted in risk and safety:

> Newton and Descartes' ideas have pretty much set the agenda for how we, in the West, think about science, about truth, about cause and effect. And how we think about accidents, about their causes, and what we should do to prevent them. Today these effects have become so ingrained, so subtle, so invisible, so transparent, so taken for granted, that we might not even be aware that much of the language we speak, and much of the thinking and work we do in safety and accident prevention, is modelled after their ideas. (2011, p. 53)

A reductionist approach assumes simplistically, that once problem parts and symptoms can be identified, then conditions may be cured or fixed. We hear this often played out in the language of risk and safety through 'cause and effect'. Adopting such an approach means that people are being treated more like objects than beings. It means that they can be broken down into components and repaired, just like a second hand lawnmower. So perhaps, pain and suffering are essential in order for people to discover, learn, manage the unexpected and indeed to live as humans.

At this point, I feel the need to pause for a moment to further address the idea (and ideology) of reductionism in risk and safety. Particularly, I ponder why it is so prominent in risk and safety thinking and methods. In doing this, I understand that it may alienate and even offend some people who feel that their job IS to fix, protect and save people from injury. I can understand how people may be seduced into this way of thinking, pain is a challenging thing to deal with and given a choice, most of us would move to avoid it. However, as we mature in risk and safety and as we better understand and accept paradox, it is only then that we may see the irony of our (perhaps well intended) actions, that while they may be aimed at fixing and protecting, may actually be doing more harm than good. Perhaps this is the 'Paradox of Safety'?

Finally, I will finish this section on reductionism by highlighting an obvious point that shouldn't be missed. I in fact have been seduced into reductionist thinking and methods in many ways in the development of this book. By aiming to 'reduce into parts' the many facets of people and risk in order to better understand them, this may be considered in itself reductionist. This is the point I make at the beginning of the book about contradiction and paradox; it seems something that we cannot avoid. Maybe it is one of our greatest challenges in risk and safety to be more aware of when we may be being seduced by reductionist thinking which in turn may help us be more critical in our thinking.

So how can we deal with this?

If we do accept that pain and suffering are essential for 'being' as a human and developing resilience, how can we go about dealing with it?

To explore this, let's consider the pain and suffering of grief.

Elizabeth Kubler-Ross gives us some structure on this subject[51]. She provides a framework to help us work through the grief and grieving process, which she condenses to five key stages of *"denial, anger, bargaining, depression and acceptance"* (2014, p.7), each stage is not described as a step-by-step process. Instead, she outlines that each stage may be difficult and it may not be sequential, rather it can jump in stages. Importantly she also recognises the paradoxical nature of pain:

> As tough as it is, depression can be dealt with in a paradoxical way. See it as a visitor, perhaps an unwelcome one, but one who is visiting whether you like it or not. Make a place for your guest. Invite your depression to pull up a chair with you in front of the fire, and sit with it, without looking for a way to escape. Allow the sadness and emptiness to cleanse you and help you explore your loss in its entirety. When you allow yourself to experience depression, it will leave as soon as it has served its purpose in your loss. As you grow stronger, it may return from time to time, but that is how grief works. (Kubler-Ross, 2014, p. 22)

Recognising, as Kubler-Ross suggests, that depression (from grief and loss) can be dealt with in a 'paradoxical way', may be why we in risk and safety struggle to understand it. This is grey and messy, and not an easy concept to get our heads around. This will be especially so if our focus is zero harm, the favoured religion of many in risk and safety. For example, 'Zero Harm' is the epitome of the lack of acceptance of pain and suffering.

Suggesting that people should '*experience*' depression, and 'allow the sadness and emptiness to cleanse you' is outlining a process that is not clear-cut and unequivocal. Instead, is it implying that at times, life, through a period of grief, may be disordered, confusing and challenging.

Can you imagine anyone working in the risk and safety industry suggesting that people should experience pain and suffering and allow sadness and emptiness to cleanse them? Not a chance, that's when the 'Crusaders' quickly jump into save you. For Crusaders, pain and suffering is an *evil menace* that must be either denied (as in workplace influenced mental illness) or eradicated and eliminated. You can hear this all through the language of safety, especially those that espouse 'zero'.

I wonder what lessons there are in this for those of us who work in risk and safety? How do we go about more 'counselling' and less 'crusading'? Is there anything in our organisational language and practice that suggests that we actually can acknowledge and accept pain and suffering? How can we better understand the paradoxical nature of risk and safety; that is, how can 'pain and suffering' and 'safety' co-exist?

I wish my friend all the best in her new role as a mentor; in her listening, in her being human, and in her 'meeting' with the women that she will support. She knows that the women don't need fixing; they just need supporting.

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51. On Grief and Grieving: Finding Meaning Through the Five Stages of Loss (2014)

Further growing and developing the ideas in this Chapter

If we recognise firstly that accepting pain and suffering may create resilience and support learning and growth, and secondly, that our temptation to 'reductionism' in order to 'fix', dehumanises people in our society and organisations, what can we do in order to be more mindful of these things?

Perhaps you might find these questions and ideas helpful:

- What are the cues we can look out for to recognise that we might be adopting a 'reductionist' approach to our systems, language and methods?

- How do we create and/ or maintain meaningful relationships in our lives so that 'meeting' (compassion, empathy and active listening), rather than 'fixing' becomes more intuitive for us all?

- How do we share a message that pain and suffering can provide opportunities for growth and learning, and build resilience, in a way that people don't think we are being sadistic and seeking or condoning harm to people?

- How many organisations provide resources, such as training and coaching, to leaders on how to respond to failure, pain and suffering? Almost none in my experience. This lack of resources can lead to a may lead to the desire to "do something" to relieve their own suffering, which may in turn lead to the "fix" mentality. By showing Leaders how supporting the person is "doing something" it may relieve this helplessness and create more positive outcomes.[52]

When I originally posted a blog on this topic, Rob Long[53] provided the comments below, which I found useful in my own reflection on this topic; perhaps they'll do the same for you:

> "One of the most critical aspects of counselling is understanding the psychological notions of 'empathy', 'Unconditional Positive Regard (UPR)', 'suspending agenda' and 'attending'. Without a solid understanding of these there will be a misunderstanding of what it means to 'accept' pain and suffering. I would suggest a reading of Egan *The Skilled Helper* (2010) as a start for the beginner. 'Acceptance' is very different from 'coping' and we need to be careful with the use of psychological terms.
>
> At the opposite end of the scale is the crazy notion from Safety that everyone has the 'right' to be unharmed (at work). Where did this inalienable 'right' come from, simply posing crazy expectations on the workforce so that zero harm becomes the discourse for disappointment, delusion and disillusionment. Again, setting up a binary expectation adds fuel to the lack of holistic perspective in the industry.
>
> By 'accepting' pain and suffering doesn't mean I invite or desire it, this is the misunderstanding of the binary mindset ('how many people do you want to harm

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52. Particular thanks to Ron Gantt for his feedback and ideas in creating this point.

53. Dr Long has unique and extensive experience in the field of counselling; see bio here: http://www.humandymensions.com/our-people/executive-director

today'). Acceptance is about the non-denial of fallibility and about 'congruence' with others. It is interesting in all the talk about 'safety differently' in the safety sector (put forward by non-psychologists) that there is no discussion on what dynamics are required to exhibit a no-blame culture. The idea that 'Resilience Engineering' makes sense is just more 'technicist' speak for no change in paradigm.

I guess the question of 'How do we go about practicing more 'counselling' and less 'crusading'? is the challenge. Do safety people even see safety as a helping activity? Maybe they don't want the skills of counselling, learning how to motivate, or the genuine skills of helping? Maybe it's just much easier to talk about 'safety differently' and keep the engineering paradigm and policing worldview on target. One thing is for sure, there won't be much creation of resilience if that paradigm remains."[54]

Segue to the next chapter

Now that we have commenced a reflection on how to deal with pain and suffering, we will extend this theme further in the next Section by taking a look at the 'system' of Workers Compensation and Injury Management through the lens of the *Social Psychology of Risk.*

Before we do this though, there is one final reflection on the topic of pain and suffering that I wish to share with you. It is through the following poem called *The Thing Is*, by Ellen Bass. Perhaps it might influence your reflection also.

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54. Source: http://www.safetyrisk.net/most-popular-safety-and-risk-articles/ accessed on 05.07.2016

Reflecting on this chapter through poetry

The Thing Is

to love life, to love it even

when you have no stomach for it

and everything you've held dear

crumbles like burnt paper in your hands,

your throat filled with the silt of it.

When grief sits with you, its tropical heat

thickening the air, heavy as water

more fit for gills than lungs;

when grief weights you like your own flesh

only more of it, an obesity of grief,

you think, How can a body withstand this?

Then you hold life like a face

between your palms, a plain face,

no charming smile, no violet eyes,

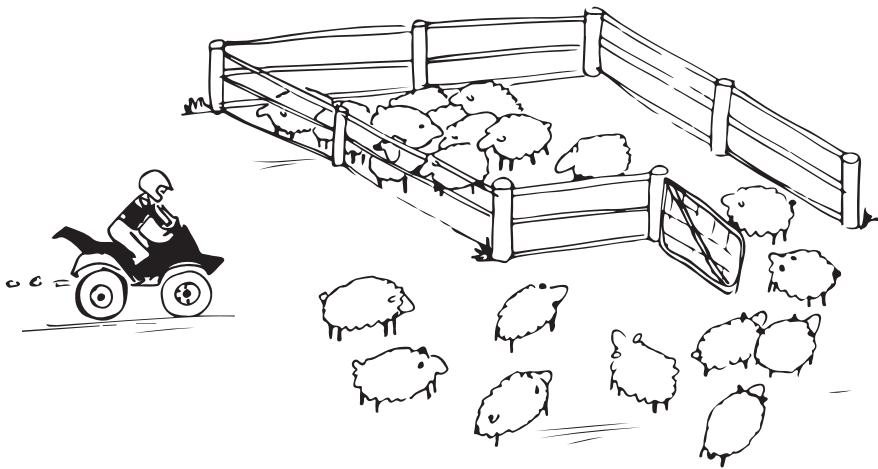*and you say, yes, I will take you*

I will love you, again

Source: http://onespiritinterfaith.org/cms/wp-content/uploads/2015/03/The-Thing-Is-Ellen-Bass.pdf
accessed on 201 June 2016

Section 5

THE SOCIAL PSYCHOLOGY OF INJURY MANAGEMENT AND WORKERS COMPENSATION

Chapter 17 – The Discourse of Workers Compensation

By James Ellis

> "Without language, we would find ourselves living in a state of emotional chaos. Our brain has given us the potential to communicate in extraordinary ways, and the way we choose to use our words can improve the neural functioning of the brain. In fact, a single word has the power to influence the expression of genes that regulate physical and emotional stress."
>
> Andrew Newberg and Mark Waldman in:
> *Words Can Change Your Brain* (2012, p. 3)

Mind your words

A friend that I study with visited me recently with his wife. Cheekily, she chastised us for overusing the word *discourse*. Why don't you just say '*conversation*' or '*talking*' she suggested? Almost simultaneously, and defensively, we responded by stating our position - that discourse is so much more than the spoken words. According to Lara Lessa (2006), who summarizes French social theorist Michel Foucault's notion, discourse is:

> ... systems of thoughts composed of ideas, attitudes, courses of action, beliefs and practices that systematically construct the subjects and the worlds of which they speak (2006, p.283-298).

Foucault maintained that discourse is about the transference of knowledge and power. In fact he argued that power and knowledge are inter-related and therefore every human relationship is a negotiation of power[55]. Power, he said, is always present and can both produce and constrain the truth[56].

Lately I've been thinking about the power differential amongst the many stakeholders in worker's compensation.

For example, those letters that workers receive from the insurer soon after becoming a *claimant*. The ones that refer to *the legislation* and even quote from it. The reference to *compliance* and the vague but implicitly threatening consequences of *non-compliance*. The notion of *provisional liability* and reference to *entitlements under the act*. If discourse is about transferring knowledge and power, I wonder how this kind of language affects a newly injured worker's sense of empowerment?

I also wonder about the sudden world of paperwork a worker is thrust into. We need a *Regulator Certificate of Capacity*, a *Return to Work Plan* and an *Injury Management Plan*. Often there's a *Treatment Plan* as well. They sign various *informed consent templates* and

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55. Power/Knowledge: Selected Interviews and Other Writings, 1972--1977. M Foucault. Selected interviews and other writings 1972,1977, 1980 - Pantheon

56. S. Strega (2005). The view from the post structural margins: Epistemology and methodology reconsidered. In L. Brown, & S. Strega (Eds.), Research as resistance (pp. 199-235). Toronto: Canadian Scholars' Press.

a *declaration* that they aren't working elsewhere. The conventional wisdom seems to be that it's all necessary. But even if we set aside the argument of the necessity of all of this paperwork, we can't ignore the fact that it has an effect.

In my conversations with insurers and employers I often hear the argument that they wish the worker would take more initiative or be more proactive. If the written component of the discourse is overwhelming, if they're flooded with threatening information, how does this impact on the workers level of empowerment? When a worker is provided with a letter explaining an organisation's privacy policy, complete with references to the relevant legislation, and then asked to sign an 'informed consent' are they really informed? Or does the social context make it very hard for them to ask, "what does this mean?"

It seems to me that the argument put forward around paperwork is well intended and is an attempt to provide the worker with knowledge. However, are we delivering this information, in large slabs, because we want to inform and empower, or because we want to be able to prove we provided them with all of the necessary information? In Foucault's language, are we *producing or constraining the truth*? Are we so myopically focused on 'telling' that we're constraining the injured workers' capacity to learn and understand? Discourse, according to Foucault (1972), is:

> ... related to power as it operates by rules of exclusion. Discourse therefore is controlled by objects, what can be spoken of; ritual, where and how one may speak; and the privileged, who may speak[57].

One of the shortcuts we all take within a sub culture is to use acronyms and jargon. They fall into common usage and we become desensitized to their use. However, in the context of discourse operating *by rules of exclusion*, I think it's easy to see how we can fall into the trap of disempowering those that are new to the process of recovery from work related injury. I wonder how workers feel when they learn they have *spondylosis* or *lateral epicondylitis*? Or when they're told to get a 'Certificate of Capacity'? One worker I spoke with this week, misheard her insurer and thought she needed to get a 'Certificate of Competency'.

I recently assisted two injured workers who worked, side by side, in the same store. One was a young lady who had been in the workforce for less than 5 years and the other was a store manager who had over 25 years of work under his belt. The young lady had never had an experience with workers compensation but the store manager had well established 'systems of thoughts composed of ideas, attitudes, courses of action, beliefs and practices' about workers compensation. Both were offered 'early intervention' in the form of treatment. The young lady jumped at the opportunity and recovered quickly but when the same offer was made to the store manager, and his wife subsequently opened a letter from the insurer and she asked him "are you on compo?". He had a very strong reaction and refused all offers of treatment and assistance.

If discourse isn't just talking, if discourse is about the transfer of power, I wonder how we can use this understanding to create a more empowering experience for both workers and employers?

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57. Foucault, M. (1972) *Archaeology of knowledge*. Pantheon. New York

Further growing and developing the ideas in this Chapter

An understanding of discourse and the trajectory (i.e. where is this taking us?) of language in our conversations and of our words and actions has been a key learning for me over the past few years. It was not part of my 'grammar' until I studied Social Psychology; it was certainly not part of my undergraduate education in 'Safety'.

This may be the same for you?

If it is, you may find it useful to reflect on your own conversations, the language and words you use and your actions in conversations. How do you talk about people? What is your, or your organisation's, language when it comes to injured workers? What is the trajectory of your discussions and language? What may it mean to and for others?

These may be critical in supporting your own learning and development about the importance of the language we use. There is no doubt that as Andrew Newberg suggests in the quote at the top of this Chapter: "*In fact, a single word has the power to influence the expression of genes that regulate physical and emotional stress*".

What words do you use; what may they mean; where do they take you?

Segue to the next chapter

In this Chapter we have explored the importance of words and language in relation to Workers Compensation. In the next Chapter, we take this one step further where good friend Hayden Collins shares his thoughts on The Semiotics of Workers Compensation. He discusses the images, symbols and signs, which are part of the workers compensation system, and how they might impact on our unconscious?

Chapter 18 – The Semiotics of Workers Compensation

By Hayden Collins

> "Semiotics involves the study not only of what we refer to as 'signs', in everyday speech, but of anything which 'stands for' something else. In a semiotic sense, signs take the form of words, images, sounds, gestures and objects."
>
> Daniel Chandler in:
> *Semiotics; the basics* (2007, p. 2)

Introducing Hayden Collins

Hayden is a friend that I met during the post-graduate program. Hayden's special interest is in semiotics, the unconscious and critical thinking. This Chapter, developed from one of Hayden's essay's in the post-graduate studies. It takes a different and deep look at the workers compensation system, and its semiotics.

We are not dealing with machines!

The current approach to rehabilitation and return to work is based on the reductionist medical model where the human body is symbolic of a machine comprised of divided parts. Wellness is then considered to be the absence of physical - and occasionally mental – symptoms, and treatment for illness involves the systematic elimination or management of these symptoms based on a predetermined treatment plan. This reductionist model does not recognise the individual as a whole person who is part of a family, community and culture, rather as a set of symptoms[58].

Recovering from injury and illness and returning to work is multifaceted. Effective rehabilitation requires a holistic perspective towards health and wellbeing, taking into consideration the physical, psychological, spiritual and social factors of the individual. The individual must be understood in their entirety. It must be appreciated that all factors are inextricably linked; and if one factor is not being attended to, the others will certainly be affected[59].

This paper will argue that labels used in return to work Guidance[60] – in particular 'injured worker' – and the failure to acknowledge the importance of social connectedness, frames the return to work process as a reductionist and mechanical system that does

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58. Aghadiuno, M., Soul Matters: The Spiritual Dimension Within Healthcare, Oxford, Radcliffe, 2010. pp. 2-14.

59. Ibid., pp. 5-14.

60. Unless specified otherwise, 'Guidance' mentioned in this paper collectively refers to the following publications:
   - Victorian Regulator Authority. Melbourne,: Compliance Code 1 of 4: Providing employment, planning and consulting about return to work;
   - Compliance Code 2 of 4: Return to Work Coordinators; Compliance Code 3 of 4: Return to Work Information; Compliance Code 4 of 4: Cooperating With Labour Hire Employers About Return to Work (VWA, 2014);
   - WorkSafe Victoria, Return to Work Coordination: The Basics You Need to Know, Melbourne; and Returning to Work: A Guide for Injured Workers, (WorkSafe Victoria, 2013).

not recognise the complexity of human beings or the significance of a holistic approach towards successful rehabilitation. I will also show how this same language creates a discourse of control, power and dehumanisation, that essentially alienates and isolates the recovering individual; damages effectiveness of relationships and return to work outcomes; and increases the likelihood that the recovering individual will experience secondary psychological conditions such as depression and anxiety.

Labels or stereotypes shape how we see the world. They unconsciously affect our perception of objects, nature, individuals (including ourselves) social communities and cultures, and subsequently influence our relationships and behaviour. Labels simplify the complexity of the world through categorisation. Once a label is in place it is extremely difficult to remove.[61] When a label is applied to an individual, they are seen as an object – something to be used, possessed, fixed or controlled.[62] The uniqueness and humanness of the individual is lost - along with it the opportunity for building relationships based on care, trust and respect – and enables the exploitation and exclusion of the individual that has been labelled.[63] Labelling affects everyone; even physicians who have taken the 'Hippocratic Oath' unconsciously treat their patients differently depending on the label and stereotype that has been applied. With kind and friendly personal treatment provided to those who are perceived as having no responsibility for the injury and impersonal treatment to those seen as negligent with no excuse.[64] I will now deconstruct the label 'Injured Worker' and explore how it can influence the return to work process and the potential social and psychological implications of its use.

When the label of 'Injured' is applied to an individual, it positions them in a class of society with certain obligations and prescriptions for how they are to behave and how they are to be treated by other members of society.[65] Individuals labelled 'injured' are to be provided with care and discharged from their social obligations, including those duties normally performed at work and home when considered healthy. The trade-off from these rights afforded them, is that they must exclude themselves from the privileges and situations enjoyed by the healthy. Being labelled as injured is stigmatising. Society perceives the injured as an inconvenience and a burden, as they are dependent on the healthy and disrupt the smooth running of everyday activities.[66] This label can cause individuals to become withdrawn, self-conscious, anxious, frustrated, angry and depressed, as their isolation from society causes them to question their usefulness, purpose and identity.[67]

The symbolism of the label 'worker' connotes the individuals' incorporation into an economic system.[68] The worker has lost their uniqueness and humanness and has

61. Alter, A., *Drunk Tank Pink*, New York, Penguin Books, 2014, p. 29

62. Buber, M., *I and Thou*, London, Continuum, 2004, p. 14.

63. Ibid., p. 30

64. Radley, A., *Making Sense of Illness*, London, Sage Publications, 1994, pp. 103-104

65. Ibid., p. 65.

66. Ibid., pp. 75-82.

67. Alter., op.cit., p. 42.

68. Although many economic systems exist, for the purposes of this paper capitalism has been chosen to use as an example. This is due to the

instead become an impersonal cog in the machine; a commodity to be used in the pursuit of profit. This system is stratified and hierarchical, with the powerful owner (or capitalist) at the top, and the worker (or proletariat) at the bottom. The value of the worker is in their ability to create goods and services for the owner, to be sold at a profit on the market. If they are no longer profitable, they are no longer valuable, and can be easily replaced like spare parts in a machine.[69] The working relationship becomes one of money and power rather than that of community, care and respect.[70]

Dehumanisation

This dehumanisation of the worker creates a discourse of reductionism, and efficiency. The worker becomes something to be used, possessed, controlled, fixed and exploited. The most important goal is returning the worker to their place in the system as efficiently as possible. How this goal is pursued will be influenced by the discourse, resulting in the disregard for a holistic approach to recovery – that incorporates the individual's social, psychological and spiritual needs – in preference for a reductionist approach that will focus solely on the systematic elimination of the worker's physical symptoms, as determined by the Return to Work Plan.

When an individual is treated impersonally and as an object, there is no opportunity for establishing a human connection or relationship, depriving them of their fundamental need to belong.[71] This deprivation creates feelings of distrust, anxiety, loneliness, depression and frustration, and can have an impact on the successful recovery of the individual. Rather than fixing the individual, a reductionist approach to return to work can create additional complications through the absence of effective relationships and the secondary psychological conditions that may develop as a result of this alienation.

The social and psychological implications of being labelled an 'injured worker' are not as visible as the physical symptoms of an injury, but are just as damaging (perhaps more-so) to the individual and their relationships at work and home. The extensive use of this dehumanising and isolating label in the Guidance[72] is propagating a discourse of power and control for employers and the healthy, and alienation and marginalisation for the recovering individual, which in turn is hampering the effectiveness of the return to work system. Creating and sustaining health and wellbeing is dependent on society's capacity to create connections and relationships rather than isolating and dehumanising. Humans' fundamental need is that of belonging, as long as individuals are perceived as objects or things that require fixing, human connection is unattainable.[73]

Labelling is not the only method in which recovering individuals can be alienated by the return to work system. The lack of recognition of the importance of remaining

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fact that capitalism is currently the system adopted in Australia - where the Return to Work guidance materials were developed for use.

69. Marx, K., & Engels, F., *The Communist Manifesto*, New York, Pathfinder, 2008, p. 39.

70. Ibid., pp. 33-34

71. Long, G., *Love Over Hate*, Richmond, The Slattery Media Group, 2013.

72. Injured Worker is referenced 820 times in the Guidance materials.

73. Op. Cit., Long, G., pp. 154-176.

connected to communities (the work community in particular) can also hinder effective rehabilitation.

In many instances work has become the primary source of social interaction and community for an individual. A substantial proportion of Australians are spending 50 hours or more per week at work[74]. There has been a decrease in religious group affiliation; and participation in organised sporting and cultural activities is on the decline.[75] The traditional family unit is also changing, with significant increases of both single occupancy households and single parent families projected over the next 20 years.[76]

The workplace is not just a source of income; it is a source of wellbeing. Humans are social by nature; community membership is necessary for health and wellbeing, and a sense of identity and security.[77] With so much time spent in the workplace and a decline in traditional community affiliations, any time away from work can increase the risk of social isolation and psychological conditions such as depression, anxiety and paranoia.[78] Behavioural research on motivation has also indicated that support from significant others – including family members, friends, employers and work colleagues – has been shown to be more influential on an individual's motivation towards an effective recovery than the support of a health practitioner.[79]

The Guidance has largely overlooked the influence social interaction and community has on wellbeing; in fact only one publication emphasised the importance of seeking family support and maintaining connections with work colleagues.[80] When guidance is principally framed by language that primes for control and process, a discourse of dehumanisation and objectivity will develop that disregards the significance of humanising elements such as support, community and relationships. This mechanistic and impersonal approach to return to work is ineffective; can alienate the injured individual, and increases the risk of secondary psychological illnesses developing.

The language used in the Guidance materials is biased towards a return to work system based on objectivity, systematicity and reductionism. This is evidenced by the use of dehumanising and process centred words such as 'injured worker' and 'compliance' being collectively referenced over <u>one thousand times</u>.

In contrast, humanising and people centred words such as 'trust', 'care', 'relationship', 'community', 'support' and 'person', are only collectively referenced <u>one hundred and fifty times</u>.

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74. Organisation for Economic Co-operation and Development, Better Life Index - Edition 2015, <u>http://www.oecdbetterlifeindex.org/countries/australia/</u>, 2015, Accessed 17th August 2015.

75. Australian Bureau of Statistics, 4102.0, A*ustralian Social Trends, Other areas of social concern, National Summary*, 19982011, <u>http://www.abs.gov.au, 2012, Accessed 17th August 2015</u>.

76. Australian Bureau of Statistics, 3236.0 - *Household and Family Projections, Australia, 2011 to 2036*, <u>http://www.abs.gov.au</u>, 2015, Accessed 17th August 2015.

77. Op. Cit., Radley, p. 2

78. Alter., op.cit., pp. 80-81.

79. Gorin, A., Powers, T., Koestner, R., & Wing, R., *Autonomy Support, Self-Regulation, and Weight Loss, Health Psychology*, Vol. 33, No. 4, 2014, p. 333

80. WorkSafe Victoria, *Returning to Work: A Guide for Injured Workers*, Melbourne, WorkSafe Victoria, 2011, p. 2.

The use of these words 'prime' the participants into a mindset of reductionist systems and process thinking, where the recovering individual is not seen in their entire humanness – as a unique person – rather, they are seen as a set of symptoms that are to be systematically eliminated or managed by a predetermined process. They are viewed as an object to be *fixed*, not a human to be connected with and related to. This treatment and perception of the individual cannot lead to the building of genuine relationships fostered by trust and care. The individual is left alienated, isolated, angry and powerless, again leading to the development of psychological conditions such as anxiety and depression.

Discounting the importance of the maintenance of social interaction and relationships for health and wellbeing hampers the effective recovery of the individual. Feeling disconnected and outcast, they are less likely to actively participate in the return to work process. This can prolong their rehabilitation, amplifying society's resentment towards the 'injured worker', fuelling their feelings of frustration, hopelessness, self-consciousness and anger, and ultimately leading to more serious psychological conditions.

In order to shift from the current reductionist methods towards a holistic approach to return to work, it is imperative that leaders replace dehumanising and process centred language with humanising and people centred language.[81]

The unconscious influence language has on behaviour and decision-making should not be underestimated. Only with a humanising discourse is acknowledgement of an individual's uniqueness and complexity, and understanding of the influence family, community and culture has on effective rehabilitation possible. Without this, we will always be trying to finish the jigsaw puzzle with only half the pieces.

Further growing and developing the ideas in this Chapter

An understanding of semiotics is critical in Social Psychology, particularly on how signs, symbols and images impact on our unconscious. For those of us with a background in traditional risk and safety roles, our view, and education of such things (i.e. signs, symbols and images) is usually viewed through the lens of how dangerous such objects are (hazards). While this is useful and important, extending our understanding of objects beyond the obvious (conscious) hazards, to the unconscious may help in our understanding of *why we do what we do*.

What signs, symbols and images do you notice as you go about your work? How may these 'communicate with our unconscious'? (Chapter 9)

Segue to the next chapter

We have now explored the critical importance of words, language and semiotics in relation to the workers compensation system. In the final Chapter in this Section, we turn again to good friend James Ellis to explore how Karl Weick's *Collective Mindfulness* construct applies to Worker's Compensation.

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81. Long, R., *For the Love of Zero: Human Fallibility and Risk,* Kambah, Scotoma Press, 2012, p. 103.

Chapter 19 – Collective Mindfulness Applied to Workers Compensation

By James Ellis

In this Chapter, my good friend James Ellis asks:

"How does 'collective mindfulness' apply to worker's compensation? How do our expectations get us into trouble? Oh, and what is the meaning of life?"

It's cool being wrong!

I'm not so sure which I enjoy most anymore, being right or being wrong? My family, who are accustomed to my insatiable appetite for being right, are (I expect) rolling on the ground laughing at this point.

Obviously there's something very satisfying about having our intuitive (and especially if they're marginalised) beliefs, confirmed by good evidence. That smugness we feel when our gut feeling is supported by someone we respect or by a credible source of evidence. Paradoxically, since I went back to 'school'[82] this year, I've been getting quite used to the warm, visceral and stimulating feeling that is induced when my long held assumptions are turned upside down. I have to say, the fallibility induced stimulation has been completely unexpected.

So why the warm fuzzy feeling when I'm wrong?

Maybe it's attributed to the liberation I have felt in beginning to truly understand how little I actually know. And that, that is ok. That *being wrong* is a portal to my holy grail – the meaning of life – that great source of stimulation that is infinitely available to the 'a-rational mind' that drives our decision making…. our capacity to learn stuff.

So now that I've so succinctly provide the answer to the meaning of life, let me turn my attention to a more difficult (some would say wicked) problem… the complex world of workers compensation. I'm afraid I'll need more than two paragraphs, and I'll certainly need more than one blog.

Weick & Sutcliffe's book, *Managing the Unexpected*, has been a real eye opener. Their research has focused on the characteristics of organisations with arguably the highest exposure to risk (e.g. nuclear power plants, aircraft carriers, fire fighters), and how they organise themselves. Weick calls them High Reliability Organisations (HROs)[83]. The book's title gives us the immediate insight that unpredictability is ok. No amount of strategic planning can eliminate the unexpected so, rather than pursuing the illusion of control, HROs set about bracing themselves for, and managing, the unexpected.

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82. Graduate Certificate in the Psychology of Risk (Social Psychology) at ACU….6 months in and boring my family to distraction *note by author, this article was written in 2014

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83. Authors Note: while in most of their texts and academic papers Weick (and Sutcliffe) use the term High Reliability Organisations (HRO), I have noted that while they continues to use and refer to this term, that they also increasingly seem to refer now to 'organising' (as opposed to just 'organisation'), which moves the emphasis toward the act of 'organising', rather than the focus being on the organisation as a whole.

Weick and Sutcliffe describe a suite of five characteristics that they call *'Collective Mindfulness'* (2007, pp. 9-16) (summarised here):

- Preoccupation with failure….continually asking "what could go wrong?"
- Resistance to our tendency towards oversimplification
- Ongoing attention to what's going on at the front line
- Recognition that those in authority are not always the best source of expertise and finally
- Resilience, or being mindful of errors or adverse events that have already occurred

To properly appreciate how we typically 'manage the unexpected' it's important to understand confirmation bias. It's crucial to understand how much we like to be right so we can appreciate the value of being constantly alert to the possibility of being wrong. Weick and Sutcliffe, when referring to confirmation bias, tell us that: *'… we actively seek out evidence that confirms our expectations and avoid evidence that disconfirms them.'* (2007, pp.25-26)

Think about this in the context of having an argument with your partner, a work colleague or a friend. How easily and freely do we rationalise away evidence that deviates from our point of view.

So how does collective mindfulness sit with our workers compensation system(s)?

Do we expect mistakes?

How does this 'system' cope with deviations from the expected pathway?

Confirmation bias weighs heavily on planning, and in workers compensation we do a lot of planning. We have Psychosocial Assessment Plans, Return To Work Plans and Injury Management Plans. In our businesses we do strategic plans and our business coaches provide pithy advice like 'failing to plan is planning to fail'. In workers compensation there is pressure to quickly settle on a diagnosis, usually with all eyes on the ineradicable question of attributability to work. Diagnosis is quickly followed by a Treatment Plan.

The thing about planning is it creates expectations

Once we develop a 'Plan' we have a strong bias towards expecting that Plan to pan out. Mintzberg (1994, p. 5) calls this the 'fallacy of predetermination'[84]. When we make plans we reinforce our expectations and this reduces our tendency to notice deviations from the Plan. Developing plans and procedures assumes that reliability of actions leads to reliable outcomes and the problem with this assumption is that it desensitises us to unexpected events.

One of my team (a physiotherapist) recently assessed Barry, who had knee pain. The clinical examination suggested a meniscus tear so an MRI was sought by Barry's treating doctor. The MRI showed no tear. So now we had a dilemma. Could the MRI be wrong? Is the clinician who diagnosed the tear wrong? The insurer, whose default

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84. The Rise and Fall of Strategic Planning: Reconceiving Roles for Planning, Plans, Planners, Mintzberg, H. 1994, p. 5, New York: The Free Press, <http://coco-net.org/wp-content/uploads/2012/08/risefall.pdf,> viewed 2nd July 2016

plan was to decline liability, rigorously argued in favour of their own confirmation bias, seeking to decline based on the MRI. They argued proof of no pathology, despite Barry's pain and discomfort. A referral to an orthopaedic surgeon was made and approval granted reluctantly under pressure from an assertive employer. The surgeon reviewed the MRI and made his own clinical diagnosis, agreeing that a meniscus tear was the most likely explanation… but his diagnosis and opinion wasn't unequivocal. That is, he made room for being wrong. Without a definitive conclusion, the recommended arthroscopy was questioned and approval hard fought. Interestingly, at arthroscopy, the surgeon found the meniscus to be fine, but a small (offending) bony fragment beneath the knee cap was found and removed.

Now, consider this example from the perspective of Barry, his Physio, the insurer, the surgeon and the employer.

Clearly none of them had enough information to reach a definitive conclusion.

How sure was Barry that he wanted an arthroscopy? How sure was the insurer that the claim should be declined? How invested was the Physio in her clinical diagnosis? And how quickly did each develop a *plan* that they locked into pursuing?

James (right) pictured here in 'humble inquiry' mode

In the end, to some extent, the clinicians and the insurer were all wrong at various stages. Ultimately however the worker was relieved of his pain and function was restored. Do you think that gave them a warm fuzzy feeling? Or did the expectation that their expertise should provide a more definitive answer, early on, leave them feeling uncomfortable? *Collective Mindfulness* doesn't suggest we shouldn't make plans, just that we should be wary of them. Collective Mindfulness provides freedom to be wrong. In fact it encourages us to vigilantly consider how wrong we might be in the face of the pressure our plans provide to forge ahead…. despite subtle signs we could be going the wrong way.

Think about that the next time you're arguing with your partner about driving directions.

Planning can easily become an effort to control the unknown, but we know so little that the unexpected is inevitable. Our *fallibility* is inevitable.

I've taken to embracing my potential wrongness more readily of late. It's very liberating. I've always been uneasy about planning because of the implicit pressure to consider an

array of considerations I have no expertise in. Embracing our potential wrongness is liberating because it frees us up to learn stuff.

Of course however, I could be wrong.

Further growing and developing the ideas in this Chapter

Weick & Sutcliffe's construct of *Collective Mindfulness* is a useful model to help us deal with the 'unexpected'. In particular, in this Chapter James' use of the construct is helpful in supporting our understanding of how we might better be able to support people and our organisations when people are injured.

Does your organisation practise '*Collective Mindfulness*'? How are you, and people in your organisation prepared to deal with the unexpected? If you were to consider the 5 elements of Weick's Collective Mindfulness in relation to your organisation, how might it fare?

Segue to the next chapter

This Section has been about people who have been injured at work and how they are dealt with in the 'system' of workers compensation. This may challenge some readers. It may also have created some new thinking and questions. That's the very purpose of this book.

We now turn to a topic that has become particularly prevalent in the discipline of 'Safety' in my home region of Australia and New Zealand in recent years, that is the way the current interpretation of Law, regulation and the perception of 'Due Diligence' impacts on culture.

Section 6

THE LAW, DUE DILIGENCE AND CULTURE
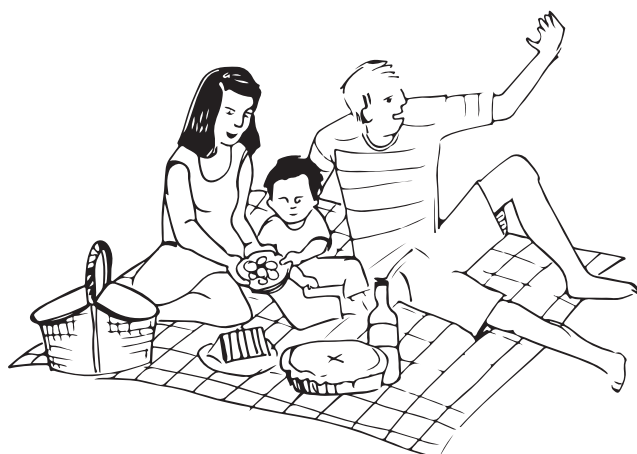
Chapter 20 – What is Excess Regulation Doing to Us?

By Robert Sams

> ... the [Safety] industry, has created a place for itself, built a fortress for itself out of these rock solid walls and those walls are made out of things like regulation, engineering and systems and we have made that the fortress. Unfortunately we have lost sight of the people inside the fortress and we now treat people in the most despicable way in the name of risk, ...

> Dr. Rob Long in:
> *Risky Conversations: The Law, Social Psychology and Risk* (Long, Smith & Ashhurst 2016, p. 9)

What is our tool of choice?

If regulation is your tool of choice, you will probably believe that when existing regulation doesn't work, that you just need more or better regulation to achieve your desired level of 'control'. If this is the case for you, a good question to ask may be what does excess regulation do to us? What impact does 'excess' have on what we do; on motivation and how we treat others? These critical questions are addressed in this paper.

When we have excess of anything in our life and we become used to it, one of the by-products can be addiction. While this paper does not aim to explore addiction as such, the key point I make in drawing this conclusion is that people who are addicted to something (e.g. alcohol, gambling or a drug) can become physically immune over time to its effects and in order to achieve the desired feelings need more and more and in greater levels, of it (excess).

The problem when we develop an addiction to regulation, just like addictions to substances, or gambling for instance, we can become immune over time to its effect and crave more and more. When one regulation doesn't appear to work, is this akin to becoming immune to substances, we need to increase the amount to achieve the desired outcome? This is dangerous in risk and safety as an addiction to regulation can lead to a focus on obedience, to leading through fear and an over-emphasis on 'desired behaviour' rather than on understanding and compassion. Perhaps it would be useful to start by exploring what regulation is and what it aims to achieve?

Regulation aims to set a 'social norm' and to influence and control people's action within a given population. In risk and safety, regulation aims to impose norms on organisations, persons within organisations and those who perform work. Regulation is necessary and sets minimum standards and expectations in both work, and life in general. Just like drinking, alcohol in moderation can be healthy, so too can regulation in moderation be healthy for work and life. However, it can have a dangerous trade-off when regulation is our only approach and when it is created in excess. So what do I mean by 'excess'?

This of course is a subjective term. 'Excess' means different things to different people. For example, let's consider it in relation to our intake of food or drinking alcohol. We have national guidelines in Australia for food[85] and alcohol[86] intake, and while these may 'make sense' to most, it is well documented that around 26% of Australian's drink beyond the minimum recommended limits[87]. Are these people drinking in 'excess' or do they simply have different standards to the rest of the community? When does drinking in 'excess' become an addiction?

This is a challenging question as setting 'norms' in a society with so many different people from different cultures who have different expectations, beliefs and standards is never going to be an exercise that will reach the agreement of everyone. There will always be different views on 'norm' and 'excess'.

So how could we try to understand what 'excess' means in the context of risk and safety?

One way to answer this question might be by comparing the amount or number of regulations we have compared to other regions. However, by recognising that the term 'excess' is subjective, we know that even if we provided some form of rational comparison of how much regulation we have compared to another region, that it would not be a useful exercise, as we know that one persons 'excess' may be another person's 'norm'. So perhaps asking the question, "what is excess?" is the wrong question. Perhaps a better question is, "how can we tune in to signs of, and be on the lookout for, situations where regulation may be in excess; and further, what might this do to us?"

For an answer to these questions, I turned to author and Philosopher, Jacques Ellul.

Ellul's work on 'technique' which he defines as, *the totality of methods rationally arrived at and having absolute efficiency ... in every field of human activity*" (1967, p. xxv) could be a good starting point. 'Technique' is about efficiency and process, and just like regulation, aims for control and considers the work of people as 'outputs'.

If we consider this in the context of regulation having as its only focus being outcomes (i.e. compliance, yes or no) and on binary ways of thinking (right/ wrong or safe/ unsafe) we come to realise that there is no place for *fallibility* and *understanding*, only efficiency. When we think of people only as the sum of 'outputs' and in terms of efficiency, we miss out on much of what it means to be human such as imagination, creativity, social connection and most importantly fallibility.

The first victim when the focus is on regulation and technique in 'excess', are freedom and autonomy and there is little room for creativity and imagination, just process. As we know from Deci's (1995) work, the best way to motivate people is to support their sense of autonomy. 'Efficiency' doesn't care too much for autonomy, or freedom, instead it craves control and conformity with process.

So if we observe signs of excess and, of 'efficiency' and outputs, what impact can this have on how we go about our lives?

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85. (https://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/n31.pdf)

86. (http://www.alcohol.gov.au/internet/alcohol/publishing.nsf Content/36E6FEE732C8DF1BCA25767200769CD8/$File/adult.pdf)

87. (http://grogwatch.adf.org.au/2013/04/new-survey-australias-drinking-habits-revealed/).

Again, Ellul notes *"Not understanding what the rule of technique is doing to him and his world, modern man is beset by anxiety and a feeling of insecurity"* (1967, p. vii).

Excess technique and regulation (just like addiction) can lead to anxiety because this approach is about fear, obedience and control. When people are seen as the sum of 'outputs' and efficiency, and as resources; and when our freedom is taken away from us, we become anxious as we focus solely on creating 'outputs' rather than having the freedom to think for ourselves (autonomy). This is anxiety is present when we feel the 'excess' of regulation.

Perhaps the most poignant and liberating point that I take from Ellul's work however, is that he acknowledges that he lives in the very society that he writes about and criticizes; he says: *"I am keenly aware that I am myself involved in a technological civilization, and that its history is also my own."* (1967, p. xxvii).

For those who have responded to my previous pieces with notes of "that's all fine in theory", and "I bet that's not how you always go about things", I must agree; and like Ellul, I am involved in the risk and safety society that I write about and I too am fallible and prone to making the very mistakes that I write about. That is the paradox of human life and I love being human!

So let's explore some examples where a focus on 'excess' regulation may impact people.

In October 2013, a truck was involved in an accident in the Sydney Harbour tunnel which caused mayhem for over one million people who do the 'morning commute'. The truck somehow had its tipper section rise up when it was inside the tunnel, causing the truck to become stuck. I remember listening to the NSW Roads Minister, Mr. Duncan Gay, report on this incident on that night's TV news coverage[88]; and thinking that the Minister could not possibly have had all of the answers, as to why the incident happened, only a few hours after it occurred.

However, when I thought of the 'social context' in which he made his report; and I thought of the community expectation of a decisive and strong Minister; one who must be focused on action and accountability (efficiency), I could see that he had no choice other than the political one. He had to demonstrate that his Government was tough and in control; he had to lay down the law and not accept this type of disruption to the community *as it creates inefficiency*. I can also see how this could create a desire for more (stronger) regulation?

The problem when regulation is our 'tool of choice' and efficiency is our focus, we allow no time for understanding, we have no space for mistakes (inefficiency); instead we cry out for more regulation on top of regulation; for 'crack-down' campaigns and for tougher penalties. This in turn drives us to more binary thinking (people just need to be safe!) and a discourse of control. The excess regulation leads our public officers to suggest, as Minister Gay did, "… a few idiots put their truck into gear before they put their brain into gear".

Is it really that simple? And so what does this mean in risk and safety, and what can we learn from this?

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88. (https://www.youtube.com/watch?v=LSmo2e79wO0).

Of course, if we want an example of how this plays out in our own industry, we need look no further than the Piper Alpha disaster. In this catastrophic event that occurred on 06 July 1988, 167 people lost their lives due to a fire on an oil rig in the North Sea. While I expect most people will be aware of this event, the key point I highlight about this tragedy is that the people who survived the fire were those who <u>did not follow the rules</u> and who, instead of going to the designated safe haven, went with their gut feelings and jumped overboard.

The people who didn't follow the regulation lived. Let me be clear on this, I do not advocate that we should have a 'laissez-faire' approach and have no regulation and anarchy. But this event does serve as a good reminder that relying only on regulation may not always lead to the 'safest' outcome; it may restrict thinking and imagination and provide only one solution to what is often a complex problem.

So, if we accept the premise that excess regulation can lead to excess control; and to fear and obedience, how do we work in risk and safety when regulation is here to stay?

Further growing and developing the ideas in this Chapter

Here are a few tips that have helped me deal with this conundrum:

- Consider thinking in reverse. For example, at the conference (mentioned earlier) I spoke of an incident investigation I was involved in where, I 'suspended' my own agenda (or at least tried to!) in the first instance, and instead of going straight to a checklist of the regulation as I arrived at the site to investigate, I first encouraged thinking, imagination and exploration of ideas. I then reviewed those ideas against regulation. By first encouraging others to imagine and brainstorm, we support them to *critically think*. If our approach is to review only against regulation, we support 'tick and flick' safety.

- Perhaps try thinking about how to create space in your life for imagination and creativity. When our focus is solely on regulation, on compliance and binary thinking, you won't have space or time to create and lead, and most importantly to learn.

- Maybe try to entertain doubt; and be aware of when you may be seduced into thinking in a binary way, or where you may create 'excess' yourself. When we get our head around the fact that things are rarely right/ wrong or safe/ unsafe, we open our mind to better understanding people and *why we do what we do*. This may be a slower approach (i.e. not efficient) and it may be frustrating at times (black and white is easier than grey) but it does help us to better understand what it means to be human.

If regulation is your tool of choice in dealing with risk and safety, what does this mean for how encourage others to discern risk?

Segue to the next chapter

So if we accept that "too much of anything is not a good thing", including regulation, how do we attempt to deal with this in our organisations? One way to be aware of this, is to consider how regulation is impacting on organisational culture. In the next Chapter, we will explore how organisations may create an excess of regulation in their culture which may ultimately lead to constructing an 'Obeyience Culture'.

Chapter 21 – Are You Creating an 'Obeyience Culture'

By Robert Sams and Max Geyer

> Culture as a collective programming of the mind thus plays an obvious role in motivation. Culture influences not only our behaviours, but also the explanations we give for our behaviours.
>
> Geert Hofstede in:
> *Culture and Organisations; Software of the Mind* (2010, p. 327)

Are we compliant?

When I started consulting in risk and safety, people would regularly contact me and ask *"are we meeting our legal requirements?"* or *"are we doing all we need to do, 'under the law'"*. Consulting in risk and safety seems to attract these questions, and people expect that this is an area I am interested in. After all, if you're into safety, you must be focused on legislation, right?

When an organisation focuses only on legislation and rules, people are often treated as objects within a system. This is because the focus often becomes about the system and perfection and there is little understanding of how people make decisions and judgments. This may actually increase risk in an organisation because people work out of fear rather than understanding; follow process rather than thinking creatively; and are more concerned with perfectionism than learning.

This is why ***I'm not that into Safety anymore***[89].

Some organisations are so fixated on meeting their legal requirements (and obeying 'the system') that they become blinded to the impact that this has on culture. Companies that focus their attention solely on a 'system' create a culture that demands obedience, in what I refer to as an 'Obeyience Culture' - obedience in the name of compliance. This type of culture fosters fear, silence and blame; all of which lead to organisations where surprises are the norm, and unusual events appear from nowhere because people in those organisations do not reports mistakes, near misses or 'oh dear' moments. This is because this type of reporting is not how things are done in an 'Obeyience Culture' for fear of reprisal (blame, loss of bonuses, safety awards etc). So why do these organisations require obedience?

The reason is that leaders in such organisations believe that obeying instructions, following directions and adhering to rules is what the law requires. You will hear such leaders say things like *"we just need clear guidelines, standards and processes, and people who will follow them"*. Such leaders are treating people like robots expecting that they should do everything that is asked of them, without question. Rules are there to be followed.

In one recent organisation that I heard of, they developed 'Sensible Standards' that *had* to be followed, and they expected 'uncompromising compliance' (which meant

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89. http://www.safetyrisk.net/im-just-not-that-into-safety-anymore/ accessed on 5th July 2016

a first and final warning if you didn't follow the standards) from everyone. They told their frontline supervisors (that to make it easy for them), that the supervisors had no discretion when it came to their people 'breaking' the standards. They were expected to punish people, no questions asked. The site leader added, *'we are doing this to save lives; that's what we are about'*. I've become attuned to words like this, and I now listen for the discourse of these words. Words like this are a sure sign that this was an '*Obeyience Culture*'.

The irony is that organisations with an 'Obeyience Culture', do not deal with risk as we well as organisations with 'learning cultures'. 'Obeyience' creates an environment that is structured, fixed and difficult to change (see Chapter 23). 'Obeyience' cannot entertain *critical thinking* because it cannot entertain being wrong. 'Learning cultures' instead provide an environment that is full of critical thinking and of challenging ideas and practices. They are nimble, creative and resilient. So organisations that strive to meet legal requirements and deal with risk through obedience, may well just be doing the opposite, because in those organisations people cannot learn and when they make mistakes, they must be punished.

So why are organisations and leaders seduced into thinking that an 'Obeyience Culture' will help them meet their legal requirements?

The seduction comes from the belief that employees obeying rules means that they, as leaders, are doing what the law requires them to do. This is often what is portrayed in various legal briefings and advice that is distributed to organisations and managers. We are constantly being advised that we must have and review policies, procedures and standards and we must create a culture where people follow them – 'Obeyience'.

I understand why it is tempting for some leaders to focus on developing an 'Obeyience Culture', however I wonder though whether they stop to consider the by-products and trade-offs that are created by fostering such a culture?

The by-products and trade-offs include silence and under-reporting; no one wants to bring bad news or to highlight mistakes (breaches of 'the rules'). However, there is a greater concern that leaders should be aware of, which is the power that they have over people and their behaviour when their focus is on obedience.

Milgram (2009) highlighted this in his social psychological studies in 1962 in which 40 people, all males, participated in an experiment that demonstrated what 'ordinary' people will do to each other when they are operating under the authority of another.

In his experiments, Milgram had actors, who were dressed in white coats to demonstrate authority, issue instructions to some of the participants to administer electric shocks to other participants when they answered incorrectly to questions they were asked. As people continued through the test they received increasingly higher doses of electric shock each time they answered incorrectly.[90].

The people, who were receiving the supposed shocks, were not really strapped up to the electricity, but those who were administering the shocks believed that they were. They were told *'they will learn more, because they get punished when they make a mistake'*.

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90. https://www.youtube.com/watch?v=fCVlI-_4GZQ accessed 5th July 2016

Of course, this was not the case at all; there was no learning for the participants who were receiving the supposed electric shock; the real learning related to how far people will go, and what they will do, when a person who is perceived to be in a position of authority, administers a command.

Milgram's experiment provides a fascinating insight into the power of authority, and demonstrates just how obedient people will be, even when they feel uncomfortable, and don't want to do what is asked of them.

So what can we learn in risk and safety from Milgram's experiments, and what do they mean for organisations with an 'Obeyience Culture'?

There are two key lessons for leaders to consider. Firstly, leaders should be aware and reflect on how their own authority and style may impact on the people they are leading. This can often be a difficult thing to detect. After all, if their style is to issue instructions and people always seem to follow these instructions, they may think everything is going fine.

Of course, if this is done in the social context of an 'Obeyience Culture', they will not hear from their team when things go wrong, because this is not the way things are done in an 'Obeyience culture'. A lack of honest feedback is another by-product of an 'Obeyience Culture'. If you are a leader and you rarely hear of problems, mistakes or errors from your team, you should be concerned that you may have created an 'Obeyience Culture'.

Secondly, leaders need to be aware of and reflect on the overall culture of their organisation. Leaders in an 'Obeyience Culture' may themselves be fearful of the ramifications of not meeting their legal, head office, regulator or other imposed requirements (their due diligence). The irony is that the leaders themselves may be blinded or at least mislead by Obeyience.

What does it mean to be diligent?

In the 'Obeyience Culture' we will hear reference to 'due diligence'. We hear people saying (and rightly so) that we have to demonstrate due diligence. But when we hear this we are usually drawn to a six-point checklist, which someone has extrapolated from *The Act*, and we hear them say that by checking off the points on this list you will be able to demonstrate due diligence.

That approach is challenged by some. Greg Smith (in his "*Risky Conversations*" collaboration with Dr. Rob Long and Craig Ashhurst has this to say:

> Due diligence, has got a lot of noise lately in the safety space... I'm absolutely convinced that the way it's being flogged around the safety industry fundamentally misrepresents what due diligence is about. I think it also represents the real lack of critical thinking that we see in the safety industry. (Long, Smith & Ashhurst, 2016, p. 20)[91]

So what does this mean?

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91. Greg Smith in: *Risky Conversations: The Law, Social Psychology and Risk* (Long, Smith & Ashhurst 2016, p. 20)

The point is that being able to demonstrate 'due diligence' is not about *having* a thing (a policy or a system) it is about *doing* a thing. Demonstrating due diligence is about *being* diligent. And diligent is defined as "showing persistent and hard-working effort in doing something"[92]. So, demonstrating due diligence is focused on *doing*; it is an **activity thing**.

So what does demonstrating due diligence really mean?

Being diligent requires 'Officers'[93] to go and look, question and understand what is going on in their business. It requires 'Officers' to enter the workplace and actively interact with the people conducting the work. It also requires 'Officers' to understand about (not just be aware of) the risks that they (actively) know are present in the business and that people are engaging with. The 'Officers' understand about the risks because they are diligent (persistent and hard working) in their risk understanding *activities*. They are diligent in their active pursuit of these activities which include: *active* questioning, *active* listening and *active* understanding.

Further, demonstrating due diligence is also about being able to (actively) confirm that '*what is going on*', is actually what they agree is '*what ought to be going on*'. It is actively confirming that what the human, fallible, error prone people conducting the work, understand the policies and procedures are saying is what they (the Officers) deem are the most appropriate ways to manage the risks that they (actively) know are present in the business. And they know this because they are active in finding out from these same people what those most appropriate methods might be; including actively ensuring 'as best they can' that these same people have the necessary resources (skills, knowledge, well-being, support, equipment, etc.) to discern and manage the risks.

But wait…. there's more: demonstrating due diligence is also about being active in knowing when the unexpected happens (what Weick and Sutcliffe (2007, p. 12) call having a "sensitivity to operations"). Again this means that 'Officers' actively engage with people to learn about what is '*really*' happening, as opposed to what they '*hope*' is happening. And most importantly it is about: stopping, reflecting (as individuals and collectively) on what has happened (good and not so) and paying *active* heed to experiences and learning from them.

I'm reminded of Dewey's philosophy on learning "... *education's purpose is to prepare us to survive and, hopefully, flourish in a future that is by nature uncertain.*" (Dewey, cited in Hildebrand, 2008, p. 125).

If you are in an organisation that focuses mainly on LTI's, risk assessment scores, completing checklists, counting 'safety observations' and 'zero harm' and little focus on understanding people and motivation, and no acceptance of mistakes; and you think that demonstrating due diligence is about ticking off boxes on a checklist; it is likely that you have an 'Obeyience Culture', or you are on the path to developing one.

So what do leaders need to be aware of in order to avoid an 'Obeyience Culture'?

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92. Encarta Dictionary: English (UK) viewed 6th July 2016)

93. That is, those who have responsibility for making decisions across the majority of an organisation (as defined in Australian Health and Safety legislation

Further growing and developing the ideas in this Chapter

Leaders who are keen to understand whether their culture may be based on 'Obeyience', may want consider these questions as a starting point:

- What words are used by leaders across the organisation and what is their discourse (or trajectory)? Words like 'uncompromising', 'must do', 'no discretion', 'zero tolerance', 'absolute expectation', 'we are serious' and 'no room to move' can all be signs that the organisation is focused on 'Obeyience'.

- What language is used in organisational policies and procedures? Is it focused on words like 'compliance', and 'adherence', or instead on *learning*, *acceptance of error*, and an open culture of listening and 'humble inquiry'?

- How are people rewarded and recognised? Is the focus on injury numbers (lag indicators), or effective conversations (lead indicators, or preferably, not measured at all)?

- How are incidents dealt with? Is an incident, near miss or hazard report seen as a failure, or an opportunity to learn?

- When the unexpected happens, what is the first question asked? If it is "who did it?" instead of "how can we learn from it?" – then you may have an 'Obeyience Culture'.

- How is the demonstration of due diligence seen? Is it an 'activity' as in a "persistent and hard-working effort" to understand that '*what is going on*', is actually '*what ought to be going on*' in order to discern and manage risk? Or is it a desk top audit process governed by a 6-point checklist?

Segue to the next chapter

Of course, understanding organisational culture is a far more complex task than simply considering these few questions, but they are a good starting point in understanding whether your organisation has, or is on the journey to an 'Obeyience Culture'.

So, how may you go about impacting on your organisational culture to make it more focused on supporting people to discern risk, rather than on trying to control behaviours?

Chapter 22 – Culture to Go!

By Robert Sams

> "It is also important to note that the concept of organisation *culture* is distinct from the concept of organisation *climate*. Climate consists of temporary attitudes, feelings and perceptions of individuals. Culture is an enduring, slow-to-change, core characteristic of organisations; because it is based on attitudes, climate can change quickly and dramatically."
>
> Cameron and Quinn in:
> *Diagnosing Organisational Culture* (2011, p. 20)

I can sort that for you!

Organisations interested in cultural change need to think about, and understand their existing culture, then work hard over time to move toward a culture that they desire. Organisations can be easily seduced into 'change programs' that promise a lot in a short period of time, but fail to deliver because the organisation and its leaders are not prepared for the work and time required to achieve change. If it is a quick fix you are after, you are probably more concerned about 'climate' than 'culture' (more on this later).

This was certainly the case when I was talking to someone recently who very proudly told me about their 'organisational change programs'. They said *"our programs are remarkable! They are fast paced, interactive and get everyone engaged."* By this point I was already starting to tune out of the conversation, though I suspect that their slick and charismatic style would appeal to many.

The cracker though was when they told me; *"our programs are so good that I turn organisational culture around in just <u>two days</u>. Our clients are always happy with our results and I never fail to impress".* They continued, (mainly because I could not stop them!), *"... in one recent program I had guys who were previously shouting and fighting with each other at work that, by the end of our program, were joking around and having fun together. That's just the effect I have on people".*

Well by now, I had completely switched off but I'm not sure they noticed. All they were concerned with was boasting about their magical programs that, as they put it, *"turned carcasses into fighting animals".* Whatever that means?

I was sharing this story with some colleagues recently and we were so impressed with the business model and particularly the results, that I got to thinking about how I might be able to develop a similar business. I brainstormed for a short while and quickly came up with our business name, "*Culture to Go*".

Within twenty minutes I had our business plan set. I decided that I would target organisations that want change fast, that want results now; and that really want to engage their teams. The operations model I decided on was '*drive through culture stations*'. I'd place the 'stations' around the country so organisations could simply arrange for their people to drive through, get a taste of the 'new culture' and wham,

there you have it, culture change would occur. For organisations wanting significant change, of course they could go for our 'upsize' service (and perhaps a burger or pizza).

At Culture to Go, we put the 'cult' in Culture...

Sadly, I suspect that there are some people and organisations out there that would think this was firstly appealing, and secondly, could work!

Of course organisations who are genuinely interested in cultural change know that it is hard work; it is not something done quickly and it certainly isn't something that should be left to a smooth talking (snake-oil) salesperson to drive in your organisation.

Cameron and Quinn in *Diagnosing and Changing Organisational Culture* describes this well when they suggest:

> Culture refers to implicit, often indiscernible aspects of organisations, climate refers to more overt, observable attributes of organisations. Culture includes core values and consensual interpretations about how things are; climate includes individualistic perspectives that are modified frequently as situations change and new information is encountered. (2011, p. 20)

This got me thinking about the things that people might see, feel and experience in organisations that focus on 'culture to go' rather than culture:

Cultural change can be fun, exciting and interactive, but to be endurable, it will take time and it is often hard work.

'Culture to go'	Culture
Three word slogans on posters placed in the lunchroom demonstrating that the organisation is committed to change	Leaders talking in small groups, or 1:1 with people, 'checking in' and supporting them to understand what they are thinking about
'Free' barbeques manned by managers handing out leaflets telling people about how change is needed in the organisation	'Communities of Practice' are formed where critical thinking occurs, the views of people are valued and considered and where feedback is provided
Staff surveys conducted where people are asked to answer leading questions and given plenty of time to consider and evaluate their answers before responding	Staff are asked to respond to targeted questions in a survey designed to assess implicit (unconscious) thinking and where people have no time to think consciously and to evaluate their answers
Staff are paid short terms bonuses for achieving results that are consistent with the 'culture I need' around here	Staff recognition is 'real', timely and reinforces behaviours and actions that are consistent with the organisational values

Further growing and developing the ideas in this Chapter

Culture is a term used so freely within organisations, I wonder though if we really understand what we mean when we talk about culture. Here are some questions for further reflection:

- How do you define culture?
- Culture is often defined in organisations as "the way we do things around here". If this is the case in your organisation, how does everyone behave when the unexpected happens? What happens when the pressure comes on? Do you continue to treat each other with respect and does everyone behave in accordance with your Values?
- When culture is discussed in your organisation, does the conversation include talk about the impact that symbols, artefacts, history and language have on that culture?
- When the talk turns to 'changing culture', what does this mean for you?
- If we are to change culture in a short period of time, what are the trade-offs and associated by-products?

Segue to the next chapter

When we consider culture, we consider people, our environment and social arrangements. In organisations it is not uncommon to hear of a culture that is about caring for people, but what does this really mean? We explore this in the next Chapter.

Chapter 23 – A Culture of Care (and sackings...)

By Robert Sams

> "Social validation means that certain beliefs and values are confirmed only by the shared social experience of a group"
>
> Edgar H Schein in:
> *Organizational Culture and Leadership* (2010, p.26)

Sorry mate it's for your own good!

I caught up with a good friend Martin a little while ago and he was telling me about his work situation. Martin works in heavy industry as a contractor, he has so done most of his life and he's now in his mid 40's.

Martin is currently contracting at a mine that is owned by a large company I think he said was called Neo Bingo, or at least something that sounded like that. We got to talking about safety *(although I usually try to avoid this topic, it inevitably comes up in my social conversations)* and Martin was telling me how working at Neo Bingo was as bad as it gets when it comes to safety.

Martin told me "*they ram safety down your throat. There are pre-start talks every day where they tell us we need to do this and don't do that. They remind us of the Golden Rules, they test us on some really basic shit that even a first year apprentice knows and they bang on about Zero Harm*". Martin went on to tell me about how they have all these sayings about 'safety at work and home', and that it is something they need to do 24/7, safety isn't just about work it's about life and about an attitude that you choose to have.

They also talk about '*caring and looking out for your mates*', about '*making safety personal*' and '*caring for your safety is what we do*'. (I'll spare you the rest of the platitudes; you've probably heard it all before).

So by this stage, I was ready to change the topic, I get bored very quickly talking about 'safety'. It's usually stories about control; people doing silly things, or control!

But Martin shared a story that I thought should be shared beyond our conversation. It was the story of a contractor who had been 'thrown off site' for a safety breach.

So you might be thinking, he failed to isolate a machine, he didn't follow a Golden Rule, or he was working at height without a harness, one of those usual scenarios. Not on this occasion. Not at 'Bingo', where safety is a 24/7 thing, where safety must be something that is in your blood, where they never compromise safety. No for this guy his 'safety offence' was overtaking one of the bosses on the way to work.

Yep, Johnno was driving to work on a public road when he overtook one of the 'bosses'. When he got to work, the Boss made a point of going to as many pre-start meetings as he could, asking if anyone owned a silver Commodore. When he found his man in Johnno, he didn't say anything else, he just acknowledged that Johnno was the owner of the car.

Within 10 minutes Johnno was called into the office of the contract company he works for and was told "*mate we won't be needing you to come back to this site, thanks. You can pack up your gear now. We'll pay you the minimum of 4 hours for this shift and might be in touch about work elsewhere, but we don't need you to come back to any other 'Bingo' site*".

There are a few questions to be asked here: was he speeding? What company rule did he breach? How can you effectively sack some (who by the way was not directly employed by the organisation) for doing something outside of work? Of course, none of these really matter all that much, what really matters is that leaders can demonstrate control and authority, they can command obedience, and dictate terms, even outside of work.

Is this really what Safety has become?

What I have become very frustrated about in 'safety' is that in organisations like 'Bingo', where the overt language is supposedly about 'care' but the discourse is all about control and about power. The sad (even offensive) thing is that they mask this control and power with silly safety slogans and language that inevitably uses the words 'care', 'mate' and 'family' but their actions are about bullying and non-care and about being proven right.

Why do they pretend that they care?

Why don't these organisations just say it like it is and put up as their policy what they really do, something like "*we will not tolerate any behaviour or actions that may put us at risk of breaking (what we interpret is) the law, so we will create a stupid obsession within our leadership that will drive out any person who does not do things exactly the way we expect them to be done.*" Wouldn't it be so much easier if the 'Bingo's' of this world were up front and stated what they really expect? Instead, they hide behind 'safety' as being the way that they demonstrate care for their people – good corporate responsibility?

Ironically, soon after Martin left, I was on the social media site LinkedIn and read a story about an organisation that not only wants to create 'zero harm', they aim to go 'beyond zero'94.

I read this with interest as it reminded me of 'Bingo'. I looked at their website, and they talk about a 'culture of care', and say that "*only a few organizations translate safety into a value, namely that the goal of "zero" (injuries, accidents, tolerance, etc.) is never compromised.*"

So, if I read this right, the goal is zero injuries, accidents and tolerance (and whatever etc. means in this context)?, but then they go on to say "*it is an organization that allows, elicits and rewards innovation, for which it must learn from failures to improve in the future.*" So a 'culture of care' is one where there is zero tolerance, yet at the same time innovation is rewarded and you learn from mistakes (the same mistakes they have zero tolerance for presumably) to improve. Is it any wonder people working in organisations like this get confused?

It reminded me of another large organisation that I visited which is also owned by 'Bingo'. At this organisation, they also talk about zero harm and Golden Rules. When

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94. http://www.jacobs.com/uploadedFiles/wwwjacobscom/20_Work_for_us/22_About/223_Safety/Jacobs Safety Making It Happen.pdf).

I spoke with the Managing Director in this organisation, he told me that he and his leaders (yes they were 'his leaders'!) all had a 'no compromise approach' when it comes to their Golden Rules.

If anyone on site breaks them, then 'his leaders' have no discretion at all, they must give the person a first and final warning for the first offence, and the person must be terminated on the second offence. He told me, "this is part of my unwavering commitment to safety, it's what safety leadership is all about". He also said, "if I have to sack someone to save their life, then I'm prepared to do that. I care so much about the people that work for me; about their health and wellbeing, that I am prepared to make that sacrifice if required. It's just part of our strong safety leadership culture here."

When I asked him how 'sacking someone for safety' in a small country town, where his business is the largest employer in town, might impact on the health and wellbeing of a person (and the health and wellbeing of their family), the conversation abruptly ended.

When I hear stories like this about 'safety', it's a strong reminder to me of why *I'm not that into safety anymore*.

I'd prefer to work for (and follow) organisations and leaders who are interested in understanding people better and who accept that we are human and will make mistakes. Organisations that aren't hell bent on 'crusading' and controlling. Who don't use 'safety' as a power trip and enjoy putting people (and their families) out of work in the name of 'care'. I wish these organisations would just be real about things and not hide behind 'safety'. But I also understand how social arrangements and context mean so much in how organisations and leaders within them behave.

I believe that there are many good people who work in Safety. They do care for people, they do want to educate and support learning, but when you work in organisations like 'Bingo', it does things to you. The social arrangements and construct that we work in does affect our decisions and judgments, and I don't imagine how working in 'Bingo' could be anything other than about control and power and fear.

As an industry, and with the many good people that work in it, I hope we can lead ourselves through this. I hope that one day that I may be proud to say that I 'work in safety' and people don't instantly think of me as a crusader. Sadly, I'm not sure that day will come, so in the meantime, I will continue on my learning adventure trying to better understand how to support and scaffold the learning of people to better appreciate *why we do what we do*.

Do you see a day when 'safety' will be about people, about understanding, about empathy and compassion, or will control continue to reign the day?

Further growing and developing the ideas in this Chapter

Caring for others' is a common catchcry in 'Safety'. It's such an easy thing to profess, but how is it really played out? It makes sense to care for others; in fact more than that, it seems to be what it means to be human. I suspect there wouldn't be many people who would argue that caring for others could be a bad thing. Or could it?

Are there situations that you can think of where we may care too much for others? Or, are there situations where our 'care' may not be accepted by others? When organisations use the word 'care' when talking about risk and safety, what is it they really mean? That is, what is the trajectory of their discourse of 'care'?

Perhaps these questions (and those of the preceding Chapter) may support your own learning and understanding of culture?

Segue to the next chapter

When we better understand the effect that our approach to 'care' may have on others, it may help us understand how this approach may impact on others. Could it be that this approach may lead to others feeling like our aim is to control them? In the next Section, we reflect on how the desire, and seduction, to control others, despite our best intention and wishes, may in fact have a negative effect on others.

Section 7

THE ILLUSION AND SEDUCTION OF CONTROL AND MEASURING

Chapter 24 – We are in Control and Other Such Delusions!

By Gab Carlton and Rob Sams

> "Organizations, despite their apparent preoccupation with facts, numbers, objectivity, concreteness, and accountability, are in fact saturated with subjectivity, abstraction, guesses, making do, invention and arbitrariness… just like the rest of us."
>
> Karl Weick in: *The Social Psychology of Organizing* (1979, p.5)

I didn't see that coming

It was sad to hear about the death of the genius man, Robin Williams. It was even sadder to hear the reason why. This is a man many of us have followed, watched, laughed with, cried with and grown up with. For some it hit hard.

It was very unexpected!

How do we manage the unexpected?

For me Robin Williams' life is an analogy for the fragility of life. It leaves us wondering 'why' but with no answers. Yet we still go on believing that we are in control. We are deluded in thinking that the tomorrow plan will prevail and save us from the fragility of life?

The risk and safety industry is no different. This industry is distracted by 'shiny things' and 'silver bullets' and deluded into thinking that these distractions will fix everything. We only need to go as far as doing a Google© search like 'safety board images'[95] and you end up with slogans like, 'Safety First', 'Safety is your responsibility', 'Work Safe Be Safe', 'We have worked [insert number] days without an incident.'

And my absolute favourite one that a good friend and colleague of mine found is *'xyzxyz is spending in excess of 2000 hours working on safety initiatives this month. Nothing we do is worth getting hurt for'*. With the retort from another good friend and colleague… *'bet they'll be glad when the 2,000 hours are up and they can get back to work…'*!!

Slogans are great but what is their trajectory? Where are they leading us? More importantly what are they distracting us from?

I was engaged by a new client towards the end of last year to look at their Safety Management System. The conversation was around culture and their people and how that was important to them. I was supposed to start with a Due Diligence training session to the 'Officers' of the business. I explained the need to educate their executive on 'knowing' safety and what that really meant. It ties in extremely well with organisational culture. To know is to understand if we look at Epistemology, which is the study of knowledge. To understand safety is to 'know' your people. But they

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95. http://bit.ly/1vJkNKp

became distracted by the need to 'know' the law. They engaged a law firm to teach them about due diligence. I guess culture wasn't that important to them after all!

Another distraction; fear and compliance!

We are deluded into thinking that if we are 100% compliant then we will have control and therefore we are safe.

Weick and Sutcliffe (2007) sum it all up so eloquently in *Managing the Unexpected:*

> Nowhere in this book will you find any mention of perfection, zero errors, flawless performance, or infallible humans. That's because "human fallibility is like gravity, weather, and terrain, just another foreseeable hazard". (2007, p. 68)

Karl Weick is one of many who discuss the illusion of control. If we believe we are in control we believe there will be no errors. Yet the unexpected does occur (often) giving the lie to the fact that 'we are in control'. How can we be a resilient organisation if we cannot manage the unexpected. Because as the saying goes, 'shit happens'! And it does. However, how well do organisations adapt and move on? An organisation distracted into believing they have control and espouse zero harm or perfectionism will not be resilient. Resilience is not just about bouncing back it's about engaging in an adaptive mindset.

Resilience is about learning, adapting, knowing, relating, conversing, engaging, being mindful and more importantly understanding that people matter.

Resilience is understanding that no system is perfect; understanding that errors will occur and that learning from errors is important. It's not the focus of 'no error' or 'error free' it's a focus of understanding *there will be error*. It's how you are able to detect the error and move forward and learn and despite the error(s), allow the system to keep functioning. That is because the system is not the focus, it's the people that are the focus. If we focus on people we understand that people will manage the unexpected far better than a system will. A system that is rigid and static and cannot adapt and if we solely rely on a system we will fall apart. If we understand that people are the key to adapting the system to move on then the organisation has the capacity to be more resilient.

Weick and Sutcliffe allude to the key being about knowledge, they suggest that: "… *these pathways to resilience demand deep knowledge of the technology, the system, one's co-workers, and most of all, oneself.*" (Weick & Sutcliffe, 2007, p 14)

So if an organisation wishes to move from a more controlling discourse to one that may be better able to deal with the unexpected when it occurs, and to be more resilient, what are some of the things that may assist? The information in the following table aims to provide some comparison between how Safety is typically dealt with traditionally against the ideas for a more resilient organisation.

Traditional Safety	Organisational Resilience
Safety Systems as compliance. People must adapt to the system.	Understanding that a rigid system, means that the system cannot adapt; and heavy reliance on such a system will cause the organising around it to fall apart People are the key to adapt the system to maintain resilience Having the capacity to adapt is critical
Safety plans to ensure compliance and belief that if we plan we will manage risk and reduce harm.	Planning to un-plan. Know that we must have knowledge and understanding but those plans must be re-evaluated continually not only at a arbitrarily imposed set time frame (e.g. 12 monthly)
Safety Slogans because we care.	Understanding the discourse and trajectory of words and language used in safety. Language is the key to affecting culture change.
Safe Work Method Statements (SWMS) are the only way to have safe people, tasks and workplaces.	Knowledge and awareness about risk perception. Understanding what influences human decision making. Many people make decisions in automatic and intuitively when on task (unconsciously). They will not rely on a SWMS alone. No assumptions that they understand. **Systems and procedures should serve the people and not the other way around.**
LTIs, MTIs & other lag indicators with a 'belief' that the lower the stats the better you are at safety	Discussing errors and occurrences to better understand the organisation and people. To learn and grow from such mistakes. No fixation on 'error free' – understanding that a focus or goal of 'Zero' is an absolute and perfectionist world view

Traditional Safety	Organisational Resilience
Toolbox talks on topics normally reactive based on injuries/incidents	Knowledge and training on effective safety conversation and critical understanding of language
	Conversations, asking questions, talking and walking, knowledge on all layers of hazards not just physical ones – at all times.
Reports, measurements, audits to ensure compliance & other such measures for reporting and evidence of due diligence & compliance	Conversations, communications, engagement, relationships, meeting, imagining possibilities and entertaining doubt and knowing our people.
Fixation on the law and safety legislation. All people must know the 'Act'	Focus on people and understanding people. Understanding the law is not how we run a business.

A resilient organisation is a learning organisation. An organisation which is mindful of: uncertainty, human fallibility, human adaptability, errors, their people and relationships. The question to ask is not "*how safe is our organisation*" but "*how resilient is our organisation*"?

***Authors note**: This raises the point of how might organisations go about this? Once again, we can turn to Karl Weick and his follow-up to the work done by Glassman[96] in relation to 'coupled systems'.

Balancing tight and loosely coupled systems (by Rob Sams)

Before we commence discussion of tight and loosely coupled systems, I pause and reflect on some of the most significant feedback that I have received since I commenced writing blogs, which is that *I don't appear to value systems and process*.

This is simply not the case. I do value (and need) systems, BUT I'm wondering if we need to consider them in a different way from that which is normally considered in risk and safety?

Foundational to my view is that all organisations and people, have to deal with, and make sense of risk, equivocality and subjectivity, despite a desire for certainty, clarity and objectivity. This is at the heart of the challenge for those of us in risk and safety. We desperately seek clarity and objective answers, views and process, yet the world is full of grey, messiness and bias.

Perhaps this is why 'Safety' is so focused on systematic approaches; it wants to eliminate the grey and create standardisation and control. Could it be that in order for systems

96. Glassman, R. B. 1973 "*Persistence and loose coup-ling in living systems.*" Behavioral Science, 18: 83-98.

to be more effective though, that Safety needs to find a balance between regulation, adaptability and freedom so that people feel more in control of what they do, and hence will be more motivated?

In their book *Managing the Unexpected* (2007) Weick and Sutcliffe expand on the concept of 'loosely' and 'tightly coupled' systems. They tell us that:

> *Coupling* (sic) concerns the degree to which actions in one part of the system directly and immediately affect other parts. A loosely couple system is one where delays may occur and alternative pathways to completion are possible. A tightly couple system has little slack, and a process or set of activities, once initiated, proceeds rapidly and irreversibly to know or unknown conclusion. (2007, p. 91)

For those who seek compliance and clear, consistent, and repeatable ways to do things, tightly coupled systems may create comfort. However, when a standardised process is the only thing that can be accepted it can lead to the situation where people are forced, by the system, to not think for themselves. This type of tight coupling leads to the controlling of others, and it also leads to demotivating, and dehumanising the very people the system is (presumably) designed to support.

So, perhaps the key question is, do we in risk and safety need to 'let go a little', and balance out what are mostly tightly coupled systems and create opportunities for 'looseness' so we are able to adapt to change as different circumstances arise? Will this help us be better prepared for the unexpected?

So, I hear: *great theory, thanks, but how does that work in real life? What can we do to create balance between loose and tightly coupled systems?*

Here are a few ideas (based on Weick and Sutcliffe's "Collective Mindfulness" Construct)[97] that may assist:

- Perhaps we might engage in conversations, not just audit - instead of a process that is focused solely on 'auditing' such as in a tightly coupled system, consider introducing a complementary 'loose' system which focuses on engaging with people at the coalface (Weick refers to this as 'sensitivity to operations'). We do this without an agenda or process and be wary of slipping back into a tightly coupled system which requires a standardised process – we need to be wary that our Safety Conversations or Observations don't turn into KPI's.

- Consider who is 'right' to do the job – be open to change where required when choosing the people to do a particular job. In tightly coupled systems, responsibilities are very clearly stated and enacted. Where the system is 'loose', the decision about who does a task is not chosen from a 'Responsibilities Matrix', it is decided when needed and is based on the person with the best skills. Weick advises us to let the problem 'migrate' to the person best able to manage it and refers to this as '*deference to expertise*'.

- Examine your '*commitment to resilience*' which may mean encouraging 'workarounds' where necessary – while a process may require 15 steps to be carried out, Weick and Sutcliffe (2007, p. 14) advise us to organise such that our systems allow "... *a*

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97. Managing the Unexpected, 2007

combination of keeping errors small and improvising workarounds that allow the system to keep functioning". Of course the key to this is good relationships between those leading and those following so that these workarounds can be discussed and agreed when necessary.[98]

I hope that this added piece has helped those who feel that by adopting an approach that aims to better understand people and how we make decisions and judgments this does not mean we dismiss the role of systems. The critical thing is that '*systems should support the people*' in their efforts at work; they shouldn't be the driver of people.

Further growing and developing the ideas in this Chapter

Being 'in control' feels good, who doesn't like that feeling? But what might this mean for others? Is control really a delusion? In what ways may you seek to control others? What impact may this have on them? What impact may this have on you and how you relate to others?

Controlling others has an impact. Can you imagine how Beavo would have felt when 'controlled'?

Segue to the next chapter

So perhaps we now understand that controlling others, while seductive and tempting, may have the opposite outcome of what we desire. But that means that we have to accept that others will make their own decisions, and these may not always make sense to us. They may be 'grey' and 'messy', does this mean that we might need to understand that if there is a silver bullet in dealing with risk and safety that this might well be by better understanding this idea of 'grey' and 'messy'? Let's explore this further in the next Chapter.

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98. Authors Note; the following point was made by Ron Gantt during his critique of the book and I feel it contributes well to this point made about resilience: *"a key aspect to building resilience as it relates to work-arounds is to build in knowledge of the system at various levels. This is something that often has to be done upon reflection, as it would be impossible to discuss all potential work-arounds in advance; there is simply too many of them. This is what makes a compliance mentality so dangerous. We put workers in a position where they are told to 'do' and not 'think', which sends them into complex situations with the proverbial arm tied behind their back. They don't know how to think about work-arounds, so they use what they have; leading to a lot of variability (some workers will do very well, some will do very poorly). The way to deal with this is by building expertise within your work environment (through building effective mental models of the work process), build in cross-checks, make errors easy to spot and recover from (particularly where risks are highest), etc. Also, managers must assume work-arounds are happening and implement processes to identify and learn from them as much as possible to identify new risks/opportunities and understand how their system is actually working."* (Gantt, 2016)

Chapter 25 – Could Understanding 'Grey' Be the Silver Bullet?

By Robert Sams

> "Everything is vague to a degree you do not realize till you have tried to make it precise."

> Author Bertrand Russell (1918) cited in:
> *Tame, Messy and Wicked Risk Leadership* (2010, p. 47)

It's messy!

Since I started writing Blogs on www.safetyrisk.net in November 2013, I've received a lot of constructive feedback, thoughts, questions, and importantly criticisms about my posts, most of which I appreciate.

A key theme of the feedback is that some of the concepts are difficult to fully comprehend because the topics are not always black or white *(binary)*. Often I write about topics that are ambiguous, grey and messy. However, what people are often looking for is a right or wrong way to do things, or for the 'best approach', something that will; 'sort things'. If you like, we seem to be on a mission for the elusive 'silver bullet'.

The thing is that when we get our heads around the fact that the world, and all of us (people that is) that inhabit it are complex; are not simple to program; and are not motivated by control, it can help free us up to stop looking for the *perfect solution* and focus on better understanding people and how we can improve on how we discern and manage risk.

I highlighted a little while ago in one blog piece, that all organisations and people have to confront and make sense of risk, equivocality and subjectivity, despite our in-built desire (need?) for certainty, clarity and objectivity. *This is at the heart of the challenge for those of us in risk and safety*. We desperately seek clarity and objective answers, views and process, yet the world is full of grey, messiness and bias. It can be frustrating when things are a constant wash of grey, especially when we seek clarity.

So what do I mean when I talk about black and white in risk and safety?

There are many examples where right and wrong (binary) thinking is evident every day in risk and safety, here are a couple, I'm sure you can think of many more:

- The compulsory wearing of PPE - while working with a team this week on the ground with nothing overhead, the safety guy came by and said *"C'mon fella's, you know the rules, hard hats on, it doesn't matter whether anything can fall or not"*. Everyone did what they were told!
- Risk Assessment – we must reach consensus on the risk score, we can't have different views about the same risk, we keep talking until we all agree.

So, if binary thinking is not always that helpful, in fact, I argue that it is very dangerous, what can we do about this?

I wonder whether instead of thinking in a 'right or wrong' way, we could learn something from the work of Karl Weick whose focus is on understanding 'trade-offs' and 'by-products', rather than the simplistic black and white? Maybe it might be useful to explore these briefly for those who are not familiar with Weick's work.

Understanding 'by-products' can be complex. One way to consider by-products is that they are the resulting actions that come about once 'trade-offs' (see next paragraph) are made. An example may be that two people may decide to meet at a certain time. Person A advises that they are not able to meet at the agreed time, so both people 'trade-off' and come up with a new agreed meeting time. The new meeting time is the 'by-product', or outcome of the trade-off. That's a reasonably simple example.

As we explored in Chapter 6, 'trade-offs' are the outcomes of decisions that we make, or the things that we give up, in order to gain or do something else. Weick (1979, p.35), when discussing 'trade-offs' describes an example. *"The more general a simple theory is, … the less accurate it will be in predicting specifics"*. The trade-off in this example is that when we choose to have a simple theory which more people may understand, the trade-off is that it will not be able to predict more difficult or more specific factors. So how might we see this play out in risk and safety?

The following is a real example where it would have been easier to suggest 'safe/unsafe', but instead we considered things in the context of 'trade-offs' and 'by-products'.

I was with Graham who had to do a job that required him to work on a residential roof. We were in a small country town and we travelled for around two hours to get to the job. Graham was 10 minutes away from finishing the job when light rain started. His instinctive question to me (as a 'safety' person) was, do you think it is safe to keep working? Well how easy would it have been for me to say, *"it's starting to rain and that increases your chance of slipping"*, or conversely, *"no it's only a light shower, I reckon you're safe to continue"*. The point is that the question is not that useful when the answer is considered only in the context of 'safe or unsafe', there is much more to it than that.

I resisted this easy course of action (controlled my inner Crusader), and instead we spoke about the situation in terms of trade-offs and by-products. The trade-off of stopping the job meant that Graham would be delayed for the next job and have to finish later in the day. This would have meant that he might miss seeing his child play sport (we conceded the social nature of risk).

A by-product of this, could have been that once he re-commenced work (after the rain), he may have rushed, because missing seeing his son play sport was not something he was prepared to trade-off. So the question became one of: *"Is the risk of Graham rushing for the rest of the day, greater than the risk of him falling off the roof in light rain?"* Of course, no-one can accurately answer that question, it is subjective, and generally so is most decision making about risk.

This is just one very simple example, made simpler by the fact that (a) Graham and I had a conversation about it and (b) I'm writing about it in retrospect and after reflection. The reality is that decisions like this (whether to stop work on the roof or continue and risk a fall/ being late) happen constantly in our lives, and so many things shape these decisions, most of which are in our unconscious.

Boy this understanding decision making about risk is tough work; no wonder we are looking for that '*silver bullet*'?

When we think about this example, and thinking about trade-offs and by-products, instead of in a simplistic, binary way, do you feel we may actually explore risk in a far more meaningful way?

Perhaps understanding *grey* <u>is</u> the '*Silver Bullet*'?

Further growing and developing the ideas in this Chapter

The terms "grey" and "messy" have been used extensively throughout this journal, they are key learnings in my understanding of people. The challenge is how we explain this to others and help them in their understanding of this important factor. In further growing and developing your own ideas and reflections on this, you may like to consider how you would explain this concept to others? We often find that if we are required to explain and articulate our thoughts and ideas to others, that this can be a good way to work through and understand our own thoughts.

How would you describe the people?

Segue to the next chapter

One of the ways that we try to deal with *ambiguity* and *equivocality* is through control. As we have already reflected on earlier, control is often an illusion; how can we *really* control others? One manipulative way that I have observed this in organisations is through trying to focus and recognise 'positive behaviours', the challenge with this though, that it still focuses our attention on 'behaviours'. In the next Chapter, I explore how this is often done in risk and safety through the implementation of Awards to recognise 'behaviour'.

Chapter 26 – Jerry Won the Safety Award (but he didn't do anything!)

By Robert Sams

> "…the task performance of prevention focused-individuals is better if their vigilance is increased (e.g., thinking about what they need to do to avoid failure on the task) than if their eagerness is increased (e.g., thinking about how they will succeed on the task)"
>
> E. Tory Higgins in:
> *Beyond Pleasure and Pain: how motivation works* (2014, p. 21)

Good Onya Jerry!

I was at a family gathering recently and got talking to Jerry who I hadn't spoken with for a while. We chatted about our work and he asked whether I was still in 'safety'. I said "*no, that's not what I do anymore, my work now focuses on people and how we deal with risk*".

Jerry was a bit surprised, he'd known me to be in 'Safety' all of my working life, and you could tell that he lightened up when he knew that I no longer worked in 'Safety'. He said the safety bloke at his work is only interested when things go wrong, *"I thought that's what you did, that's 'safety' isn't it?"* You could tell that we haven't spoken for a while!

But this story is not about Safety people, it just always amazes me how people respond when the word 'safety' is mentioned, and the ideas that it conjures up for people. Anyhow, back to Jerry. This is about Jerry's wonderful achievements……

Jerry was proud, although slightly embarrassed at the same time, to tell that he had won the safety award a few years ago at his last workplace. He worked in a petrol (gasoline) station as an attendant, a job that he had done for over twenty years with the same company. He enjoyed his job, interacting with customers and checking out the many cars that passed through the site (Jerry is a 'car man').

One day while he was busy serving a customer inside at his console, something caught his attention. A man was filling up a small metal container with fuel when Jerry noticed that the man's arm caught alight. It turns out that he didn't have the metal container on the ground and that meant that it wasn't earthed, which then caused a spark. A quick thinking customer at the next bowser swiftly assisted the man and put the fire out. Thankfully, everyone was ok.

Jerry saw all this from his console inside with the whole event over and done with, in about twenty seconds. When both of the people involved in the event went inside to pay, Jerry diligently asked them for some basic details, filled out an Incident Form and copied the footage of the event from the store's video surveillance system, then sent all the details off to head office.

A few weeks went by and Jerry received a letter that was headed "Your Invitation to our Safety Awards". Jerry was confused, as to what this might be about. He spoke with a few of the blokes at work and none of them received the same letter. He called his boss, the Regional Manager, and asked what these 'Awards' were about and his boss had no clue.

This was becoming a mystery for Jerry, so he called the guy who wrote the letter, Benjamin the National Safety Manager. Benjamin explained that Jerry was being recognised for going 'above and beyond' to create a safe workplace.

Many organisations have reward and recognition programs in place, and it is common for one of the key areas of focus for such programs to be 'safety'. Usually these awards are given for people, sites or leaders who either:

- Have a reduction in 'safety numbers'
- Implement a new 'safety' initiative'
- Pass audits, inspections (or both).

I'm not sure what category Jerry's award fit into?

Jerry went to the Awards, not really sure what to expect, or why he was there, but he was pretty happy. As he recalled to me "mate it was great, they paid for me and the missus to stay overnight at The Hilton, there was all the free grog (alcohol) that I could drink, and they even paid me petrol money to drive down!" Jerry had a great night and he won the regional award. He was presented with a trophy and $500 shopping voucher and was feeling pretty chuffed.

The next step was a trip to Melbourne for the National Awards. Jerry and his wife were provided with flights (from Sydney) and again put up in a 'five star' hotel and hosted to a night of free grog. Unfortunately he didn't win the National Award, but instead received an 'Encouragement Award'.

When Jerry had finished telling me the story, he said two things that should have people in risk and safety thinking:

1. "*I got this award, but I didn't do anything*" – (to this day, Jerry still has no clue why he was personally recognised for 'going above and beyond' for safety)
2. "Mate, I had a ball, and the missus just loved it (I was in the good books for months), but instead of spending all that money on stupid, meaningless safety awards, I reckon it would be better to just lower the cost of petrol. Our customers would then be happier and I'd enjoy my job more".

Jerry resigned from his job at the petrol station two days after getting back from Melbourne. He told me "*I got a great job offer from a company who seemed fair dinkum. They don't give out awards, but the boss knows what we do, talks to us and often says thanks. That'll do me!*"

Further growing and developing the ideas in this Chapter

The idea of 'reward and recognition' within organisations can be an important component of an overall motivation strategy. However, if not done well, and if not genuine, the trade-offs and by-products may lead to outcomes that your organisation may not have thought of, just as in Jerry's case.

The question of how to recognise people who perform well is one where we can be easily seduced into promoting and selling safety simply by recognising people for doing their jobs. Some questions that may assist with your own thinking in this area are:

- What is the trajectory of your 'reward and recognition' program'?
- What may we 'trade-off' when we implement more formal programs rather than just having encouraging conversations with people?

Segue to the next chapter

In this Chapter, we have reflected on the impact that measuring in risk and safety may have within organisations and on people. Such measurement is usually aimed at controlling people, by directing them in the way that the organisation would like them to go. As we have already learnt about in Chapter Three on motivation, such an approach based on 'carrot and stick' does little for self-motivation. However, it is a tempting path to travel down for leaders, after all direction and instruction make the role of the leader seem so much easier. But is it? Does direction and instruction make the leaders role easier? We explore this question further in the next Section.

Section 8

THE STRONG TEMPTATION TO CRUSADE

Chapter 27 – Beware the Safety Crusader

By Robert Sams

> "For us, effective leadership is always about how leaders and followers come to see each other as part of a common team or group – as members of the same *in-group* (sic)"

<div align="right">

Haslam et. al. in:
The New Psychology of Leadership (2011, p. xxi)

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It's my job to make sure you go home safely...

One of the things that have become clear to me, through my reflection on the adventure of the last three years, is that the *way* that we engage with other people about safety and risk will determine the effectiveness of the engagement. If our aim is for others to lead in risk and safety, we must be prepared to suspend our own agenda and let go of control when engaging with people. This allows us to hear, understand and respect the views of others, and for them to take control (see Deci 1995 on 'autonomy support').

If we don't suspend our own agenda, then we project that agenda onto others, which means that they are not likely to lead in safety; at best, they may just follow instructions (some of the time!). Let's explore an example of this approach of suspending our agenda?

I was involved in reviewing an incident after a customer was struck by a vehicle in a car park. The customer was ok, but the organisation wanted to make sure they responded and took appropriate action.

In the past when I approached an incident like this, I usually went armed with a checklist of things in my mind as to what I would look for, along with (pre-prepared) suggestions for actions based on what I've seen work before. For traffic incidents, this usually involves high visibility signage, line markings, bollards, pedestrian crossings, speed humps and the like.

This is not an unusual approach for people in the safety and risk industry where we are considered '*subject matter experts*' in these situations. However, when we take our agenda into conversations with others, we shouldn't be surprised when they don't appear interested in safety. This is particularly prevalent when our agenda is about control, compliance and binary (black and white) thinking. This is the rule, the law, the code, and this is what I (and you) need to do.

On this occasion, I approached things differently.

While I was busily working through the checklist in my mind, along came George, the site Manager. As George started talking I was conscious of the need to suspend my own agenda, to put that (mental) checklist away, hand over control, 'hear' what George had to say, and engage with him. Suspending my own agenda meant going into the conversation not only prepared to hear the views of George, but more importantly resisting the temptation to impart my own ideas and suggestions (control).

This (suspending of agenda) can be difficult for some people in safety and risk. It is certainly different from the way that I see most people in safety and risk operate which is in an approach that I call the "*Safety Crusader Model*". This is where people feel the need to be the subject matter expert, the only one with the answers and worst of all, feel that if they are not there to check on 'things', then those things could not be safe (control). This is a very dangerous model and one that leads to 'ownership' of safety being with the safety and risk person (control) and not with others (leaders, workers).

The Safety Crusader doesn't facilitate, nor seem that interested in learning. They tend to jump to conclusions; they shut down conversations with fixes and answers; for theirs's is the only view that counts (control). The Safety Crusader isn't really interested in others; they are armed with the Act, the Codes, the Standards. Their focus is on compliance with these things (control). I need to be cautious of the Safety Crusader; these guys will tell you they are '*safety nuts*', that they have a passion for making sure others are safe, and that it is their job to *ensure everyone's safety*.

But what does this mean for the 'others' and how *they* manage safety?

For people like George, who has a real interest and enthusiasm for safety at his site, if he were faced with a Safety Crusader (controller) on this day, he would simply have shut down, and done as he was told. Safety Crusaders tend to have strong opinions and leave little room for others to participate in conversations (control). Critically, George wouldn't have learnt anything other than what the Safety Crusader imposed on him. He would not have 'owned' the actions; he would have just followed directions.

I have to ask what value the Safety Crusader Model adds to an organisation and consider whether this Model really improves safety in the workplace. The Safety Crusader can't be there all the time, and if their approach is focused on compliance with laws and Codes (control), rather than facilitating learning, engaging with people and providing support, how will others learn about safety?

I did suspend my agenda when talking with George.

It would have been quicker and easier for both of us if I had just told George what to do. That is, how he should comply. But safety is not just about compliance, it can't be, this is not what motivates people. Safety is about how I deal with every day and changing situations, it's about leadership, culture and importantly learning. But where does the learning take place when the Safety Crusader is focused on what's right or wrong, or on what they feel must to be done (control)? How could George have learnt if his own agenda was trumped by my superior knowledge of legislation and codes?

Instead, I supported George to think through various options, prompting him with questions about his ideas and encouraged him to explore as many options as he and his team could think about. Importantly, I didn't judge these ideas against my own agenda, I handed control to George. He and his team came up with actions, they weren't what I had in mind, but they were their ideas and they were keen to implement them. I participated in the discussion; I asked questions and prompted the thinking that helped them explore different ideas. That was my job; it was not to *control* George, it was to support his learning.

When a Safety Crusader goes into a conversation with the agenda of *"I must get them to take safety seriously"*, they cannot be open to the agenda of others, and really understand what the 'others' are thinking, because the Safety Crusader thinks that their views are the only ones that count (control).

I hear regularly from people in the safety and risk industry who say things like *"Managers don't take safety seriously"* and *"They always opt for production over safety"* and *"They never walk the talk"*. It seems to me that I often take the approach that it's 'us' *(people in risk and safety)* against 'them' *(anyone who's first words in the morning aren't, "let's be safe!")*. This 'us' and 'them' stereotypical thinking is a real problem and it is dangerous. If I create 'us' and 'them', I limit our thinking and learning because 'I' feel 'I' have the answers (control) and 'they' don't see them as a priority.

You see George didn't feel the need to *'make sure others are safe'*, instead, his focus was to make sure others knew about the risks and keep them mindful of this, rather than try to control their behaviour. I could have considered George one of 'them', especially if his response was not filled with the same enthusiasm for safety as mine. This was not the case though, George did care; he just didn't express it as openly and enthusiastically as I hear from some safety and risk people.

George is a smart operator; he knows that people can't be controlled through rules, policies and procedures. He knows that people are motivated by feeling autonomous and in control of their own actions. His role is to develop relationships through effective leadership and engagement with people who will manage their own safety. George is not a 'Crusader', he doesn't feel the need to control a person's every move. He allows mistakes and learning, and he provides support, he is a leader.

Further growing and developing the ideas in this Chapter

'Crusading' is the easy, and tempting, path to travel when it comes to 'leading' in risk and safety. I've been there and I understand that it can be seductive. I suspect we can all be influenced in relation to how we go about things when we sense a little bit of power in relationships. Has this happened for you? Are there situations and relationships in your life where you recognise that the power may be impacting on how you relate to others? Have you, or do you 'Crusade' in risk and safety? How can you go about dealing with this?

Segue to the next chapter

If the alternative to 'Crusading' is 'leading', how might one go about this? In the next Chapter we explore one idea of what it means to be a leader by examining a case study of sorts which is the Reverend Graham Long who is the CEO and Pastor of The Wayside Chapel in Sydney's Kings Cross. Graham knows a thing or two about *'followers'*, a critical thing to understand for anyone aspiring to be a *leader*.

Chapter 28 – You Don't Need to be a Hero to be a Leader

By Robert Sams

> "…when a meeting between two people truly takes place, when there is just you and me and we are interacting in a very real and honest way, dropping agendas and stepping into a wide open space where the air is fresh and competitors become brothers and sisters and threats become people, this is when I come to life."
>
> Graham Long in:
> *Love Over Hate* (2013, p.35)

There are no heroes around here

The Wayside Chapel (www.thewaysidechapel.com) is located in Sydney's red light district of Kings Cross and it is overseen by the Pastor and CEO Graham Long. Under the banner of '*love over hate*', The Wayside Chapel strives to create a community where there is no '*us and them*' by breaking down the barriers of judgment and providing a safe place where people from all walks of life are welcome just to '*be*'. Their programs and services are designed to ensure that the most marginalised members of our community have access to essential health, welfare, social and recreational services

I was privileged to be able to visit 'The Wayside' as part of an 'off campus' learning experience as part of my post-graduate studies in *Social Psychology of Risk*. Our visit to The Wayside was just one of the many experiential learning activities in this course, and this 'excursion' was part of a Unit on 'Leadership'.

There is much written about leadership, and in particular the traits that make great leaders and on what 'it takes' to be a great leader. When you visit the Wayside though and hear Graham talk, it becomes obvious that leadership is not about traits, status, knowledge, intelligence, heroics and hierarchy; instead leadership is about people, followers, community and cause.

People that come to the Wayside don't visit because Graham, or anyone else for that matter, are God like or heroes and have answers to their problems. Graham is not an overly charismatic man who uses grand speeches to spread his word. In fact, Graham doesn't use many words at all, and the reason that people '*follow*' Graham at the Wayside may well be because his greatest skill is *listening* and hence *hearing*.

As I listened to Graham talk to the group, one thing that really stood out for me and that I think many people in the safety and risk field could learn from was: "*we tell people they are not 'problems' to be solved but rather 'people' to be met. We know we have had a good day if someone walks out our front door feeling 'met', rather than 'worked on.*" (Long, G., personal comment, 2014)

If we really want to be Safety *Leaders* in our organisations, maybe it might help us to think about how Graham's advice and methodology might apply in our industry.

In the previous Chapter we looked at the importance of suspending our own agenda when engaging with others. When a 'Safety Crusader' goes into a conversation with the agenda of *"I must get them to take me/ safety seriously"*, they cannot be open to the agenda of 'others', and really understand what the 'others' are thinking, because the Safety Crusader thinks that their own views are the only ones that count (control).

The Safety Crusader cannot be a Safety Leader, as the Safety Crusader is not interested in '*meeting*' others, they are interested only in '*fixing*'. This just makes them a 'Hero', not a *leader*.

Graham is the author of a great book *Love Over Hate, Finding Life by the Wayside* (2013). In this book, Graham shares many stories about both his life and 'life at the wayside'. There are many stores about the 'Wayside' community and how they go about achieving their vision which is ***"Making community with no 'Us and Them'"***

It is only when we consider our community, our social construct, and the followers who are part of that community that we can even begin to think about playing a role of Safety Leader. A true Leader is one who understands that there can be no leadership without followership, and no followers without community. As Graham so eloquently puts it:

> We do ourselves much damage when we divide the world into saved and lost, in and out, good and bad, Christian, Muslim, Jew and Gentile, housed and homeless, sick and well, us and them. (Long 2013, pp.34-35)

Safety Leaders realise that they need to be part of a community, part of the cause, engaging and supporting fellow members of the community. Safety Crusaders on the other hand, are not concerned about followers and community, they are concerned with rules and compliance; with objects and process. People are just a resource engaged in those things, almost an inconvenience for Safety Crusaders.

Safety Leaders will see it as their role to 'meet' and not 'fix' people. Safety Leaders understand that people are fallible; they will make mistakes and occasionally do things that others don't expect or predict. When we see it as our role to 'meet' people; to listen and to really hear them, we will consider that our organisations are humanising, that they will allow people to be people and not machines or resources in a process.

Safety Leaders are not worried about how others perceive them, they are not focused on ego and self, they are focused on others. I take one final quote from Graham's book, which I think sums this up well:

> It is impossible to meet another person if we are worried about how they will affect us, or how we will perform in front on them. These kinds of meetings always become 'an event'…". Long (2013, p.75)

I never thought that I would learn so much about what it means to be a safety leader by visiting a chapel, but, I look back now and wonder why visiting The Wayside Chapel, and talking with people like the Reverend Graham Long were not some of the first things I should have done when I got into this field. After all, isn't it about people and

'humanising' our organisations and not just about objects, fear and process. We could do so much better if our focus was people rather than objects, couldn't we...?

Graham and the team at The Wayside are not heroes, but they sure are an inspiration to many people.

You can learn more about The Wayside Chapel, and possibly donate to support their important (life changing) work at http://www.thewaysidechapel.com/ donations.php

Further growing and developing the ideas in this Chapter

When considering and discussing the topic of 'leader' or 'leadership', it is common for such conversations to turn to 'traits' and questions of what makes a good leader. While this type of conversation may be helpful in some respects, in keeping with the key theme of this journal, perhaps there are other questions to ask about what is *good leadership* rather than traits and individual characteristics. Perhaps these questions may be handy in your reflection on this:

- Can one be a leader without followers?
- What is it that followers follow, if it is not leadership traits?
- When we talk about leadership traits, are we perhaps referring to what may instead be 'management' traits?
- What social arrangements may allow an authoritarian leader to thrive?

Segue to the next chapter

We have explored and reflected on topics such as a better understanding of people, a review of injury management and incidents, and the challenges of measuring and 'Crusading'.

We now turn our attention to some ways that people, and organisations, may go about things in a different way in order to firstly, be better prepared for the unexpected (i.e. what are the signals or cues to look and listen out for), and then deal with the unexpected when it occurs. We now focus on what we can do 'differently'.

Section 9

A FOCUS ON RESILIENCE AND COMMUNING
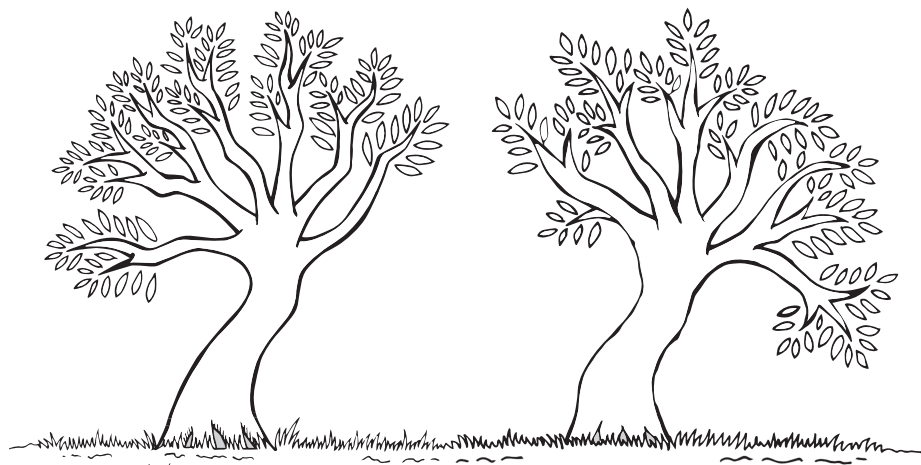
Chapter 29 – Building Resilience Trumps the Prevention of Harm

By Max Geyer

> "The resilient organisation carries the scars of its interactions; it learns and becomes better prepared as a result of dealing with the unexpected but *not by wrapping itself in more defence systems*; it does so by *building its capability to respond.*" (paraphrased)
>
> Weick & Sutcliffe in:
> *Managing the Unexpected: Resilient Performance in an Age of Uncertainty 2nd ed.*, (2007, p. 72).

The prevention of harm is about trying to see, predict and control all things that may deliver an undesired outcome. Society and organisations develop regulations, rules, systems, procedures, structures, training, inspections, investigations, and punishment and reward programs, in order to manage the interaction of people and work activities. At the same time we have insurance policies, rehabilitation programs, law courts, audits, re-training programs, review and improvement programs, all because of the humanness and fallibility of humans; because we know that where people are involved, not all will be anticipated, mistakes will be made, things will not go to plan and on occasions, harm will result.

This paper argues that, when dealing with risk and safety, it is preferable to develop resilience than to try to prevent all harm. It does so by highlighting the limitations and by-products enacted by attempting to eliminate all harm and then identifies the advantages of developing *resilient capacity* when dealing with the *unexpected*.

The Collins English Dictionary (2003) defines harm as "*physical or mental injury or damage*". A search of the top one hundred Australian listed companies will reveal many with declared values or risk and safety policies which espouse the *elimination of harm* and or have *zero harm* as a goal[99]. In relation to the discerning and managing of risk in the workplace, having the capacity to eliminate or prevent harm implies we would have the capacity to identify <u>all</u> physical or mental injury or damage associated with the operations of the organisation. Further, having an ability to identify <u>all</u> harm also implies we would have a capacity to foresee all events which could bring about that harm; that is, we would be omniscient, which is clearly not possible.

The elimination of harm is not only not possible; as a negatively framed goal, it primes the organisation, its management and its people for failure (Custers, 2009). And as a by-product, it drives a culture of fear in relation to the reporting of incidents, it restricts the individual's ability to exercise judgment and it stifles innovation, learning and improvement (Long, 2012). In essence it stifles what it is to be human.

The international standard related to risk management *AS/NZS ISO 31000:2009 Risk management – Principles and guidelines*, defines risk as the "*effect of uncertainty*

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99. BHP Billiton, Glencore, Rio Tinto, Woolworths, Leighton Holdings (CIMIC), Lend Lease, Downer EDI, all have, or include, zero harm in their espoused goals as viewed on their websites as accessed on 20 August 2015.

on objectives"[100] (cited in HB 327:2010). The companion guide to that Standard, *HB 327:2010 Communicating and consulting about risk* (The Handbook) warns that "*Communicating and consulting about risk requires an understanding of the central role of uncertainty in the generation of risk.*" (HB 327:2010). When one further examines the attendant notes to the definition from the Standard (see footnote below) Note 2 points to the holistic nature of risk by emphasising that risk is not confined to health and safety or to any one part or level of an organisation. Indeed, in support of the view that the nature of 'risk management' is a concept to be dealt with as a holistic issue, the World Health Organisation defines health as:

> ... a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (cited in Aghadiuno, 2010).

The Australian Government Comcare website points to the health benefits of work as it references some of the hazards which are to be addressed when attempting to eliminate or minimise workplace harm, when it states:

> Work is generally beneficial to mental health and personal wellbeing. It provides people with structure and purpose and a sense of identity. It also provides opportunities for people to develop and use their skills, to form social relationships, and to increase their feelings of self-worth. (Australian Government Comcare, 2014, accessed 22/09/2015).

For most people their stability of employment would be a critical component of their mental and social well-being and an attack on that employment would constitute an instance of harm. This indicates that our search for the sources of harm, and the elimination of that harm would need to consider all components of the organisation, no matter how small that may impact of the success of the business and hence the well-being of its employees. It further highlights the *holistic nature of harm and the implausibility of eliminating it*.

Australian workplace health and safety legislation acknowledges that the total elimination of risk is not likely. Indeed, the basis of the legislation is "*reasonable practicability*" (Model WHS Act 2011, Section 18). In order to exercise their workplace health and safety due diligence, management are required to take "*reasonable* steps", and apply "*appropriate* resources and processes" in the fulfilment of their duties and obligations (WHS Act 2011, Section 27 (5), emphasis added).

The methods used to identify and assess risks, as described in the risk management Standard mentioned above, are subjective in nature and not an exact science. The identification and assessment processes are heavily dependent on: the knowledge, expertise and understanding of the people involved in the risk assessment exercise; on their knowledge and expertise related to the thing or process being assessed; and on how they make decisions. The process is dependent on the perception of those involved, and The Handbook accepts this when it states:

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100. The definition is accompanied by four "Notes" as follows: (1) An effect is a deviation from the expected (sic) – positive and/or negative. (2) Objectives can have different aspects (such as financial, health and safety, and environmental goals) and can apply at different levels (such as strategic, organization-wide, project, product and process). (3) Risk is often characterized by reference to potential events and consequences or a combination of these. (4) Risk is often expressed in terms of a combination of the consequences of an event (including changes in circumstances) and the associated likelihood of occurrence.

Perceptions are what people apprehend to be true - particularly through reliance on their own senses, concepts, experiences, assumptions, knowledge, value sets, intuition and prejudices.

Perceptions may therefore reflect, or vary from, reality but are often a powerful element in the way further information is considered. Consequently, different individuals may view the same information differently and draw different conclusions. (HB 327:2010, p. 11).

The Handbook further warns us that in consulting and communicating about risk we need to also consider that:

… a number of demographic and socio-economic determinants such as age, sex, education, social class, ethnicity and income strata also affect individual and group perceptions. (HB 327:2010, p. 14).

We know that people have 'bounded rationality' (Gigerenzer & Todd, 1999) and generally make decisions as resourcefully as possible by employing:

... satisficing heuristics for searching through a sequence of available alternatives, and fast and frugal heuristics that use little information and computation to make a variety of kinds of decisions. (Gigerenzer & Todd, 1999, p. 7).

Research informs us that when people make judgments and discern situations, which may involve risk, they take account of salience and accessibility; they make decisions based on their own schemas (Hogg & Vaughan, 2010); and they apply their personal and collective biases such as: group think, clustering, confirmation bias, overconfidence (hubris), selective perception, anchoring bias and availability heuristic (Gigerenzer & Todd, 1999; Hogg & Vaughan, 2010; Plous, 1993; Slovic, 2010; Sunstein, 2004), and their intuitions or 'gut feelings' (Gigerenzer, 2007). The Handbook acknowledges the humanity of people and the valuable role that heuristics play in decision making about risk when it states:

… heuristics are valid risk assessment tools in some circumstances and can lead to "good" estimates of statistical risk in situations where risks are well known. (HB 327:2010, p. 13).

The employment of short cuts, by the use of satisficing and heuristics, and the application of biases, ultimately results a great deal of "exformation", that is, information which is either not considered, or is briefly considered and discarded during the decision making process (Norretranders, 1998, p. 92).

Decisions and assessments made about risk are subjective. They are as much dependent on the makeup of the cohort considering the risks, the means those involved employ to identify risks, and the means they adopt to help their decision making process, as they are on the nature of the risks themselves. With so much subjectivity involved it is clearly impossible to identify all sources of harm let alone prevent all harm.

Another issue with preventing all harm has to do with the humanness of those involved. Billett, Gruber and Harteis tell us that:

> …Firstly, complex problems and fuzzy rules shape an environment of human behaviour which makes errors unavoidable; and, secondly, errors can be fruitful incidents for further development. (2012, p. v)

This leaves us with a number of challenges. What do we do in relation to the harm that we cannot identify and/ or control? What do we do to manage harm from events that are unexpected? What do we do when people, as fallible humans, make mistakes? And how can we benefit from the lessons learned in order to better prepare for the next unexpected event?

We understand from Social Psychology, that risk management is a "wicked problem" it cannot be totally resolved; it can only be tackled and worked on (Conklin, 2006). However, one answer is to enable people to be ready for and to deal with the unexpected when it inevitably happens. This means that we need to be ready for when things go wrong such that we: recognise the '*wrongness*' as soon as we can; we limit the harm caused, both in terms of its impact and its sphere of influence; and we either return expeditiously to the pre-incident state, or quickly adapt to our "*newly enacted*" environment (Weick, 1969, pp. 63-64). Weick and Sutcliffe call this process having a "*commitment to resilience*" (Weick & Sutcliffe, 2007, p. 68).

Weick and Sutcliffe adopt Allenby and Fink's definition of resilience as:

> … the capability of a system to maintain its function and structure in the face of internal and external changes and to degrade gracefully when it must. (cited in Weick & Sutcliffe, 2007, p. 69).

Zautra, Hall and Murray (2010, p. 4) tell us that "… *resilience* (sic) *is best defined as an outcome of successful adaptation to adversity.*"

A critical point here is the importance of *adaptation* to the enacted environment, in the role of developing resilience. Denhardt and Denhardt state that:

> Resilience involves the ability to adapt creatively and constructively to change, and change is the one constant in organizational (sic) life today. (2010, p. 333)

Importantly, Weick and Sutcliffe advise us that the resilient organisation carries the scars of its interactions; it learns and becomes better prepared as a result of dealing with the unexpected but *not by wrapping itself in more defence systems*; it does so by *building its capability to respond* (Weick & Sutcliffe, 2007, p. 72).

Adaptability is something that is developed over time and is something that actually *benefits from the mistakes of people* and the errors and failures, which are noticed and recovered, before they escalate into major events (Amalberti, 2013). This acceptance of failure is something that organisations, which are focussed on eliminating harm, cannot accept or acknowledge.

For the resilient organisation, what is critical is that the response to challenges and the unexpected does not result in brittleness and inflexibility (Denhardt & Denhardt, 2010, p. 337); instead it results in 'antifragility' (Taleb, 2012) and an ability to learn from failure. Conversely, an organisation which is focussed on the elimination of harm is in danger of becoming brittle, inflexible, fragile and stagnant.

Denhardt and Denhardt (2010, p. 337) encompass a holistic approach to managing the unexpected when they identify that resilient organisations are characterised by five key elements:

- they have a capacity for redundancy; i.e. they have a capacity for their systems to degrade but, and at the same time, for the organisation to survive as components fail;
- their robustness and vigour, is typified by promoting "… the mental and psychological health of their employees";
- they have flexibility and a willingness to "… try new approaches rather than relying only on standard operating procedures";
- their reliability is based on organisational infrastructure, which is "… sound, providing reliable and accurate data, working communication channels, and management of resources"; and
- they have a culture of "… respect and trust".

So how does the zero harm organisation measure up to these characteristics when dealing with uncertainty?

- As pointed out above, such organisations cannot tolerate failure, they compensate by building more and more elaborate systems of control and control redundancy; they become so "tightly coupled" that they eventually lose the capacity to adapt (Weick, 1982, p. 674).
- Their focus is on mechanistic systems and people as human factors fitting into those systems, as opposed to promoting the health and psychological well-being of people.
- Adherence to procedures is fundamental and *uncompromising*.
- The pressure to achieve zero harm impacts negatively on reporting and the accuracy of data, and it stifles communication channels, the by-product of which is:
- The loss of respect and trust in the organisation and its leadership.

Not a good report card, by the look of it.

An organisation which is focussed on resilience embraces uncertainty and the inevitability of mistakes, and develops capability such that the impact of uncertainty and mistakes is restricted (when negative) or embraced and enhanced (when positive). (Weick & Sutcliffe, 2007)

Of course the desire for resilience does not mean the acceptance that all harm as good; although often times good comes from harm (Taleb, 2012). Life and decision making is never binary it is always *grey and messy*. The athlete knows that by stretching muscle tissue and developing small tears encourages the development of bigger, and more resilient muscle tissue and more strength.

We cannot see all harm, although we can acknowledge that unforeseen harm does exist. Therefore, we need to develop the capacity to identify and deal with that which we cannot see. We need to be able to *manage for the unexpected*. In particular, we need to be ready for when things go wrong such that, harm is limited, consequences are constrained, damage can be controlled and a return to productivity can be expedited.

In other words given that we cannot see the future, and that the *unexpected will happen*, we are better off developing our capacity for resilience than attempting to predict and control harm.

Further growing and developing the ideas in this Chapter

Resilience is a commonly used phrase today, both in organisations and in society, however do we really understand it's meaning. One exercise that you could do to come to your own meaning and understanding of resilience is to research the various definitions and interrogate them in order to come to a meaning of your own.

Segue to the next chapter

When we take time out to critically think through and challenge the 'norm'; when we use our imagination to better discern risk, we open up our eyes, and importantly our minds, to new thinking and innovation in risk and safety.

In the next Chapter, we extend the idea that in order to develop resilience, we may first need to experience pain (or fragility), this is certainly a concept that is challenging the norm within the risk and safety disciplines.

Chapter 30 – Fragility and the Risk Paradox

By Dave Whitefield

> "Wind extinguishes a candle and energizes a fire.
>
> Likewise with randomness, uncertainty and chaos: you want to use them, not hide from them"
>
> Nassim Taleb in:
> *Antifragile: Things That Gain From Disorder* (2012 p. 3)

Introduction

During his studies in the *Social Psychology of Risk*, our good friend Dave Whitefield developed a particular interest in the work of Nassim Taleb, the author of such works as *Black Swan* (2007), *Fooled by Randomness* (2001) and *Antifragile* (2014).

In this Chapter Dave shares his reflection on Taleb's work, and examines risk and safety through the lens of Anti-Fragility.

The Question - What is the opposite of fragile?

I first came across this seemingly simple question while reading a book by Nassim Taleb, and it changed the way I look at people, organisations, and the systems that support them.

While the question may seem simple, the implications of the answer (which may not be what you think it is) are quite complex, so long as you're prepared to take a challenging exploration of the word.

A discussion about fragility is also not for everyone. In my experience it's quite normal for people to initially resist the concepts, and to need time to process them. So while my intention is not to annoy you to the point where you stop reading, I do want to challenge some of the traditions that are no longer serving risk and safety. I share with you my reflection on this topic here.

The Answer

Did you say that the opposite of fragile is 'strong', or 'resilient', or 'robust'? I know that's where I went when I first read the question; and that's where were most people go when I discuss this topic in open forums. The problem however is, that the opposite of fragile is not robust, or strong or resilient. Well not if you take the challenging and complex view of the definition. So now let's discuss why.
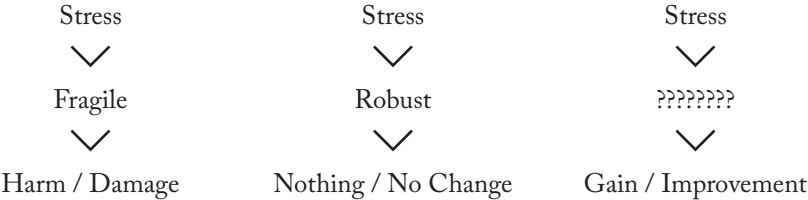
Fragility and Robustness

First, if we stress something that is fragile it breaks (or is harmed), and usually in a pretty permanent way. Something made of glass is an obvious example in that when it breaks there is no coming back, and the breaking (stress) point is relatively low.

Second, we can stress something that is robust and nothing happens. Concrete, steel, rubber and bricks are all examples of things that are robust because what we rely on is their ability to be stressed (up to a point of course) and remain essentially the same.

But, here is the next key question. Are there things that gain or improve from stress?

It could look like this:

Stress	Stress	Stress
∨	∨	∨
Fragile	Robust	????????
∨	∨	∨
Harm / Damage	Nothing / No Change	Gain / Improvement

The Opposite of Fragile

As soon as we slow down the discussion on what the opposite of fragile is, and highlight things as I have done above, it can seem obvious right?

Of course there are things that *can* gain from stress. One of the most obvious is the human body. We know that to strengthen it we need to put it under some stress, and we know that removing all stress is unhealthy. In fact, most organic systems fit this description, and depending on your personal beliefs, it is essentially describing the process of evolution.

However there is no word for it (in English anyway), hence Taleb coined the term *"antifragility"*. Antifragile things *gain from disorder*; they become stronger following stress. For things that are antifragile, stressors act as cues or *informing signs*; and not necessarily problems.

The Next Big Question - So What?

So far all we have done is come up with a word for something that already exists. But what if I now asked: *'How would you like your organisation and systems to be?'* I'm yet to meet a leader who doesn't describe something like what we have labelled here as antifragile.

Interestingly, I've also met plenty that assume their organisations are already antifragile. In most cases they are not. So this is again a reason why I believe there is a need look at this a little closer, because the lack of awareness of the discrepancy is important.

At this stage I also think it's important to understand that I'm not suggesting that every organisation should be antifragile. I'm merely pointing out that when asked, many leaders say they want their organisations to be it; yet few actually understand it; and almost all are unaware that many things we do in traditional safety and risk actually do the opposite of what they are aiming to achieve and this has the effect of actually adding more fragility and risk. It can be complicated, let's now explore why this is.

The Paradox

That many of the orthodox safety and risk strategies and interventions currently employed within organisations are actually adding fragility, and therefore risk, is the primary paradox of fragility. It can be difficult to understand when two things (in this case antifragility in an organisation that is focused on reliability) co-exist when they seemingly shouldn't.

So how do organisations deal with this paradox?

Typically, adding fragility and risk in this way happens over time and behind the scenes. It's often one of the *trade-offs* that are always there in organisations, but rarely seen. This is because it may not be obvious until something goes wrong. However, when there are unexpected outcomes, fragile organisations are more likely to be hit hard.

Antifragile organisations on the other hand, are more likely to be able to keep operating and come out the other side of an unexpected event in an even better position. Antifragile organisations learn from such events and change, as opposed to sending out alerts, tightening systems and hoping the unexpected never happens again (which is the typical response in more 'fragile' organisations).

What Makes Things More or Less Antifragile?

As mentioned earlier, this is a complex and broad topic. We do not have the space here to reflect on it in detail. There are numerous factors that influence fragility, some of which are about mindset of people and culture within organisations, as well as more structural and systemic factors. In providing just an introduction to this topic, my hope that it triggers in you an interest to reflect and investigate some of the detail further.

Outlined below are a few key factors for organisations which may be *antifragile* and what they may do:

- **They treat risk as non-linear**. They know that some risk can be OK, and others can be disastrous. Fragile organisations treat all risk as unwanted. For example they may seek to ban all manual handling, rather than understanding that some manual effort is good for the body, but too much can be harmful. It's also how we end up banning all ladders from a site, or issuing warnings to people who don't hold the handrail on stairs, while ignoring underlying cultural issues that are contributing to adverse mental health issues.

- **They understand that stressors and unexpected events are valuable sources of feedback** about their systems and processes, rather than things to be avoided at all cost. Fragile organisations are anxious about unexpected events, and this is seen in how people react to incidents. Antifragile organisations are anxious when there are no unexpected events. This is because they understand that something is missing; there is less information coming in, and that it is most likely being hidden.

- **They place more value on learning that focuses on developing understanding**, rather than just transferring content. Fragile organisations have a false sense of the competence of their people because everyone passes the test.

- **They resist 'tightly coupled', centrally controlled structures. They have flatter, more distributed control structures** that are better able to learn and are more tolerant (absorbing) of failures. Importantly, they understand and accept the *trade-offs* that come with that approach.
- **They have a policy where they gather information first, and then decide if an intervention is required** following an unexpected event. Fragile organisations tend to have a policy of intervention. In fragile organisations there is very little space to say '*we just don't know what happened*'. Antifragile organisations investigate first, and then decide if further action is needed.
- **They take a longer-term view**, which leads to more of a 'wait and see' approach, rather than reacting to every event. Fragile organisations tend to react to every unexpected outcome. Consider how some organisations react to changes in incident rates. If they dip down it's celebrated as an indicator that things are safer, and of course if it rises up it's time for a change in direction and strategy. This reaction to short-term issues adds fragility through uncertainty and destabilisation, and reinforces incorrect messages, such as suggesting that 'incident rates' mean something.
- **They expect that people will deviate** from established processes as a normal thing, rather than expecting 100% compliance to these processes. Pause for a moment to think about driving a car and whether we are all 100% compliant the whole time, and what the road system would look like if it was designed that way. So, antifragile organisations expect variation. It actually gets designed into systems and processes, and therefore builds natural tolerance.

So how might an organisation become more antifragile?

Antifragile Organisations:

At a broad level, there are some things that can be done to move closer to antifragile, including:

- Ensure decisions are being made or influenced by people[101] who will be impacted by them (**skin in the game**). In short, whether you are going to be impacted by a decision, or not, influences the decision making, particularly over time. Changing a shift roster without involving anyone working those shifts is more likely to introduce fragility. Taleb says it introduces "tail risk", or uneven distribution of risk, where people are making decisions, but are not directly exposed to the outcomes of those decisions.
- **Consider the ethics** of an intervention (why they are doing something and how it will be used) before they implement. For example, were incident rates originally meant to be used to do things like award bonuses or assess the suitability of contractors? In reality, incident rates are used this way, and it introduces fragility because people fudge the numbers to meet the expectation. Antifragile organisations work out why they are going to do something before they do it to try and prevent misuse later.

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101. In *Black Swan* (Taleb, 2007)

- **Separate investigation and intervention**. As mentioned earlier, they have a protocol to determine whether 'intervention' is required, not a policy of intervention. They investigate, gather the information, and then determine *if they need to do something* (not what to do as that still implies something needs to be done). It's entirely possible that some investigations could have no recommendations.
- **Have smaller, flatter, more loosely coupled** systems and organisational structures, and are OK with the trade-offs that come with that. They consider that engagement and connection is more important than data and forms. They think trust is important, and also understand that asking for proof damages trust.
- Try to **maintain optionality**, rather than always seeking to limit choice. Fewer options equals more fragility. Again, it isn't about giving free choice to all; it's about *understanding the implications of choice*. So antifragile organisations might focus on an outcome (safe operations of a vehicle), but not try and tell people the only way they are allowed to achieve it, especially in circumstances where there is the potential for natural variability to be introduced.

Final Word

Antifragility is not a new concept; all I have done (through explaining Taleb's approach) is to give it a label. It's also completely normal that people want their systems to be antifragile. The trouble starts when we discuss what makes things more or less fragile, and what we can do about it if we choose to. This is where the concepts and strategies of antifragility require a move away from tradition. Again, it's not that everything should be antifragile; it's that we are often blind to the impact of our actions on fragility and risk.

In the end, the idea of control through vast and complex systems and processes is an illusion. It is a dangerous one because it adds risk in the background while giving the impression that risk is being managed in the foreground. Large, irrelevant, imposed systems shift power away from people, who in the end are the source of safety and not a problem to be fixed or controlled. It is paradoxical, and it's normal that any discussion of antifragility creates discomfort.

But isn't the thought of just doing what we are doing now, forever, even more uncomfortable?

Further growing and developing the ideas in this Chapter

Dave creates some great discussion in this Chapter on Taleb's work. While it may seem counter intuitive to accept Dave (and Nassim's) notion that through accepting some harm, growth can occur, and this is certainly not within the discourse of modern day Safety; but it is such a critical point that we must accept if the discipline of Safety is to move forward.

How will you reflect on the points made by Dave for both you personally and in your organisation(s)?

What language and grammar could you use to support people in your organisation understand these concepts?

I trust that this will help in your own reflection.

Segue to the next section

We're almost to the end! Our reflections to date have been on better understanding and challenging how things are done in the risk, safety and HR disciplines, aiming for a better understanding of people. In the next Section we reflect on how we have been able to apply *Social Sensemaking*.

Section 10

PUTTING SOCIAL SENSEMAKING IN PRACTICE

Social

SENSEMAKING

Chapter 31 - Thinking Groups

By Robert Sams

> "But if we believe that people in organisations contribute to organisational goals by participating inventively in practices that can never be fully captured by institutionalized processes, then we will minimize prescription, suspecting that too much of it discourages the very inventiveness that makes practices effective."
>
> Etienne Wenger in:
> *Communities of Practice* (2008, p. 10)

Introduction

This Section of the book is dedicated to sharing a collective learning from the many Contributors to this book, and in particular about our experiences of putting *Social Sensemaking* into practice. This includes Chapters on 'Thinking Groups', an interview, and a reflection on the future of the Safety Profession. We'll begin with a review of Thinking Groups.

Learning Through 'Communities of Practice'

Etienne Wenger's research and subsequent book, *Communities of Practice* (2008), is a very useful piece of work in helping us understand the importance of learning through practice, particularly when we are practicing together with others in community.

Wenger's main thesis is that we learn as much, if not more, through participating in shared activities with others as we do through more formal and planned learning formats, such as traditional models of training, education and schooling. She notes in relation to this:

> But if we believe that information stored in explicit ways is only a small part of knowing, and that knowing involves primarily active participating in social communities, then the traditional format does not look so productive. Wenger (2008, p. 10)

In most organisations, and groups, when the topic turns to learning, there are all manner of formal options usually considered. But what of the role of informal learning? How can organisations and individuals alike, take the concepts proposed by Wenger in this research and support a different (complementary) model of learning? These are the questions that will now explore.

What are 'Thinking Groups'

Building on Wenger's research and concepts, one of the critical aspects of *Social Sensemaking* (and learning) is communing with others who too are willing to share, practice, critique and challenge with each other, all for the purpose of developing and maturing. This is why over the past few years, a number of fellow 'sense-makers' and I have formed '*Thinking Groups*' in various regions in Australia where we live or work.

In keeping with the principles of *Communities of Practice,* these groups are all self-regulating. We meet as often or little as we like, and we exist only for the purpose of practicing, learning and maturing together.

Our *Thinking Groups* started when a few of us studying the post graduate program were looking for different ways to support our thinking and the new learning we were sharing and practicing. We were exploring so many new ideas and concepts together, and sharing our learning through practice was a great way to test and understand our ideas and our thinking.

As importantly we recognise that we were doing our fair share of 'unlearning' along the way, so the support from each other (community) was important and cherished. We had a need for a forum beyond our formal studies to share our ideas in a '*safe environment*'. It's great that the *Thinking Groups* have now expanded beyond our 'study group' to include other people that we 'practice thinking' with and who are also keen to learn and think more about people and understand *why we do what we do*.

This idea and concept behind a *Thinking Groups* is to take time out to think, critique and share. We try to think critically and to challenge the 'norm' by exploring beyond the first layer or two of the metaphorical onion. For example, when talking about risk, we try to understand it beyond objectiveness and regulation.

The simplest way to explain how our meetings run is to think of them as similar to a book club. In fact, we often use a book, or at least a key question or thesis from a book, as the topic of discussion/ (thinking) for a meeting.

An example of a topic that one group chose was "*can a bully also be a good manager?*" This initially created discussion that focussed on the definition of bully and manager. The really good thinking and discussion however began when someone asked the question: "*So what is it about the social construct and environment that allows some mangers to bully others?*" That's the nature of these Groups, the conversation may start in one direction, but could head to a whole new destination, that's due to the very informal nature of the Groups.

We try to explore topics beyond the standard and the 'norm', and try to understand some of the 'why' behind questions and challenges, not just the 'stuff' that sits on the surface which I believe has been done many times over.

Our meetings are very informal (no agenda or minutes are required) and are usually in Cafe's or similar over coffee. Forming a Thinking Group can be a great way to start *Social Sensemaking* amongst a group that you belong to.

Social Sensemaking through 'Conversation Corner'

Conversation Corner is our way to bring together the unique blend of semiotics, listening, learning, life and critically, conversation, to an understanding of the tackling of any challenge you may face. This is an approach that leads to sharing ideas, experiences and information in ways that may not be achieved through traditional meeting arrangements.

The foundation method for Conversation Corner is known as 'World Café[102] however by using the principles of *Social Sensemaking*, our model is much more than this. It is infused with understandings and adaptations from the *Social Psychology of Risk* to create something different.

Social Sensemaking through Conversation Corner is a mode of working together that has a unique methodology to draw out and share, listen and facilitate, map and 'prime', reflection and maturity in responding to risk and challenges in the workplace. The use of graphic design, Social Psychology, dialogue, language and listening all work together to create *Social Sensemaking* and offers organisations a way to explore critical thinking and strategy in risk.

So how do we go about conducting Conversation Corner?

The first point to note is that it is a nice balance between 'tight' and 'loose' in the way that it is planned and run. While there is a basic structure and planning that go into running it, the importance of letting things flow is critical.

Each component of Conversation Corner is thought through and is important in combining together for the experience as a whole, these include for example:

- The Space and Place
- Choosing the Right Questions
- Small Groups to Share Ideas
- Graphic Design and Semiotics

What is the role of the Graphic Recorder?

The role of the graphic recorder is twofold:

1. They assist the small groups to draw out their ideas (pun intended!) and;
2. They travel between the groups listening for key themes. The culmination of this is one combined piece of art that provides a summary of the various group conversations.

Can you imagine the outcome of your organisations annual strategic plan or corporate risk strategy being a piece of art?

How different would communicating your strategy be by using a piece of art rather than a pages of text or a slideshow?

How can Conversation Corner be used in your organisation?

Conversation Corner can be used to support learning, sharing and understanding in your organisation through:

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102. (http://www.theworldcafe.com/)

- **Exploring Challenging Situations** - have you ever come to a roadblock where it seems that options and ideas have been explored but you just know that there is more to be learned? *Social Sensemaking* might be helpful for you and others in your organisation work through these challenges in a way that allows everyone to contribute in their own way.
- **'Risk Assessment'** – whether this be at a Broad-brush (overall business or department level), or working through risk factors associated with a particular project or challenging problem.
- **Planning and Strategising** – *Social Sensemaking* is ideal for any form of planning exercise such as organisational or departmental. The use of the graphic recorder and the art that is generated at the end of the session can be used to share and communicate ideas and experiences with a larger group of people.
- **Problem Solving** – our approach to problem solving is to use fun, connection and the art of conversation to create an environment that encourages thinking at all levels, both in our conscious and non-conscious. The use of art and semiotics is particularly important as ideas that come out through drawing are usually very different to those used in traditional and more mechanistic problem solving methodologies.
- **Engaging with your team** – *Social Sensemaking* is a great way to engage with your team to share ideas, experiences and learning.

What does Conversation Corner look like?

Further growing and developing the ideas in this Chapter

If you are interested in forming your own *Thinking Group*, we share below some of the other topics that you might like to discuss. These are provided courtesy of Dr. Robert Long where they were included as topics for reflection during the post graduate program:

- What is the 'hero myth' and how is this evident in modern management and leadership discourse?
- What is the 'art' of followership?
- Can an effective leader be authoritarian?
- What is The Authoritarian Personality (TAP)? Why should managers know about TAP?
- Discuss the nature of power and the attraction of leadership.
- What part does altruism, giving and sharing play in successful leadership?

Each of the contributors to this book are members of the various *Thinking Groups* which are established in the various parts of Australia and they would be pleased to share their 'Thinking' about them with you.

Further, if you would like to hear more about how Conversation Corner may work for you or in your organisation, you can drop us a line at contact@dolphyn.com.au and we will be happy to share more with you.

Segue to the next chapter

We have now explored one way to share and practice in community (communally) for the purposes of learning and maturing. The idea of 'community' is one that is very close to the heart of Scott McArthur, the subject of the interview which is transcribed in the next Chapter.

Scott is a graduate of the Post Graduate *Social Psychology of Risk* program and has a long history of working at the coalface in risk and safety roles. Scott is a self-confessed 'working class man', who was born in Scotland and spent most of his working life either involved at the frontline in the theatre of war, or as a 'safety policeman'. Over the past few years Scott has been through a change, he shares his story through an interview with me.

Chapter 32 – From Army to I-Thou

An Interview with Scott McArthur

> "The *I* of the primary word *I–It*, that is, the *I* faced by no *Thou*, but surrounded by a multitude of "contents" has no present, only the past. Put in another way, in so far as man rests satisfied with the things that he experiences and uses, he lives in the past, and his moment has no content. He has nothing but objects. But objects subsist in the time that has been taken"
>
> Martin Buber in:
> *I and Thou* (2000, p. 27)

Introduction

One of the people that I have been privileged to get to know during the 'adventure' described in this journal is Scott McArthur, a proud Scotsman and no a 'new Australian'.

Whilst sharing the odd 'Chardy' or two during the past few years I have come to know Scott and I am particularly honoured that he shares his 'story' here.

In this warm and honest interview, Scott shares the story of his personal journey in what he describes as: "*From the Army to I-Thou*". This includes a short history covering his upbringing through to his time in the British army and then into safety. It's Scott's reflection on how he has moved from an approach focused on objects through to one that better understands people that is particularly appealing to me.

The interview was transcribed in several ways; firstly, by Scott sharing his thoughts in a written essay, then through face to face chats and finally through our shared reflection of the final account of Scott's story.

My hope is that readers will find Scott's story more than useful and it may induce a few 'aha moments' that may support you in your own adventure. Enjoy!

Scott's Story

Rob: *Scott, thanks for sharing your thoughts here, would you mind starting by telling us a little about your early life growing up in Scotland, and about your family?*

Scott: I was born in the small town of Glenrothes in the Kingdom of Fife on the East Coast of central Scotland. I'm the son of Margaret and Billy and brother to my two older sisters, Shirley and Alison

Glenrothes is one of the six post World War II towns developed to accommodate the overspill from Glasgow due to the declining coal pits in the West of Scotland. Glenrothes was originally built to house the community and subsequent workforce who were to service the Rothes pit, which, due to geotechnical issues, in due course, flooded and subsequently closed. Prior to the development of Glenrothes the main industries in the area were papermaking, coal mining and farming. The Tullis Russell paper mill was the largest paper manufacturer in the area and operated from its site for over two hundred years.

Mum worked her way up to be the Manageress of the Tullis Russell Social Club for almost all of my childhood. The Social Club played a central role in both the working mill and the local community, everyone knew '*Margaret and Billy*' and I have fond childhood memories of visiting Mum at work with my friends and feeling a real sense of community. We were, in the main, a blue collar, working class, '*work hard, play hard*', township. It shaped what I have become as a person.

Dad had a few jobs, but mainly worked in the North Sea oil and gas fields off the North coast of Scotland which involved high risk work in gas compression and being away from home for two weeks at a time. With Dad working away and my Mum working full time, it was my sisters who quickly taught me to look after and administer myself.

Rob: *What do you remember about growing up in Scotland?*

Scott: In the mid-eighties I left school. There was high unemployment and low prospects for a boy of my age. It was the *'Thatcherism'* period where unemployment was particularly high in Scotland and the North of England. Memories of growing up in this period were dominated by the Falkland's war, the troubles in Northern Ireland, the Miners' Strike and the Piper Alpha disaster. All of which hit my community pretty hard for a number of different reasons. I reflect back now and there is so much that I learnt during this period which only now I am becoming conscious of.

I started out my working life as an apprentice painter for a local company called Roland Decorators in the adjacent town of Markinch. My role as an apprentice painter mainly formed around all the less meaningful tasks which made me reflect on *'is this what life has in store for me?'* It didn't seem like there was a lot to look forward to. I started to think of different options.

One lunch time, my friend Alan (who subsequently became the best man at my wedding), and I, decided to go to the local army careers office to see if there was anything exciting on offer for a couple of sixteen year olds with a lust for adventure and risk.

Rob: *Can you share a little of what it was it like in the army?*

Scott: I first enrolled in the corps of Royal Engineers and served a year as a Junior Leader (a kind of military boarding school), till I was old enough to join the regular British Army, which I did and stayed for a further twelve years. I served on active duty in Northern Ireland, Bosnia (twice, both times as a peacekeeper with the United Nations Protection Force) and Kosovo (in bomb disposal) ensuring the liberation from Serbia. I finished up as a Military Instructor at the Royal School of Military Engineering in Chatham, Kent. My time in the Army was a memorable period in my life.

Life in the army however was not without its challenges. Spending time '*at War*' with others, changes how you think about things; there are memories and images that will stay with me forever.

I recognise now that the army has to create certain social constructs in order to allow those who join it to exist and 'belong'. That is, a social environment that assumes that

the job is to somehow either control others (or in the language often used in War; '*liberate*'), or in the worst case be part of killing '*the other side*'.

There is so much that I reflect on my time in the army with my knowledge and understanding of Social Psychology; the theatre of the army, the language used, the hierarchy and associated power; the 'in-groups' and 'out-groups'. Social Psychology has (retrospectively) taught me so much about the army and its culture. The strong themes that stand out to me are: hierarchy, power, structure, process and control.

Rob: *So how did this impact on your life?*

Scott: Whilst serving as an Instructor I was encouraged to make the most of being based in the one location for an extended period and to do some study to set myself up for 'civilian life'.

At the time, Health and Safety was starting to become a 'trade' in its own right and make a few headlines in the construction industry. A few of my friends were booked into the next safety course at the local college so, with an open mind, I went along to see what the fuss was about.

I spent the next year at 'night school', while still serving in the army, being told all about the Health and Safety legislation and how to report on potential breaches. I recall being energised in a way about this. It seemed to fit in well with what I had learned and practised in the army; I was a natural fit I thought.

Rob: *Did that lead to you working in health and safety?*

Scott: Yeah it did. There was a shortage of people with my new found qualifications and I subsequently left the army and was employed as a 'safety professional' in a consultancy called *'The Health and Safety People'*.

My work routine mainly involved inspecting at least three construction sites per day in London and throughout the South East of England. My job was to descend upon these projects and report any breaches and *tell* them how to 'do safety' and comply.

I knew site managers who would see me coming and run in the opposite direction. It seemed a perfect job for an ex-soldier, it was about process, control and discipline; I was pretty good at all these things. There were lots of ex-army people 'doing safety'; we called it the old boy network. We were taking the industry by storm; it seems that our background and experience was exactly what 'Safety' needed.

I was good at it and felt well respected for my ability to '*sort sites out*'. My methodology was similar to the '*utopia complex*' (McKay, 2013), where everything could be perfect if only '*they*' would only listen to what '*I*' had to say. It seemed pretty easy really; follow the procedures I had written as I was the 'expert in safety'.

I felt like I could lead them to perfection and keep them all from harm; this was my world view of what 'Safety' meant at the time. In the language that I know you use, you might have described me at the time as a '*Crusader*'.

Rob: *So how did that play out for you?*

Scott: This world view led to many head to head battles with people as I went about stopping work; of course all in the name of safety. I felt that I knew what was best for them. In order to keep up this charade, I had to become two very different people; one was my work self, and the other my real self. This caused a lot of internal tension in my life, what I now understand to be '*cognitive dissonance*'. The person that I was at work seemed inconsistent with the person that I wanted to be. I was constantly thinking that there must be something better than this? Surely this can't be it in safety?

Rob: *What did you do about that feeling of tension and unease?*

Scott: By then Anita and I had moved to Australia and I was determined to find that *different way*. I spent a lot of time researching and thinking. I eventually stumbled across a website called Safetyrisk.net run by a guy called Dave Collins. I read a lot of the articles on there and things started to make better sense for me.

I also found a reference to a book called *Risk Makes Sense* (2012) by Dr Rob Long, I found the book hard to put down. It kept raising so many questions and challenges for me, it was written from a completely different paradigm than I had come to know about risk. It is not over exaggerating to suggest that reading that book changed my life.

Anyhow, before I knew it, I had myself in my first formal University study program and I commenced what you would call a 'learning adventure'. The post-graduate program in the *Social Psychology of Risk* has created a whole new world for me; a world that I find so much more fulfilling and meaningful.

Rob: *What would you describe as your key learning from the program?*

Scott: I have moved from viewing and valuing the physical things (objects) in life, to better understanding people as 'beings' or subjects. I've come to this insight in part by reflecting and learning more about myself and *why I do what I do*. Through this learning it has also emerged that both life and risk are about creating community, as we are social beings who long for connection with others.

Another key learning was the importance of 'followers' when it comes to leadership. If our focus is to lead and motivate others, Social Psychology can teach us so much. I feel like I have further clarity around the question of what it is to lead or be a leader. The Social Psychological perspective has helped me understand that if you don't have '*following*', you don't have '*leading*'.

We are social beings and to live with others is not only a necessity, but it seems we are hardwired to follow as following is a fair exchange; i.e. followers provide leaders with something they want (followers) and leaders provide followers with something they want (leaders), both groups stand to gain from the arrangement that nature intended.[103]

Rob: *How has this played out for you in your work?*

Scott: I think one of the key questions that large tier one contractors should be asking is not "*how can leaders motivate followers?*" but rather, "*how can leaders create the conditions within which followers will motivate themselves?*"

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103. This is a concept expanded on by Barbara Kellerman, in her book *Followership: How Followers are Creating Change and Changing Leaders* (2008).

The leadership discourse in the construction industry in general implies that motivation is something that gets "*done to people*" rather than something that people "*do for themselves*". A Social Psychological approach to motivation would be the concept of intrinsic motivation, which refers to the process of doing an activity for its own sake of doing an activity for the reward that is inherent in the activity itself.

My learning's have taught me that I need to create a trusting and valuable leader-follower relationship when communicating and consulting about risk; where my followers feel both competent and autonomous to carry out their role or function. This supports others to feel that they have some '*skin in the game*' and are motivated to doing their activities, of their own volition and at their own initiative so they will continue this into the future without me having to prompt them.

The knock on effect (by-product) from this is I have noticed that people begin to manage their own risk and feel free to utilise and promote inspiration, innovation and creativity in problem solving.

Probably the greatest learning that I've had is the importance and impact of the unconscious on our decision making and thinking. If we want to better understand motivation and why people do what we do, *understanding the unconscious is critical*.

Rob: *What is it that you've learned about the unconscious in our thinking and decision making?*

Scott: I learnt that the vast majority of decisions that we make both, in life, and when managing our risk are made in the unconscious mind. It is a common misconception to think that the conscious (rational) mind is in control of everything. I've come to realise that this is not the case. It's not always an easy concept to understand though as it seems counter-intuitive that we make decisions in this way. I've had some very testing conversations with people in the construction industry about this. While not everyone comes around to this understanding quickly or easily, when I do take the time to talk through examples with people, it starts to make sense. I talk about examples of how we often work in 'automatic', like when we've learnt to do a job or task that well, that we don't really need to think much about it at all when we are doing it. As I wander around sites talking with people I see more examples where people seem to be operating on automatic.

Rob: *What are some of the ways that you talk about this with the people doing the work?*

Scott: Well basically, I explain the unconscious to people by referring to the journey I would take to work each morning in a car. As I drive along I'm not really aware of the traffic and I'm already thinking about what I need to do when I get to work. The traffic and driving seems to be taking care of itself and a whole range of actions are taking place without much (or any) thought from me as my mind wanders back to the day's tasks and I start to create my mental checklist of what I need to achieve at work. I'm actually driving my car using my unconscious decision making process which has been developed over many years of driving.

If I remember back to when I first started driving I was really slow and clumsy, and I had to think a lot more about what I was doing. I now realise that initially, to learn to drive, it took my conscious (rational) mind, however, now it seems so natural I feel

that "*I'm in the zone*" when I drive. I then explain that the Social Psychological term for being '*in the zone*' is 'automaticity'[104] or automatic as I mentioned before.

It's kind of dawned on me over the past few years when I have been thinking about this, that it is the working on 'automatic' and being in the zone that can, on the one hand be so easy to understand because we all do it, yet ironically in Safety, be so frustrating because it means that we can't *control* things when people are working in automatic.

Rob: *So, as we wind up, I'd like to explore a little about the idea that you describe your journey as: 'from army to I–Thou'. Can you finish by helping us understand what you mean by I–Thou and what this looks like in your life now?*

Scott: Yeah sure, let's end with an easy one, by explaining I-Thou! I couldn't possibly do Buber any justice in describing his amazing work and ideas. However, I think I can at least portray some of his ideas in translations of Buber's, work that I heard, through Graham Long when we went to The Wayside Chapel in mid 2014 when we did Unit 2 on Leadership.

As you know, Graham is the Pastor and CEO of The Wayside Chapel in Sydney, a place created to provide a '*community with no us and them*'. Graham and his team at The Wayside aim to provide a place where there is no '*I*', only '*Us*'. The '*Us*' is a community where no-one is better than the other; no-one is judged for what they have, or don't have, and everyone is welcome, *in community*.

Buber's concept of *I–Thou* goes much deeper than this and is effectively a poem to help us better understand ourselves as a whole person, that is one who lives in communality with others, rather than being a 'self'. I like this quote from Buber:

> When *Thou* is spoken, the speaker has no thing for his object. For where there is a thing there is another thing. Every *It* is bounded by others; *It* exists only through being bounded by others. But when *Thou* is spoken, there is no thing. *Thou* has no bounds. (Buber, 1958 p. 20)

In 'Safety', we have become fixated and obsessed about 'things', about 'objects' and about 'measurement'. These are all 'its' in Buber's language. If we wish see our fellow work mates in a light that is closer to *Thou*, we too might adopt an approach akin to The Wayside Chapel. Imagine 'Safety' without 'us' and 'them' and only 'us'. This would create an environment where humble inquiry could flourish; we could better engage and embrace with people. This is what I would like to think 'Safety' is about.

To summarise my learning to date is to realise that I don't know everything; in fact I have even more questions now than when I started, but, I'm ok with that.

I feel human again and connected both at work and in my personal life. My journey of learning about risk is far from over; in fact, this is just beginning.

My writing of my essay on this topic and then in discussing it in interview, it has helped me search for further answers and while I realise that my past has provided me with many valuable experiences that have shaped my life significantly, I now feel that

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104. Barge et.al discuss the topic of "automaticity" in Chapter one of their book *Social Psychology and the Unconscious* (2007)

I am moving nearer to a world focused more on *Thou*; and my life feels much richer and with greater meaning and purpose. This translates into my private life as well as at work, and that dissonance that I used to feel is dissipating rapidly.

Further growing and developing the ideas in this Chapter

Scotty is a great bloke and what an adventure he has been on too! I've enjoyed getting to know Scott and learn about his story, there is a lot of rich ideas and 'take-aways' in it for us all.

As you reflect on Scott's story is there anything that resonates particularly for you? What is your story? What does Buber's *I-Thou* mean to you?

Perhaps these questions may assist with your own reflection?

Segue to the next chapter

Scott has changed. He has moved on from the policing and 'gotcha' role of the Safety Officer and moved to a role and a method that is focused on conversation and communing. That is how Scott see's the role of Safety today. In this next Chapter, we are both excited and honoured to share with you a further reflection on the topic of the 'Safety Professional', in a reflection shared by Ron Gantt who lives and works in the United States of America.

I originally wrote to Ron asking if he would be interested in critiquing a final copy of this journal before it was published. Ron quickly agreed and the conversation between the two continued. It reached a point where Ron reviewed some of the early Chapters of the book and shared in the stimulation of the reflection, which got to the point where Ron agreed to write a Chapter of his own.

We trust you will enjoy Ron's reflection on the role of the Safety Professional.

Chapter 33 – The Future of the Safety Profession

By Ron Gantt

> "The purpose of this website is to celebrate new and different approaches to safety. More specifically it is about exploring approaches that boost the capacity of people and organisations to handle their activities successfully, under varying conditions."

> *Safety Differently Website*
> (http://www.safetydifferently.com/about/)
> As accessed on 02 July 2016

Introducing Ron Gantt

Ron is the Vice President at SCM, a very successful family run consulting business, started by his father. Ron is also an Editor and Contributor to the Safety Differently website (www.safetydifferently.com) its aim is to challenge how 'Safety' is done in organisations. We are privileged that Ron shares a reflection of his own in this Chapter where he considers; *The Future of the Safety Profession*.

Ron's Reflection

"They tell us to do these things, but they don't want to know how we get them done." Others in the focus group nodded in agreement. Myself, I was taken a bit aback. I was facilitating the focus group with the intention of learning about the organization and how it manages safety and learning. My organization had been speaking with many of the line employees who expressed varying degrees of frustration with different aspects of the work environment, management, the union, etc. These frustrations were typically specific to a given task, tool or area. For example, concerns about the lack of training, not getting appropriate gear for a task or areas that were particularly dangerous or troublesome. But this statement struck me as a particularly profound summation of the picture that was developing – a gap between the decision-makers and those enacting the decisions.

This gap is not a product of a lack of care or concern on the part of the organization or its leadership. The organization in question hired us, after all, to help them improve their ability to support their employees in creating safety. They were putting their money where their mouth was, so to speak. So this wasn't a question of evil, immoral, greedy and calculating management. There was something else much more dangerous at play here.

Sociologist Diane Vaughan makes a similar point when she points out that:

> Too many critics of the organizational and political sources of our troubles see diabolical plots where there is only drift, a taste for reckless adventure where there is only ignorance of risks, the machinations of power where there is, in William James' phrase, only a 'bloomin' buzzin' confusion.'[105]

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105. Vaughan, D. (1998). Rational choice, situated action, and the social control of organizations. *Law and Society Review*. 32(1). 23-61.

In another place, Vaughan makes reference to "structural secrecy" as a potential cause of the gap between decision-makers and those carrying out the decisions. Secrecy is a feature embedded in the very structure of many organizations, she argues; as we create bureaucratic policies and procedures (formal or informal) that are well-intended, but hinder the flow of information through the organization.

I've seen many examples of this structural secrecy in my dealings with organizations and groups. For example, how many organizations have a strict deference to hierarchy? If you have a problem you need to report it through your chain of command! After all, that's why we have a chain of command! But what if the chain of command is the problem I want to report? Who do I report to if the concern I have is related to my supervisor?

Another example – how many organizations put those at the figurative top of the organization (i.e., the executive management) literally at the top of the organization (i.e., on the top floor of their corporate headquarters)? What sort of signal does this send to workers who now have to overcome both a literal and figurative distance to bring information to the top of the organization? And this in an environment where workers often do not have a lot of time (after all, they have a job to do!). Often workers have to bring these concerns to management during their breaks, and the physical separation makes this even more challenging, leading many workers to report that it's simply not worth the hassle.

Now, again, I'm not saying that reporting through a chain of command or having executive leadership in a place of prominence is intended to have this effect, nor do these practices only have negative effects. There are advantages to each and every policy or procedure that develops structural secrecy. But, as you've heard many times in this book, our world is never so simple as to be an all or nothing. The structural secrecy that develops as a result of well-intentioned policies and practices such as the examples above have real world effects that can blind organizations and potentially lead to disasters. One of the primary functions of leaders in organizations is to make decisions and one of the best ways to ensure consistently bad decision-making is to make decisions based on bad information.

As an example, in 2005 in Texas City, here in the United States, a refinery owned by BP exploded, killing 15 people and injuring about 180. In the aftermath of the disaster, many pointed to what looked like greedy, immoral decision-making on the part of the organization's management as a potential 'causal factor'. After all, management had consistently cut spending on maintenance at the refinery many times in the past, and poor maintenance was a key factor in allowing the disaster to occur. But consider a few points:

- The explosion occurred when operators overflowed a tower, causing a gasoline precursor to vent into the environment. Management did not even consider overflowing the tower a possibility because they had multiple procedural controls and defences in place to prevent this scenario. However, unknown to management, but known to some of the operators, many of those control measures did not work or were routinely violated.

- Although many have been critical of the cuts to maintenance in the refinery, management hired a consultant to benchmark their maintenance practices with other refineries in the country. The consultant reported (accurately) that the BP Texas City Refinery spent more money on maintenance than other refineries in the country.
- BP Texas City Refinery had what many would consider an exemplary safety and risk management program (based on traditional standards). According to the ways that they measured success, injury statistics, they had a world-class program, with extremely low numbers of injuries.

So, putting the pieces together, what did management see? They were spending a lot of money on maintenance, perhaps too much. They had a great 'safety record', so if you cut maintenance spending it might affect 'safety' but probably not that much. And, the places they would cut would be to those areas where the risks were perceived to be low, such as the tower that was eventually overflowed.

In light of the information they had, the decisions they made make sense. We can criticize the information they used, but if you take the information in light of what they knew at the time you just might have made the same decision they did. Structural secrecy would claim more victims.

Enter the "Safety Professional"

Where does the safety professional fit in all of this? Well, traditional understandings of the role of the safety profession likely would have no bearing or effect on structural secrecy. Take the definition of the role of the safety professional from the Board of Certified Safety Professionals' website:

> Safety professionals identify hazards and evaluate them for the potential to cause injury or illness to people or harm of property and the environment. The safety professional recommends administrative and engineering controls that eliminate or minimize the risk of danger posed by hazards[106].

Or, this one from the American National Standards Institute's standard for the "Criteria for Establishing the Scope and Function of the Professional Safety Position[107]":

> The scope and functions of the professional safety position shall be to:
>
> - Anticipate, identify and evaluate hazardous conditions and practices.
> - Develop hazard control designs, methods, procedures and programs.
> - Implement, administer and advise others on hazard controls and hazard control programs.
> - Measure, audit and evaluate the effectiveness of hazard controls and hazard control programs.

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106. Board of Certified Safety Professionals. (2016). *The Safety Professional Today.* Retrieved from http://www.bcsp.org/SH-E-Practice

107. ANSI (2003). *ANSI/ASSE Z590.2-2003 Criteria for Establishing the Scope and Functions of the Professional Safety Position.* Des Plains, IL: American National Standards Institute/American Society of Safety Engineers.

The focus is almost entirely on identifying and controlling hazards. The picture is one of a technical profession, one that goes to job sites and can identify the technical issues with the jobs. This could be physical hazards, such as ensuring that cranes do not pick up objects greater than their rated capacity, or 'unsafe practices', such as overflowing a tower in a refinery. Once those hazards are identified, the safety professional can recommend ways to control the hazards that will make the job 'safe'.

There's a significant problem with this technical model of the safety profession though – it puts the safety professional into a position where they are telling people how to do jobs that they have never done. Now, this fact alone is a source of considerable frustration for workers. They often report having a negative perception of safety professionals because they feel the safety professional doesn't understand how the work actually gets done (notice the similarity between this situation and the gap between management and workers identified above?). But does the lack of detailed knowledge of how the work gets done inhibit the safety professional's ability to effectively identify "hazards"?

Researchers in the aviation world wondered about this in the context of identifying "human error." They had experts in aviation safety and 'human error' evaluate the performance of air traffic controllers to identify specific instances of 'errors'. Each expert did their own evaluation, not comparing notes until the end of the study. They were using the same rating criteria, so the results should have been the same. They were not. At the end of the study the experts couldn't agree on which actions were 'errors'. and which were not. Even the actions they unanimously considered 'errors' differed in the type of 'error' each expert believed it would be, making classification and counting impossible. But the real interesting part came when they shared their results with the air traffic controllers themselves. In nearly every case where experts identified "errors" the controllers were able to show how those actions were not errors at all, but strategies designed to meet some other goal that was not considered. Without the specific knowledge of the task at hand the experts completely misinterpreted the actions of the controllers. Had they not shared their results with the controllers the experts may have recommended controls that not only wouldn't have improved anything, but may have made things worse!

So, the model of the technical expert who provides recommendations on how to do tasks (in which they are not subject matter experts) is clearly problematic. Luckily for the safety professional, society has realized this and has given the safety professional an 'out' – regulations. In nearly every industrialized country in the world volumes of laws, regulations and standards exist designed to provide a minimum standard of protection for us. As a result, safety professionals no longer have to know about the jobs in question, they only have to know about the regulations that apply and provide expertise in how to apply these regulations to the jobs in question.

Unfortunately, this shift of focus away from the work processes to the applicable regulations has created an obsession in the safety profession on what the regulators are doing to the detriment of the worker. We become more interested in what the regulator thinks is 'safe' than what our workers care about.

What's worse, by substituting job-specific knowledge for regulatory knowledge, we have tried to solve a problem of not knowing enough about the details of the job by relying on those who are separated even further from the work environment. The underlying problem still exists and in fact is made even worse.

There are those in the safety profession that have recognized some of these problems and are looking for ways to build competency standards for safety professionals. Unfortunately, the competency standards appear only to be doing what we're already doing, but doing more of it. We need better training, education, certification in technical issues is the rallying cry. But this approach doesn't fix the underlying issue. The technical expert model of the safety profession is based on the idea that the safety professional should be the proverbial 'jack of all trades, master of none'. We should provide technical advice on engineering principles, without being an engineer. We should provide solutions to deal with behavioral issues, without being trained in social sciences. We monitor and provide legal advice on regulatory compliance, without being attorneys at law. We give recommendations on how to do jobs that we have very little knowledge of our own knowledge in how the job should be done in the first place. And at the end of the day, this model does nothing to deal with the structural secrecy that enables slow, steady organizational drifts into failure.

A Different Model — Speaking Truth to Power

Lately, I've been reflecting on the growing gap between what I see as the main problems organizations seem to be facing in terms of managing risk and the role of the safety professional in facilitating this. More and more, for the reasons stated already, the current model (the technical expert model) seems to be insufficient in dealing with, and may increase, the information gaps that exist in organizations. After all, the more I learn from people in organizations, the more I see that the technical expertise needed to solve organizational problems often already exists. For example, the workers in the focus group discussed at the beginning of this chapter already knew about a lot of the problems that management had no clue about. And because they knew about the problems, they also had developed numerous novel solutions already, some of which were obviously better than others. The problem was that this expertise related to those specific problems was not getting to the people who had the power to make real, lasting changes.

In light of this, perhaps a better model for the safety professional is as one who connects decision-makers with those who have the domain-specific knowledge to help those decision-makers make good decisions. In this way, the safety professional is a lot like the quintessential journalist, someone who speaks truth to power. They make sure that the mental models of risk within the organization are constantly receiving updated information about what's really happening in various parts of the organization. They no longer see their role as someone who provides answers, but as someone who values questions and creates structures that enable answers to emerge through dialogue and story-telling. Safety is no longer merely the responsibility of the safety professional, but of the entire organization (which is more an admission of reality than any real substantive change).

Now, I do not believe that the safety professional's role in this model is to physically get all pieces of information themselves and share them with top management. Rather, the goal of the safety professional should be to develop structures, processes, practices, etc. that combat secrecy and encourage transparency, information sharing and trust.

I saw a great example of this approach in one organization I worked at in a very high-risk industry. They realized that often people within their plant had really good solutions to problems, but the challenge was often getting the right people to the table. So they created what they called their SMART Team. SMART stands for Sharing Minds, Actions, Resources and Technology. They hold regular meetings (every five weeks so they can catch people who do shift work) where basically anyone in the plant is invited. In the meetings anyone can bring up problems or ideas they have related to any topic (safety, production, quality, etc.). All levels of the plant regularly attend, from top management to the line workers. The most important rule is that everyone has an equal voice in the meeting. So when an engineer brings up a project he's starting that he's having problems on, maintenance workers can bring up their opinions just as legitimately as the plant manager. This plant has not only seen significant gains from this (they are the most reliable plant in the corporation), but the plant has also built a foundation of trust that causes outsiders to notice immediately and has won the plant awards for being a 'great place to work' for the past few years.

What This Requires — New Competencies

Obviously if the role of the safety professional changes from being the technical expert to being the conduit for learning and information sharing, there will be implications for the competencies we expect from the safety professional. Education in 'safety' would need to adjust from learning about engineering and regulation to learning about how people make sense of their environments, perceive risk (both good and bad) and interact socially and structurally to create resilience. Safety professionals would need a healthy foundation of social science and communication. Success would be measured by their ability to facilitate dialogue more than their ability to create compliance.

A key competency that the safety professional would need to foster in the organization would be the building of a transactive memory system. Transactive memory in the context of organizations is the ability to know who is good at what. If the safety professional is expected to be able to bring together expertise within the organization, a key component of this is knowing who is the expert in the task at question. Safety professionals need to learn who the 'go to' people are, in their organizations, for various tasks, tools and topics. This requires not only a healthy understanding of 'who does what' in the organization, but also understanding who are the informal experts in your organizations. As my friend and colleague, Daniel Hummerdal[108], has said, *"… your employees have a capacity greater than what is in their job description."* They are more than what you ask them to do. If the safety professional can become aware of this informal expertise that can be a powerful hidden resource that the organization can bring to bear to solve problems and create sustainable performance.

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108. Hummerdal, D. (2015). *People are the solution*. Retrieved from http://www.safetydifferently.com/people-are-the-solution/

What this Requires — New Practices

A safety profession model that moves away from being a technical expert to being the connector within organizations will also change the practices of the safety professional. To illustrate this, imagine what this model would do to the traditional tools in the safety professional's toolbox. For example, building a 'safety management system' would be more about building structures within the organization that encourage flows of information and feedback loops. 'Hazard identification' would be about identifying those policies and practices that discourage sharing of information or keep people apart. To audit the effectiveness of our processes the safety professional could trace the flow of a specific piece of information through the organization, similar to how one uses smoke to trace airflow when testing ventilation systems. At phase, we would be monitoring the decision-making processes, rather than the outcomes of those decisions. We would ask questions like:

- "do we have the people involved that we need to have involved?";
- "whose perspective is missing from this decision?"; and
- "what information would be necessary to lead to a different decision?"

The "control" measures safety professionals would focus on would be on creating conditions that facilitate dialogue, sensemaking and good decision-making at all levels. What this would look like varies depending on the type of decision to be made, but in almost every case there would be an intense focus on building in time for reflection. This is based on the idea that expert performers routinely evaluate their performance, whether it was good or bad, so that they can learn and improve. In this new model, learning would be viewed as a key intervention. Therefore, the role of the safety professional would be to create an environment where learning is not a discrete activity, i.e., something we do only when an accident happens or when we're in training. Instead, learning is continuous, built into the fabric of how the organization functions.

The most important tool in the safety professional's toolbox though will be conversation. Getting as many perspectives as possible directly from the source will be seen as a crucial datum point. The safety professional will see conversation not as a distraction, but as a fundamental aspect of creating a resilient organization. To facilitate this, the safety professional will not only look for opportunities to get out of the office and meet with people, but will also encourage the organization to build in 'collision points' into physical and work process designs. These are points that naturally force people to interact.

For example, one safety professional I spoke with about some improvements in her organization pointed to the movement of her office to being at the location where most of the workers started their shift, and the changing of her shift schedule to match the majority of the workforce. What she said about this was rather profound and stuck with me. She said that merely arriving in the parking lot at the same time, asking how their weekends were, how their families are doing as they moved to start their days created relationships that enabled her to identify issues and solutions that she never would have gotten to on her own.

You May Say I'm a Dreamer

Now, obviously asking for a wholesale change of an industry as large and entrenched as the safety profession is a bit of a pipe dream. After all, if you apply for a job as a safety professional with only the competencies I've described above you probably will not be hired. And if by some chance you are hired, doing the practices I recommended will likely raise some eyebrows and perhaps get you sacked. Unfortunately, the technical expert model of the safety professional is too well established. There are a lot of organizations that have significant interests in keeping the current model in place. This isn't to say that these organizations are bad or stupid or greedy (see the above discussion about management decisions), it's just to say that making changes is going to take a lot of effort, time and thought.

Of course, if you are a safety professional reading this, you likely have a lot on your plate already as well. You've got to make sure all your compliance training is completed and your inspections receive the appropriate follow-up. And those accidents aren't going to investigate themselves! At the end of the day though we have to take stock and ask what we're really achieving with all of this. Sure we might keep the organization out of hot water with the regulator, but are we any safer?

If you're like me, and you're frustrated and tired of doing the same things over and over without seeing much improvement or benefit, then let me challenge you a little bit. If we want change we have to show that change is necessary, which not only means showing that the current way is not good, but also showing that alternative ways are possible (and better). One thing that you can do in your organization to facilitate this is to set aside some time in your schedule to just try this out. Maybe it's an hour, maybe a day or maybe more, but set aside the time and pretend that your job is no longer to be the technical expert, but to create learning, dialogue and connection in your organization. During that time, spend some time teaching yourself some of the competencies we talked about above (and in other parts of this book) and then spend some time trying out the practices. Give it a try and see how it goes, how it makes you feel. Ask others what they think. If it doesn't help anything after giving it a good try then you won't lose much. But chances are you'll find that in that short period of time you start becoming more effective, you start learning things about your organization and the people in it that you never knew, and you probably will like it. And if that's the case, try it a little more and see what happens. After a while, you just might find that you don't have to make the case for change, because you've already changed the organization by changing how you respond to it.

Further growing and developing the ideas in this Chapter

What do you think the role of the Safety Professional should be in organisations? Have you ever taken the time to map this out and consider this from a perspective of doing '*Safety Differently*'? Ron's personal and sharp reflections here may spark your own reflection on this important question.

Segue to the next chapter

Ron's reflection on the future role of health and safety, as being one of support and coach, provides a critical insight into how we can be more effective in our roles in risk, safety and HR when our focus is on supporting others.

As we move to the next Chapter, we reflect on another profession where the art and practice of *Social Sensemaking* is critical, that of Human Resources. In this Chapter, De Sullivan reflects on her career from '*money to people*'.

Chapter 34 – From Money to People

By Deanne (De) Sullivan

> "Focus on challenges and allow for resourceful responses to cries. Hold back from over defining the experience or making it too safe"
>
> Dario Nardi in:
> *Neuroscience of Personality* (2011, p. 91)

Introduction

De is an experienced Organisational Development professional who has spent the past ten years working in a range of Human Resources management positions. De has been an instrumental part of the 'adventure' described in this book, both through a shared learning experience in her many conversations with Rob, and in a new formal learning adventure of her own as she completed a Diploma in Positive Psychology in 2015 and commenced another Diploma in Counselling in 2016.

De shares a short reflection on her career: '*from money to people*'.

The beginning

Like many school leavers I didn't have a clear view of my career path when I first left school. I wasn't really sure what I wanted to do, so I decided to pursue work in an industry where I thought that the subjects that I had done well in at high school would serve me well.

Maths was always my strongest subject in high school and I was fortunate enough to be successful in a graduate intake in the banking and finance industry which allowed me to study and work in an environment that gave me many opportunities, very quickly.

My first job was in personal lending where I assessed loan and credit card applications. After about three years, I was seconded to the Human Resources function to manage employee salary packages. For some reason numbers always stayed with me!

This was my first opportunity to try to understand what motivates people and what doesn't. In the first three months I thought I had the best job in the world; I had the opportunity to share the money, make people happy and help them package options which best met their financial and personal needs. This is what people are after aren't they, 'monetary rewards'? I was about to learn a whole lot more than I knew previously about motivation.

I very quickly learnt that money only seemed to motivate people for a month (or so), and this was usually the month after annual bonuses were paid. For the remaining 11 months of the year money was no longer a motivator. There just never seemed enough of it, basically everyone wanted more of it but it (of itself) didn't really seem a motivator for much other than greed. What else did I learn?

At the time I moved into Organisational Development, the banking and finance industry went through significant change, moving from having customer interface

branches to online banking. This was an enormous shift in the way customers would be banking and how customers were supported by our staff.

I soon realised after a new organisational restructure was announced that some people loved the change and couldn't wait to start their new roles, while others found the change particularly difficult, and didn't cope well at all. How could it be that we have two people doing exactly the same job, with the same skills, both great performers, both highly valued by the organisation, yet change had such a hugely different impact on each individual's wellbeing?

As I reflect now, there is a lot I was learning about people and motivation, I was just not realising it at the time.

When organisational restructures happen, HR always seems to be asked to come and '*fix people issues*' and get those people who are not supportive of change 'on board' with the organisation's new direction. After around 7 years working within the banking and finance industry, and being that person whose job was to '*fix people* ' I was starting to ask more questions about my role in HR. It seemed to me that there was no fixing that could be done for people who didn't want to be fixed. There was more I needed to learn about people and why we do what we do.

A change

One of the things that struck me most was that I learnt that organisations will always be looking to change; and make decisions that suit their needs. This is despite their rhetoric, and discussion about people, after all, that's what organisations do, they organise to achieve the greatest gain (and profit) that they can. That is their purpose; looking for efficiencies and innovative solutions that create cutting edge solutions which generate positive returns to shareholders, is the end game. It's hard to care about people in a large corporate environment, it just doesn't seem to fit their purpose.

I also recognise that people too will often make their own decisions if they want to be a part of a change or not. For some people this may cause pain. Change is not always easy and especially when people are not expecting it; it can hit them like a rocket. I've seen this so many times. I think the challenge for the HR professional is to know what to do when people experience this pain; we can't always fix people - I'd learned that already. I felt that I wanted to do things differently; I felt that we needed to move from 'fixing people' to 'supporting them'.

So, if our aim is to support people through pain what do we do?

Firstly, I've learnt that one of the key ways that adults learn can be through the most painful periods in their life. It seems that some people need to have the space to be present with their pain to make whatever decisions are appropriate for their situation. If we make decisions on behalf of other people (i.e. try to fix them as we do in HR), we limit their ability to learn. So how do I know about this?

The short answer is that it wasn't until I moved outside of the HR profession that I started to gain a better understanding. It was then that my learning about how to support people really started to accelerate. So how did that come about?

In 2014, I felt a need for further inspiration and had a desire to learn more about people and how they 'tick'. I needed a new path of learning; one that would help me better understand how to best *support*, rather than *fix*, people. So, in 2015 I completed a Diploma in *Positive Psychology* and in the following year I commenced a Diploma in *Counselling*.

At around the time, I also commenced in the role as a Mentor supporting people who have been the victim of domestic violence.

It is through the combination of the formal learning and associated life experiences in supporting others, that I have come to realise that if we take the role of '*fixer*' in organisations, we can in fact do great damage to people.

So what can people in HR (as well as risk and safety) learn from this?

The fact is that, as much as we would like it to be the case, a '*one size fits all*' approach, doesn't actually fit at all. But it is unfortunate that this is the way that organisations seem to deal with the different people and their response to change and at times when they may be in pain. As has already been outlined many times in this journal, the key to supporting others is to listen without solving, to 'be with' them, to suspend your own agenda, and as they suggest in Counselling, 'attend' to the person. Just don't try to fix them.

Perhaps I can demonstrate what I mean with a real life example of how people can be faced with change and challenge yet work their way through it and learn. I will finish my reflection with a story of a beautiful person that I met recently at a business networking function.

The woman's personality instantly filled the room with colour, and on face value, she seemed to have her life all sorted; a perfect family and a business that she started herself. She then shared her story, and despite all of the positive experiences that seemed to suggest that this woman had life under control, she rocked the room through the telling of her story.

This lady had lost three of her family members at one time, and if that in itself doesn't seem challenging enough, it was to the hands of her own brother-in-law; he had murdered them.

In sharing the details of her trauma we could see the depth of pain which stays with her; however, her strength and determination to make a difference to the lives of others is remarkable. Her learnings have taken her on a new journey where she now works with the most senior police officials to reform policy around the breaching of Apprehended Violence Orders.

I found it remarkable that someone could experience something so tragic and yet still have the ability to function and be present with others?

The thing is that we can't change significant events that happen in people's lives, however, what I have learnt is that we can make room for them; we can give them the space and respect to work through their challenges and we can '*enable*' and support them to make the decisions that are most appropriate for themselves.

Offering platitudes and telling people that everything will be 'ok' and offering our *solutions* stagnates their ability to discover and learn and to deal with the reality which sits with them.

By supporting people to be 'present' with their pain, and by helping to scaffold learning through discovery, we can enable people to connect to new possibilities (away from their trauma); that then enables them to move towards what is known as 'post-traumatic growth', and from there forward movement becomes possible.

Perhaps there are some things that I can take from my learning and life experiences into HR and help the profession become more humanising?

*Authors note

I'm delighted that De decided to write a short reflection for the journal. We have shared in each other's learning 'adventures' over the past few years', despite being on different learning paths. It is our (many) conversations in between, and because of, our more formal learning where we have both gained so much together.

As I reflect on my own relationship with De and our special journey (adventure) together, I'm reminded of the words of Viktor E. Frankel who, in his book recalling his time in a Concentration Camp in World War Two *Man's Search for Meaning* (2004), proposes that: *"The salvation of man is through love and in love."* (p.30), he then turns to his love for his wife and reflects:

> "My mind still clung to the image of my wife. A thought crossed my mind: I didn't even know if she were still alive. I only knew one thing – which I have learned well by now: love goes far beyond the physical person of the beloved. It finds its deepest meaning in his spiritual being, his inner self"

> (Frankl 2011, p. 31)

Chapter 35 – Final Reflections

By Robert Sams

> "Authentic spirituality wants to open us to truth – whatever truth may be, where truth may take us. Such a spirituality does not dictate where we must go, but trusts that any path walked with integrity will take us to a place of knowledge. Such a spirituality encourages us to welcome diversity and conflict, to tolerate ambiguity and to embrace paradox"
>
> Parker J. Palmer in:
> *To Know as we are Known* (1993, p. xi)

Some thoughts and tips for your own reflection

As this journal comes to an end, the final Chapter in this section is a reflection on some of the ways that I have conducted my reflections over the past few years. While there is not one specific 'technique' that I have used, nor recommend, I have found it useful to keep a diary style journal, and doing a lot of drawing and 'doodling' as I reflect on a day, or a particular event that I may have attended.

I find the power in taking the time out at the end of a day or week critical in becoming clear in my thoughts. I will often do this after a good chat with a friend or group of friends as a way to keep the ideas alive. I have a terrible memory so for me this is key.

Learning to Write (and think) Better

One of the greatest rewards that I have gained over the past few years was learning to become a better writer. As I recall back to my Undergraduate Degree in *Occupational Health and Safety*, and review some of my essays written for that program, compared to now, I can recognise how I have improved in that time (which is not to suggest that there isn't more improving to do).

It is a great reward, and I will be forever grateful to Rob Long for his guidance support and encouragement with this.

So what is my 'formulae' for writing? This is a question I am asked often enough so I thought I would share some of the tips passed on to me by Rob.

The key, and most critical thing is to be clear on your thesis. That is, what is your clear and concise worldview on the topic about which you are to write? If you are not clear on this, I suggest; don't start until you are.

For example, the thesis of this book is that; *in order to make sense of risk, we need to commune and converse with others; it is a social activity*. The whole book is written around this one theme and whenever I felt I may have been going off track in writing the book, I turn back to the thesis and test what I am writing against it. The same applied to Max when he was editing the book.

Once you have your thesis clear, the key is to then interrogate it with questions. Ask

why it is that this is what you believe, ask how it holds together, ask for evidence to support your view.

The next key thing to consider are transitions, how you go from one topic or idea to another (while still maintaining connection to the thesis). You will see in this book that this is often done through questions, and more formally at the end of each Chapter through the Segues. This helps your reader to stay on track with what you are aiming to say and to understand your 'story'.

When deciding to write a piece, whether that be a blog or essay, I always start with the thesis, and then brain storm ideas around it. I usually come up with the title at the end if something doesn't jump out at me as I am writing.

If you are interested in learning more about how you can improve your writing, and presenting, Rob Long has made available two great videos that were shot during the post-graduate program. The links are included below and I highly recommend them to you.

1. Video 1 - https://vimeo.com/89941587
2. Video 2 - https://vimeo.com/89980690

Reflecting and sharing through art

One key theme that has been hard to escape throughout this book is that of how so many factors 'communicate with our unconscious' (Jung). We should not underestimate the power of symbols, colour and images (among many other things) and how these may impact on how we think and make decisions.

Being 'adventurous' through attempting to express our thoughts and ideas through art for example, and not just text or discussion, is one way that I find helpful. It engages another part of our 'selves' and brings different thinking and ways to examine ideas. The art work included below for example, was the outcome of one of our *Social Sensemaking*

sessions held at a conference in 2015. Instead of walking away from the gathering with pages of notes and minutes, this piece of art was our 'take-home'. The question that was asked in the session was: *"What is risk?"*. The picture to the left is the answer (according to the people in that session).

I will leave you with one final reflection from Lynne Twist from her book *The Soul of Money (2003)* which appropriately describes in one sentence the 'adventure' that has been described in this journal:

> "The journey for me has been both geographic and spiritual, emotional and ontological, private and public"

<div align="right">(Twist, 2003, p. xxi)</div>

Segue to the Final Section

We have almost reached the end of our reflection and this journal. In the next, and final Section, we 'wrap things up' by suggesting some resources and sharing a little more about the contributors to this journal, plus a full bibliography.

Reflecting on this Section Through Poetry

The Way of Love

Though I speak with the tongues of men and angels,

And have not love,

I am no better than a clanging gong or a brass bell.

And though I have the gift of prophecy, and know every hidden mystery; and
though I have faith enough to move mountains,

And have not love,

I am nothing.

And though I give away all I own to the poor, and offer my body to be burned,

And have not love, I do not gain a thing.

Love is patient, love is kind,

Love knows not jealousy,

Love is never boastful, nor proud, nor unseemly.

Love is not selfish nor easily provoked.

Love knows nothing of wrong and does not rejoice at the misfortune of others. It
only delights in the Truth.

There is nothing love cannot bear, no limit to its faith, its hope, or its endurance.

The reign of love will never end.

But where there are prophesies, they will end;

Mere there are tongues of ecstasy, they will end;

Where there is knowledge, it will end.

For our knowledge is only of a part, and our prophesies tell of but a part.

And that which is a part vanishes with the arrival of the whole.

Letter from Saint Paul to the Corinthians; 1 Corinthians 13

Section 11

WRAP UP, RESOURCES AND REFERENCES
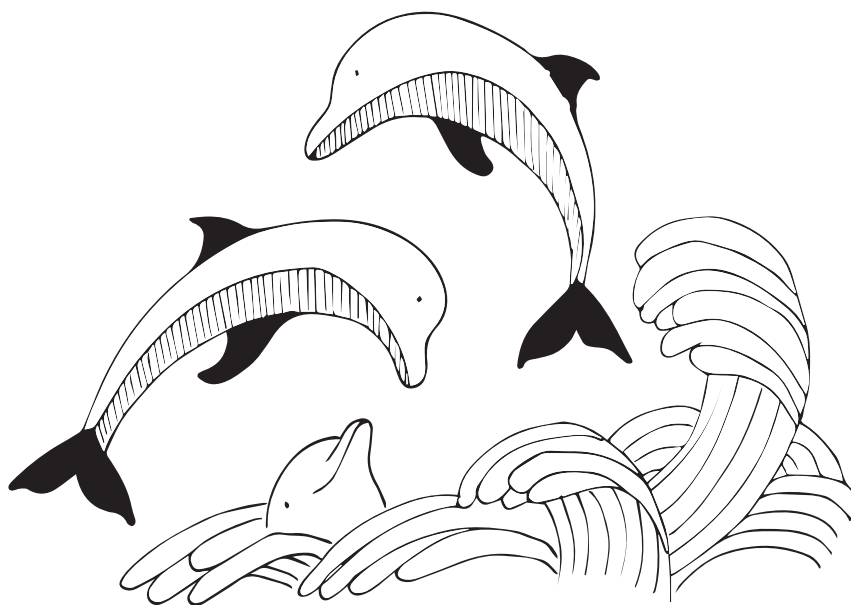
Chapter 36 – Wrap Up, Next Steps + Authors and Contributors

> "But my point is this: when a meeting between two people truly takes place, when there is just you and me and we are interacting in a very real and honest way, dropping agendas and stepping into a wide open space where the air is fresh and competitors become brothers and sisters and threats become people, this is when we come to life."
>
> Graham Long in:
> *Love Over Hate* (2013, p. 35)

Thanks for joining us

We've made it to the end (of this book anyhow) and what an 'adventure' it has been to share in these reflections with you. All of the Contributors hope, and trust that you have been able to gain something for yourself from our reflections and learning, and that you may continue to develop and share that with others in your own *Social Sensemaking*.

As we wrap up, we have included what we hope will be useful information to continue your own learning adventure.

Enjoy, and we look forward to staying in touch.

Reading List, Websites and Staying in Touch

Social Sensemaking on the Web and Facebook

To stay in touch and learn more about upcoming projects and titles you might like to follow *Social Sensemaking* on the web (www.socialsensemaking.net.au) or Facebook (https://www.facebook.com/Social-Sensemaking-1641594376087217/).

Further Recommended Reading

One of the many pleasures that I am enjoying as a key part of the adventure is being re-introduced to reading, and I mean real reading; not articles on LinkedIn, Facebook and other social media. The most special room in my house is now my library/ study, it is a place with character and with artefacts and symbols that mean something to me, and a place where I can sit back and learn away.

I (and my fellow study buddies) have also been extremely fortunate to receive great guidance from Dr. Rob Long in relation to what to read and when I might be *ready* to read it (scaffolded learning). He has this uncanny knack of knowing just what to throw up next in order to build upon and challenge my thinking and learning. In addition to Rob's recommendations, I'm proud of some of my own discoveries and of course shared ideas with my many good friends who have written in this book. Books now seem to be the order of the day when it comes time to give a gift to each other.

To assist those who are interested in further reading, I thought I would include a list of books that I have particularly enjoyed and hope that you might find a great support in your own adventure.

Foundational Reading:

- *Risk Makes Sense* – Dr Robert Long
- *Love Over Hate* – Graham Long
- *The Psychology of Judgment and Decision Making* – Scott Plous
- *To Know as we are Known* – Parker J. Palmer
- *Why We Do What We Do* – Edward Deci
- *The Good Life* – Hugh McKay
- *Humble Inquiry* – Edgar H. Schein
- *Risk Savvy* – Gerd Giggerenzer
- *Risky Conversations* – Dr Robert Long, Greg Smith & Craig Ashhurst
- *Motivation: Beyond Pleasure and Pain* – E. Tory Higgins
- *Organisational Culture and Leadership* – Edgar H. Schein
- *Essentials of Social Psychology* – Michael Hogg & Graham Vaughan
- *Managing the Unexpected* – Karl Weick & Kathleen Sutcliffe
- *Reclaiming Conversation* – Sherry Turkle
- *The Technological Society* – Jacques Ellul
- *I and Thou* – Martin Buber
- *The Psychology of Goals* – Gordon Moskowitz & Heidi Grant
- *The Social Psychology of Organising* – Karl Weick
- *Pedagogy of the Oppressed* – Paulo Frieire
- *The Undiscovered Self* – Carl Jung
- *Drift* – Sidney Dekker

Useful Websites:

- Learn more about the life and works of Carl Jung - http://www.cgjungpage.org
- Social Psychology Network - http://www.socialpsychology.org
- Society of Australasian Social Psychologists - http://www.sasp.org.au
- Human Dymensions, research, papers and videos in the *Social Psychology of Risk* - http://www.humandymensions.com
- An 'uncommon approach' to workers compensation - http://uncommonapproach.com

Blog Sites

- http://www.safetyrisk.net
- http://www.safetydifferently.com

Our Videos

You can view the range of Videos on Communicating About Risk on the *'Social Sensemaking'* Video Page – https://vimeo.com/user40295388.

Further books

This is the first in an intended series of books. Upcoming books in the series are likely to focus on our own research, further shared learning and reflections, and the possibility of a series of further practical tools aimed to assist you in your own adventure in learning.

A Special Cohort of Friends

The reflection undertaken to develop and write this journal, has been a practice of *Social Sensemaking* in itself. While the specific contributors are made more real in the following pages, there have been many other wonderful friends made along the way; too many to name here.

For all of those who have been a part of *The Social Psychology of Risk* adventure, thank you for your friendship, your sharing, your questions, support and your sense of community.

May the learning adventure continue for us all!

GRADUATION DAY – 13 MAY 2016. THE WAYSIDE CHAPEL (SYDNEY, AUSTRALIA)

In this photo (from left to right); Dave Whitefield, Max Geyer, Rob Sams, Gab Carlton, Dr. Rob Long, Rod Esdaile, Scott McArthur, Hayden Collins. Missing, but not forgotten on the day – James Ellis!

About the Authors and Contributors

Many of the Contributors to this book studied together under the guidance of Dr. Rob Long, while others have come through our networks and friends from across the world. Contributions are deeply valued.

Robert (Rob) Sams

Rob is Dad to Laura and husband to De (see below).

At work, Rob has 20+ years experience working with organisations in the fields of risk, safety, human resources and organisational culture. Rob has a particular interest in mental health, hence his long association with Lifeline Hunter Central Coast where he has been a Director since 2012.

Rob holds formal qualifications in *Occupational Health and Safety* (B.OHS), *Social Psychology and Risk* (Grad Dip.) as well as Coaching, Training and Leadership. Rob is a certified Myers Briggs Type Indicator (MBTI) trainer and facilitator.

Rob is an accomplished presenter having been invited to present at international, national and industry conferences and events. Rob is a regular blogger with his many articles published on www.safeyrisk.net.

Rob is also a member of the Society of Australasian Social Psychologists and Director of his own consultancy, Dolphyn. You can learn more about Rob by visiting the website: www.dolphyn.com.au and he can be contacted at robert@dolphyn.com.au.

Deanne (De) Sullivan

De and Rob have known each other since 2008. After working together and forming a strong friendship, on 28 September 2014, De and Rob married and now live and work in the Hunter Valley in NSW.

De is a lover of abstract art, geology and learning. In 2015 De completed a Diploma in *Positive Psychology* and at the time of writing, is completing her Diploma in *Counselling*. De also has a Diploma of *Human Resources*.

De is passionate in her support of others and community, volunteering her time as Mentor with women who have been victims of domestic violence. De has worked in various organisational development roles across many sectors including Retail and Distribution, Banking and Membership associations.

De's work is currently in HR Management in the local government sector.

Max Geyer

We are proud to call Max and his beautiful wife Sylvia dear friends. Max is a proud Dad, as well as a wonderful role model as 'Grampy' to his 5 gorgeous grandkids, who he affectionately refers to as his *'vitamins' of life'*.

At work, Max specialises in supporting leaders and teams to become 'Risk Savvy'. Max believes in taking a holistic approach to improving business effectiveness through facilitating an understanding of the nature of risk and the way people discern, make sense of, and work with risk.

Max has a Graduate Diploma in *Social Psychology of Risk* and has Post Graduate qualifications in Human Resource Management as well as many other people support focussed qualifications, along with more than 35 years' work experience in operator, supervisor and senior management roles in a variety of industries including: the Pastoral Industry, Manufacturing, Earth Moving, Mining and Transport and Management Consulting.

Max runs his own consulting business Rysk Savvy™ (asking "Y" brings meaning) and is part of Dolphyn's 'Community of Practice'.

You can learn more about Max's work at www.rysksavvy.com and he can be contacted at max@rysksavvy.com

Gabrielle (Gab) Carlton

Gab is a super proud, and fantastic Mum, to two cheeky and clever boys, Toby and Archie, and a special partner to Mish. Our friendship with Gab and her family mean a lot to us.

At work, Gab is the principal consultant and owner of Resilyence. A keen student of Social Psychology, (she has completed the Graduate Diploma in *Social Psychology of Risk*) and has under graduate qualifications in OHS and Psychology. Gab has a curious nature, constantly searching for ideas and answers to life's many challenging questions.

Gab has a wealth of experience working across industries such as Electrical Generation and Distribution, Aged Care and Disability, Property Management, Manufacturing, Construction, Rail, as well as Commonwealth and State Government.

Gab is a passionate leader in her field and has specialist skills, qualifications and experience in the Social Psychology of Resilyence and Risk.

You can learn more about Gab's work at www.resilyence.com and she can be contacted at gabrielle@resilyence.com

James Ellis

James is the proud Dad of Sam, Hayden and Jake, plus proud 'house host' to a small number of other people who James supports.

James is a family man who values community, friendship and a more 'humanised' the world. Our many liberating conversations have helped me make much sense of the 'adventure' of the past few years. James is a 'top mate'.

At work, James is the founder and MD of Framework Group. He is a physiotherapist with 20+ years experience in helping organisations to understand injury prevention and management. James and his team of health professionals have developed an innovative approach to injury prevention and management that favours people over process. Framework's challenge is to help their clients to humanise injury management within a system that typically dis-empowers employers and injured workers.

James is studying Social Psychology (having completed the Graduate Certificate in the *Social Psychology of Risk*) and is enthusiastic about sharing and eliciting ideas with his clients, team and strategic partners.

You can learn more about James at www.frameworkgroup.com.au and he can be contacted at james@frameworkgroup.com.au

Hayden Collins

Hayden is the husband of Liv and has been a close friend for a number of years now. Hayden and I regularly share deep and fascinating discussions, and he also progresses my thinking which I can't thank him enough for.

Hayden has a passion and real talent for Social Psychology and Critical Theory; in particular, understanding how culture, objects, symbols and language affect how we feel, and how we make decisions and judgments.

Hayden has worked in a range of industries including recently in manufacturing and construction. Hayden is a deep thinker and keen student of philosophy. Hayden's ability to tackle complex and challenging topics and translate them into understandable ideas, and practical undertakings is a key strength. Hayden has formal University Qualifications in Occupational Health and Safety as well as a Post-Graduate Diploma in the *Social Psychology of Risk*.

You can learn more about Hayden at http://www.riskintelligent.com.au and he can be contacted at hayden.collins@riskintelligent.com.au

Scott McArthur

Scott is the husband of Anita and great mate to his dogs, Barney and Cleo. While Scott is quietly spoken and a man of relatively few words, when he does speak he makes much sense and is such a considered bloke. His contribution in sharing his personal story in this book is greatly appreciated.

Scott McArthur has a story to tell; a story of a man from humble working class beginning who recently completed his first post-graduate studies.

At work, Scott has a special way of engaging and influencing 'the lads'. His unique ability to take the theory of The *Social Psychology of Risk* and apply it in the field with the minimal of fuss is a real talent. It's clear when you walk into Scott's workplace that the people there respect his for his 'realness' and down to earth nature. His ability to connect with people is what stands him out from the rest. Scott's qualifications include a Post-Graduate Diploma in the *Social Psychology of Risk*.

Scott can be contacted at Funkygreendog@hotmail.com

Dave Whitefield

Dave is the husband of Kathy and Dad to the very talented Emma and Luke. Dave is someone that I reckon most people would find hard not to like. He is engaging, intelligent and a bloke who cares immensely about others.

At work, Dave specialises in human focused safety, helping organisations understand and improve workplace culture, safety leadership, and employee engagement. His qualifications and experience in psychology, leadership, and safety are brought together to help clients understand and improve their approach to managing people and risk in the workplace. Dave has over 20 years' experience within the safety field, supporting a wide variety of businesses as either an internal safety manager or external partner. Dave's qualifications include a Post-Graduate Diploma in the *Social Psychology of Risk*.

You can learn more about Dave at www.peopleandrisk.com and he can be contacted at dave@peopleandrisk.com

Ron Gantt

Ron lives in Alamo, California, in the United States, with his lovely wife Catherine and his four crazy dogs. He loves whiskey (which always tastes better when drinking with friends), music and good stories (whether they be in conversations with others, books, movies or television).

At work Ron is the Vice President at SCM (www.scm-safety.com), a family business started by his father. Ron has worked there for about 15 years, conducting training and consulting with organizations regarding occupational safety and health. He looks for opportunities to change people's perspectives on safety management, from seeing workers as merely a problem to control to being the solution to harness. This involves moving beyond a compliance, blame-centered focus to enhancing workers' ability to be successful.

Ron can be contacted at rgantt@scm-safety.com

Dave Collins

Dave is the Partner of Sharyn and extremely proud Dad of Bryce who is a talented baseball player currently playing in the US and his youngest Ryan who is currently in his final year of High School.

At work, Dave has been running the Safetyrisk.net blog site since 2009, a site that has helped many businesses get up and running by publicising their latest book or software to an audience of now over 15,000 a day.

Dave is also a great mate to many. A turning point in his life, and the blog, was when his dear friend, the late George Robotham, started writing as a guest author in 2011 (see: http://www.safetyrisk.net/george-robotham-2/). George had a long career in safety and his stuff was practical, to the point, no BS and he told it the way he saw it.

Dave and George became great mates. Sadly, George passed away suddenly in 2013; that was a very sad day for Dave however he is so grateful that he was able to leave behind an incredible legacy. Dave found out after George passed that his articles had touched and helped so many more people than Dave could ever imagined; not just from their reading his articles and Ebooks but he also made personal contact with many to offer support and advice – he even mentored some over a long period.

We dedicate this book in memory of George's passion, energy and thoughts.

You can learn more about Dave at http://www.safetyrisk.net and he can be contacted at dave@riskex.com.au

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What is the Book Social Sensemaking About?

After a lifetime of working in Risk, Safety and Human Resources, the Contributors to this book take time out to reflect on these fields. They ponder why there is such a fixation on control and power; this ultimately restricts people's thinking, autonomy and hence motivation and innovation. It seems that the seduction to want to reign in and control people, is difficult to resist in many organisations.

This book, and the idea itself of *Social Sensemaking*©, was born from a search for a more humanistic approach and methodology to supporting people to deal with risk. That is because in order to make sense of risk, we need to commune and converse with others; it is a social activity.

The book is written in the form of a 'reflective journal'; it is not a text book or a report on formal research. Instead, it is a collaboration of stories and experiences in how we make sense of decisions and judgments; particularly about risk. It questions the traditional controlling and dictating methods that can be too easily adopted by the Risk, Safety and HR fields, and offers ideas that are more 'humanising'.

We invite you to join in the 'learning adventure' shared in the book.

What are People Saying About the Book?

"Social Sensemaking fills a critical gap in the risk and safety profession's in that it provides a different, more humanistic perspective on how to deal with people, our most precious resource. Rob does a great job balancing very technical, sometimes sensitive topics, but in a way that is approachable and practical. These ideas are powerful and have great potential to make positive change in any organization."

Ron Gantt

Vice President - SCM & Editor of Safety Differently

"I love the idea of a reflective journal; this fits so well with both Rob's style and the intention of the book in being one that inspires people on their own 'adventure' as Rob calls it.

I have learned that life and people can be challenging to understand; as Rob says, we are grey, messy and at times perplexing creatures, and our decisions and responses are layered and complex and nuanced. It can be hard to make sense of things. That is where this book provides some great insights.

This is a book for anyone interested in learning more about people, about why we do what we do and how we make sense of things – or even whether we need to. I feel most privileged that much of what is written in this book I have experienced firsthand. I have gone on my own journey as a result of my many discussions with Rob, and I look forward to future travels."

Shona Tarrant

Director, Performance, People and Culture – Harris Farm Markets

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