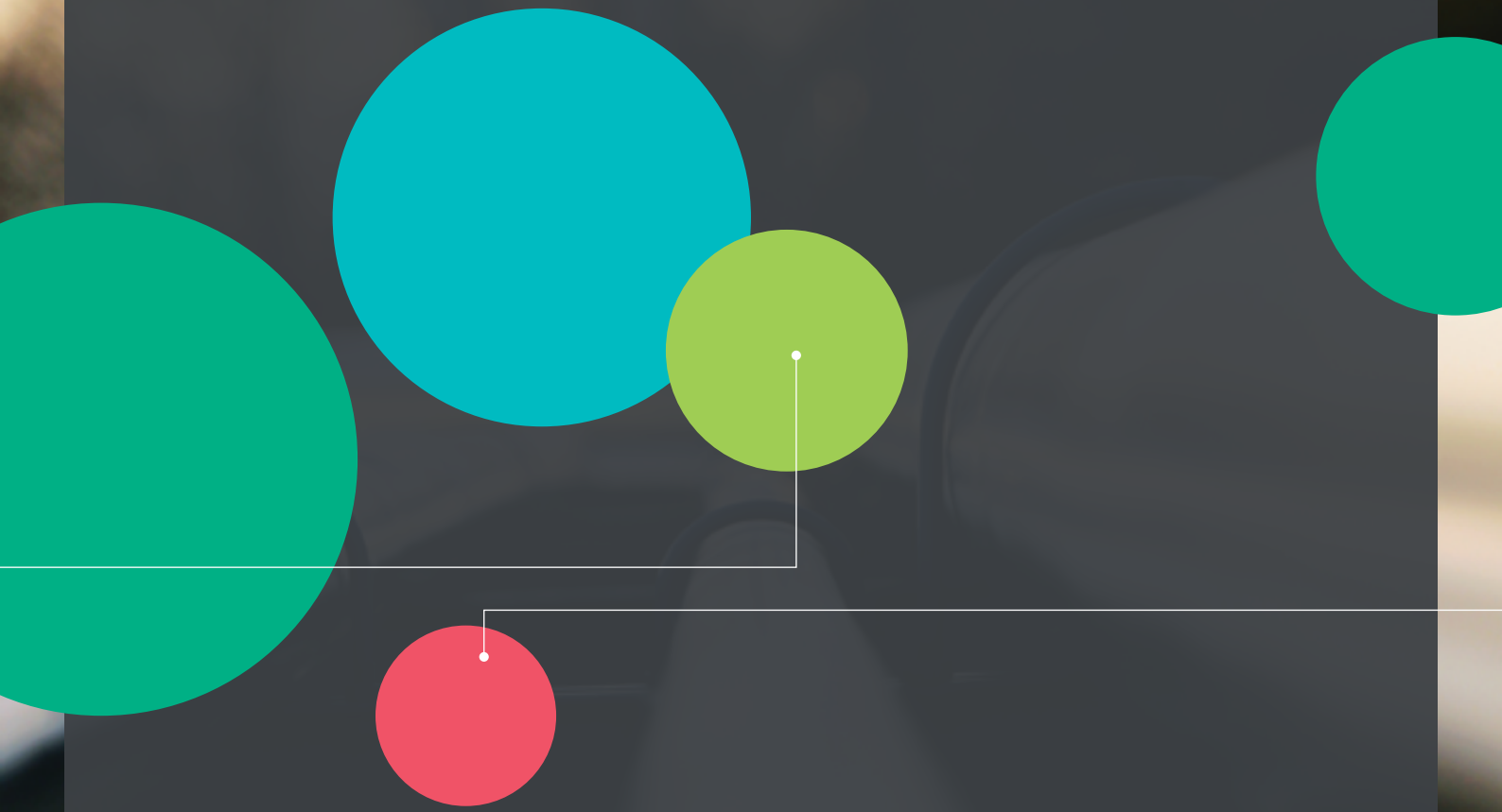
UNDERREPORTING OF SAFETY INCIDENTS IN THE WORKPLACE

Recommendations for Improved Safety Outcomes



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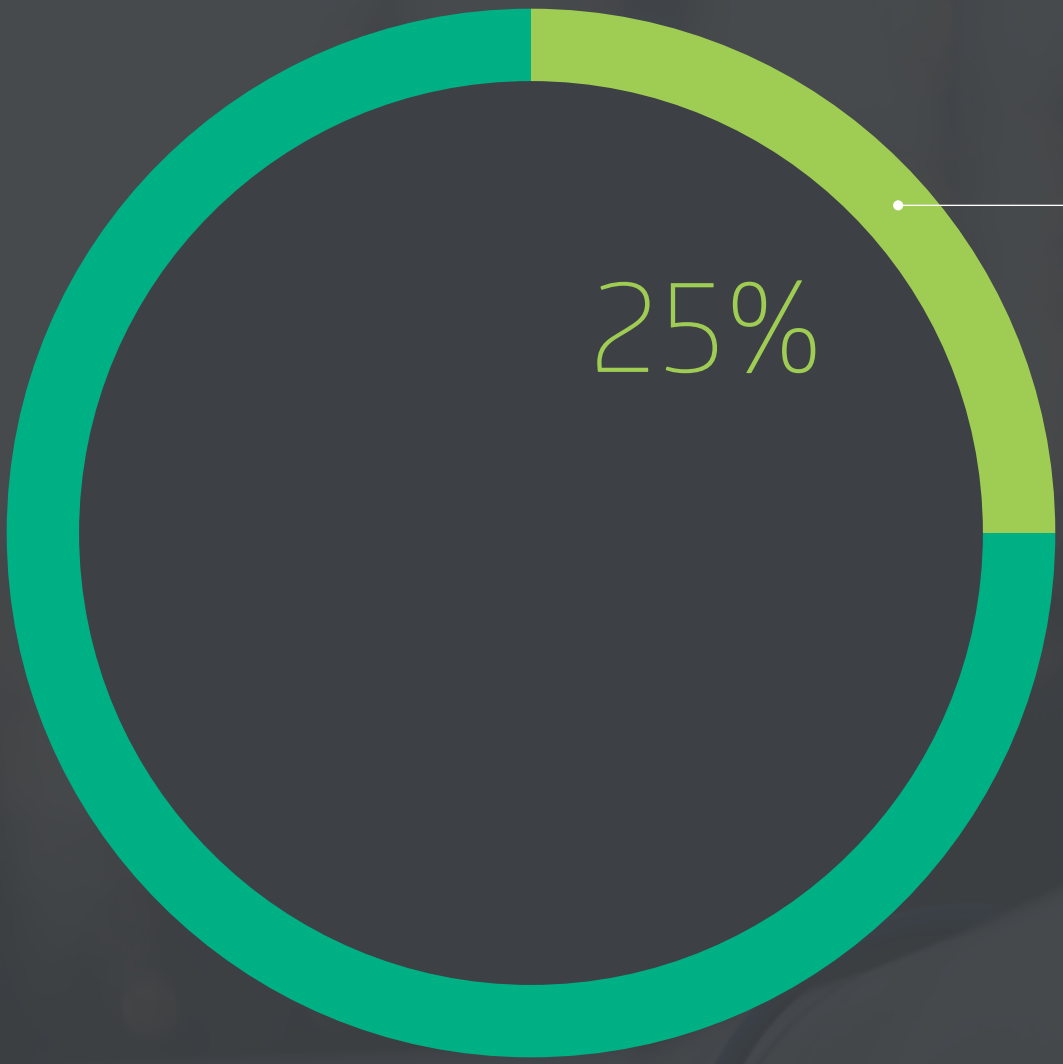


If we don't find a way to capture the 25% of incidents not reported, we will keep hurting people.

INTRODUCTION

Accurate and timely reporting of safety incidents (including near-misses) is a key characteristic of a positive safety culture. These invaluable learning opportunities allow us to adapt, make improvements and prevent future injury.

Yet, as this study will explore, 25% of incidents go unreported. Concerningly, Australian figures show this rate to sit even higher at a staggering 31%. That's nearly 1 in 3 incidents that fail to be reported. In some organisations this figure rises as high as 1 in 2. But it's not just frontline workers who fail to report; leaders and managers also underreport at alarming rates. In fact, of those leaders who experience an incident, 1 in 4 fail to report an average of 8 incidents per year.

Many leaders acknowledge a problem with underreporting in their business, but few know the extent of the issue or reasons behind it. Unsurprisingly, even fewer leaders acknowledge they are part of the problem. But it's not enough to put underreporting in the 'too hard' basket, shift responsibility or plead ignorance. Failing to address the issue has very real and very serious consequences for leaders and for safety.

Best case scenario, the incident reoccurs and it's another near-miss; no one is hurt and this time maybe someone considers reporting it. Worst case scenario, the last line of defence is breached and a serious injury or fatality occurs. It may seem dramatic, but in many industries failing to report or address an incident to prevent it from reoccurring can mean the difference between life or death.

As leaders, it is our responsibility to ensure our team members return home safe to the people, places and things they care about most, each and every day. But if our people don't tell us when something goes wrong (or has the potential to), how can we be expected to be aware of the problem, let alone address it?

If we don't understand the types of incidents that occur in our business, we can't put measures in place to avoid them. We can't pinpoint where the last line of defence might fail. We can't know what's working and what's not, or where to invest resources to improve safety and efficiency. Importantly, we can't learn or improve.

If we have an issue with underreporting in our organisation—and the data suggests we do—we are more likely to be operating within a negative safety culture, characterised by:

- increased critical incidents, injury rates and severity,
- higher risk of fatalities,
- damage to plant and machinery,
- increased insurance premiums, and
- unhelpful safety attitudes and behaviours.

Acknowledging that an issue exists and committing to address it is the first step towards positive change. The following report shares key findings from a study of more than 12,460 participants across agriculture, construction, education, government, industrial services, manufacturing, mining, oil and gas, and utilities. It explores the three main drivers of underreporting, as well as practical strategies for encouraging a positive culture of reporting in your business.

AGRICULTURE

CONSTRUCTION

EDUCATION

GOVERNMENT

INDUSTRIAL SERVICES

MANUFACTURING

MINING

OIL AND GAS

UTILITIES

THE COST OF INACTION

According to Safe Work Australia figures on the cost of work-related injury and illness, Australian employers are responsible for 19% of total incident costs or $11.5 billion annually.[1] This includes costs associated with loss of productivity from absent workers, recruitment and retraining, fines and penalties from breaches of health and safety regulations, and workers' compensation premiums.

Figures also show that 88% of reportable incidents are defined as 'minor' (short and long absences where employees return to work on full duties).[1] When we consider that employers bear majority of the cost for minor incidents when compared to incapacities and fatalities, this is a major area of concern for organisations.

Consider the following example from Workplace Health and Safety Queensland:[2]

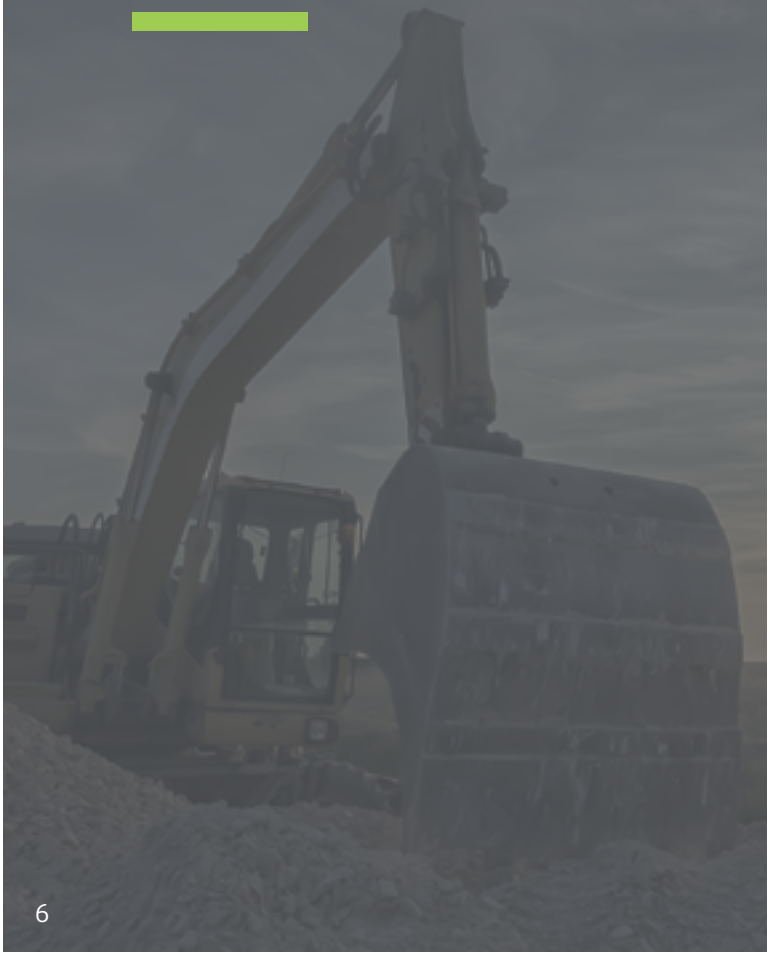
> *"At the time of the injury the worker was carrying out jackhammer works using a 70lb hammer. While hammering the wall, the point of the hammer slipped off the wall and dropped down. The worker attempted to stop the hammer falling and felt pain in his lower back. The sum of $8,090 was the cost to the organisation for one worker who sustained a minor back injury—a cost that is not covered by WorkCover."*

While on the surface, $8090 may not seem like a huge expense, consider the cost to the business beyond the injury itself. In this particular scenario, it took the business nearly two days to recover. Operating at a 15% profit margin, this represents $53,933 in revenue that the business needs to earn to recover the total incident cost—and this was just a minor injury. Imagine what the impact could have been if the incident had been more serious.

It's important to note that the $11.5 billion quoted by Safe Work Australia only captures reportable incidents and does not represent totals costs when we consider other flow on effects. Unaccounted for flow on effects include lost productivity due to disruption and delay, reputation damage and reduced employee morale.

Consider the less obvious ways in which incidents or near-miss events might impact your bottom line:

- lost productivity as workers scramble to cover up an event;
- a drop in quality while focus is taken from production;
- inefficiencies created as multiple people experience the same near-miss and choose not to report it, dooming the organisation to see the same incident repeated.



The following scenario demonstrates the potential cost of a single incident that could have been avoided if a previous one had been reported:

A team using a piece of machinery at a processing plant noticed some minor equipment damage. The machine was still operational and, under pressure to meet production deadlines, the workers took a 'she'll be right' approach and continued work. The incident was not reported. The next day, there was a major failure that left the machine inoperable. Replacing this piece of machinery required a complete site shut down that lasted nearly 24 hours.

In this scenario no one was injured, but had the original damage been reported, the equipment could have been repaired instead of replaced. Not only is the business up for the cost of the machinery itself, but potentially millions of dollars in lost productivity and revenue. Consider the additional ramifications the business could have faced if someone had been in the line of fire.

Contrast this with a client who recently shared a positive reporting story:

A dump truck operator had noticed an unusual noise in the tyre of his truck and reported the problem. Upon assessing the truck, maintenance uncovered a bigger issue. Not only was the tyre lacking tread, there was also a significant crack in the wheel rim. Had this gone unattended, the truck would have inevitably failed. The implications could have been catastrophic and led to a serious injury or fatality. By reporting the incident, the worker helped to avoid something more serious from occurring.

What if the things we've seemingly deemed as 'unimportant' are actually precursors that could help us prevent a serious catastrophe?

When we ask clients about reporting, it's not uncommon to hear things like "but all the big stuff is captured" or "we hear about the important things, the rest are just papercuts and take more time to investigate than they're worth". We challenge them (and you) to consider the following: what if reporting the 'little' things prevented the 'big' stuff from happening in the first place? What if the things we've seemingly deemed as 'unimportant' are actually precursors that could help us prevent a serious catastrophe?

In 2012-13, 2610 people died from an Australian workplace injury or disease, an additional 1000 were fully incapacitated and 60,200 partially incapacitated.[1] That's 63,810 people and their families, friends, colleagues and communities who were changed forever because of a work-related incident—a truly devastating personal and social impact for those involved. If encouraging a culture where people report each and every incident could prevent even just one of these cases, wouldn't you?

All incidents and near-miss events are worth knowing about. It is only through learning about what is going on in our business, even the 'little' things, that we can truly improve our safety, quality and productivity. If we don't capture the 25% of incidents that fail to be reported, we will continue to experience unnecessary costs to our business. More importantly, we will continue to hurt people.

Addressing underreporting not only helps us to avoid devastating personal and financial loss, but also allows us to learn and improve as a business. Every incident and near-miss provides a valuable piece of data. Every incident, regardless how minor, is a learning opportunity and potential precursor to a more significant event. There is no doubt that the higher your organisation's underreporting rate, the higher your risk of incidents. A positive safety culture—where each and every incident is reported and learned from—provides opportunities for improved engagement, productivity, quality and efficiency, not only in safety, but across your whole business.

STUDY OVERVIEW

The extent of an organisation's underreporting is often unknown or underestimated. By its very definition it seems almost impossible to measure, at least on the surface. Through our work with clients, we collect substantial data on a range of safety culture dimensions, including willingness to report incidents and errors.

By exploring this data, we can gain insights into the state of underreporting and its drivers to better understand:

- who underreports,
- why they underreport, and
- in what circumstances they underreport the most.

The insights gained allow us to identify the areas we need to target to create meaningful change; only then can we better equip leaders to tackle an issue that otherwise evades detection. In doing so, we can help leaders to mitigate the risks associated with underreporting to drive a more positive safety culture.

The following study uses a combination of quantitative and qualitative data to uncover patterns in underreporting. Specifically, respondents were asked to indicate the number of incidents they had experienced in the past 12 months and the number of incidents they had reported. This allowed us to calculate the number of incidents not reported, which is represented by the underreporting rates throughout this study.

To further clarify, when considering the remainder of this report, underreporting rates represent *only those individuals who experience an incident* and not the entire employee population or sample. For example, when we say that "1 in 4 leaders underreport an average of 8 incidents per year", we are referring to those leaders who have experienced an incident. We cannot ascertain underreporting rates for those individuals who have not experienced an incident and therefore have not been faced with the decision to report or not.

To ensure a consistent understanding of what constitutes an incident, the following definition was provided to all participants:

> *'Safety incidents' refers to any near-miss, minor/major injury or property damage event you personally experienced at work.*

This data was supplemented with our qualitative sample to provide additional context and a more comprehensive picture of underreporting trends.

RESEARCH METHODS

In addition to providing training, coaching and consultation, Sentis offers a suite of comprehensive safety culture diagnostics. This study draws on data collected from real clients who have completed one or both of the following Sentis assessments:

Safety Climate Survey (SCS) – A quantitative diagnostic survey that identifies organisational strengths and opportunities across environment, practices, person and leadership. It enables the measurement of leading indicators of safety performance and develops specific actions to improve safety. It is also used to track the impact of safety interventions over time and provide a benchmark against industry.

Onsite Safety Evaluation (OSE) – A qualitative assessment of an organisation's safety culture maturity. Using focus groups, interviews and observation, the OSE measures the workforce's safety attitudes, beliefs and behaviours, providing a third-party perspective. The OSE also allows a benchmark against the Sentis Safety Culture Maturity Model.

More information about the SCS/OSE diagnostic process and how it fits into a complete safety culture intervention is available at sentis.com.au/sentis-way

RESEARCH SAMPLE

QUANTITATIVE

12,460 participants

63 sites across
16 companies

QUALITATIVE

1800+ participants

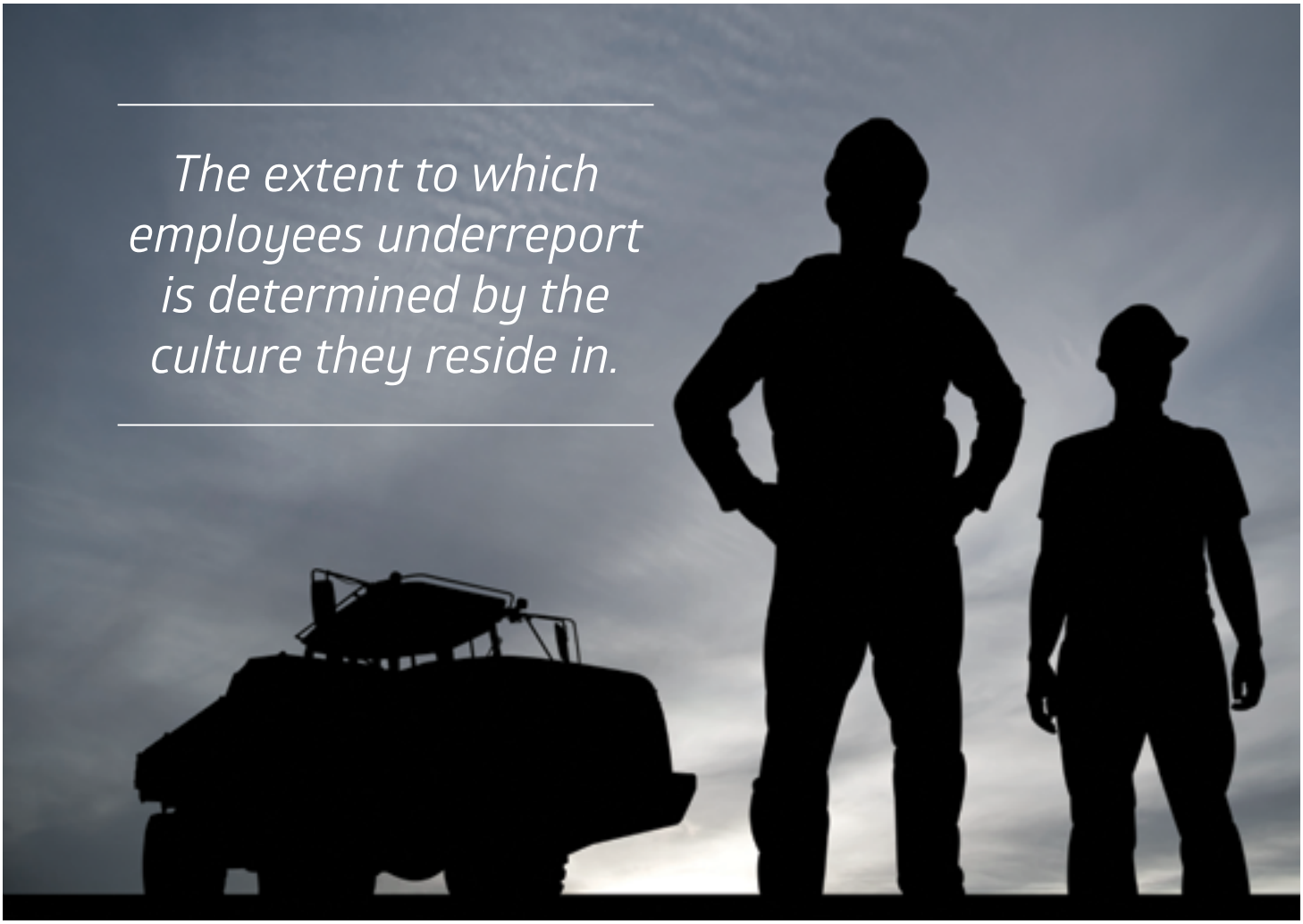
29 sites across
15 companies

8 COUNTRIES

Australia, Botswana, Namibia, New Zealand, United States of America, United Kingdom, Germany, Canada

9 INDUSTRIES

Agriculture, Construction, Education, Government, Industrial Services, Manufacturing, Mining, Oil and Gas, and Utilities



UNDERSTANDING THE IMPACT OF CULTURE

Before we delve into the full results of the study, it's important to consider cultural context. It makes sense that safety culture influences attitudes and behaviours towards reporting, but how do we know who is most at risk?

Think of safety culture as 'the way things are done around here in relation to safety'. Specifically, employees' attitudes, values and beliefs when it comes to safety in the workplace, including the implicit safety rules or guidelines present at the frontline. Safety culture has four overarching dimensions: environment, practices, person and leadership (see Figure 1). Organisations need to invest in all four dimensions to effectively manage risk and create a positive and strong safety culture.

The Sentis Safety Culture Maturity Model describes the journey organisations take as they progress towards safety excellence (see Figure 2). On this journey, organisations possess different types or 'profiles' of safety culture. Each of these profiles differ in their level of maturity or effectiveness and more mature safety cultures are more conducive to good safety performance.

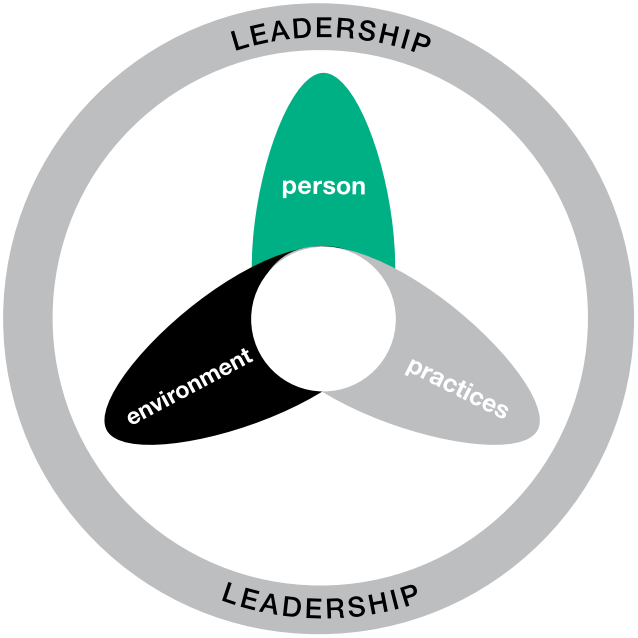
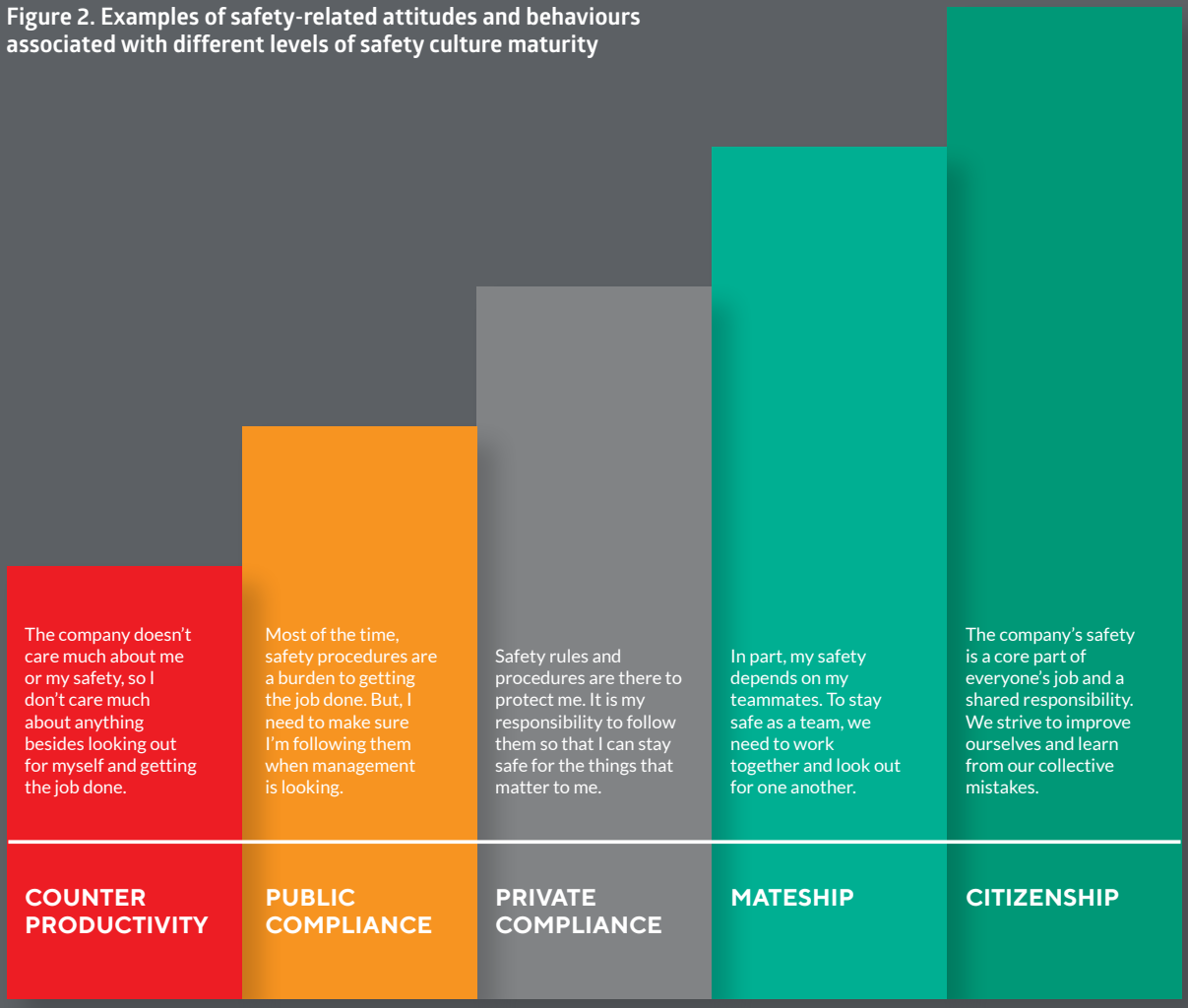


Figure 1. Sentis Safety Culture Model

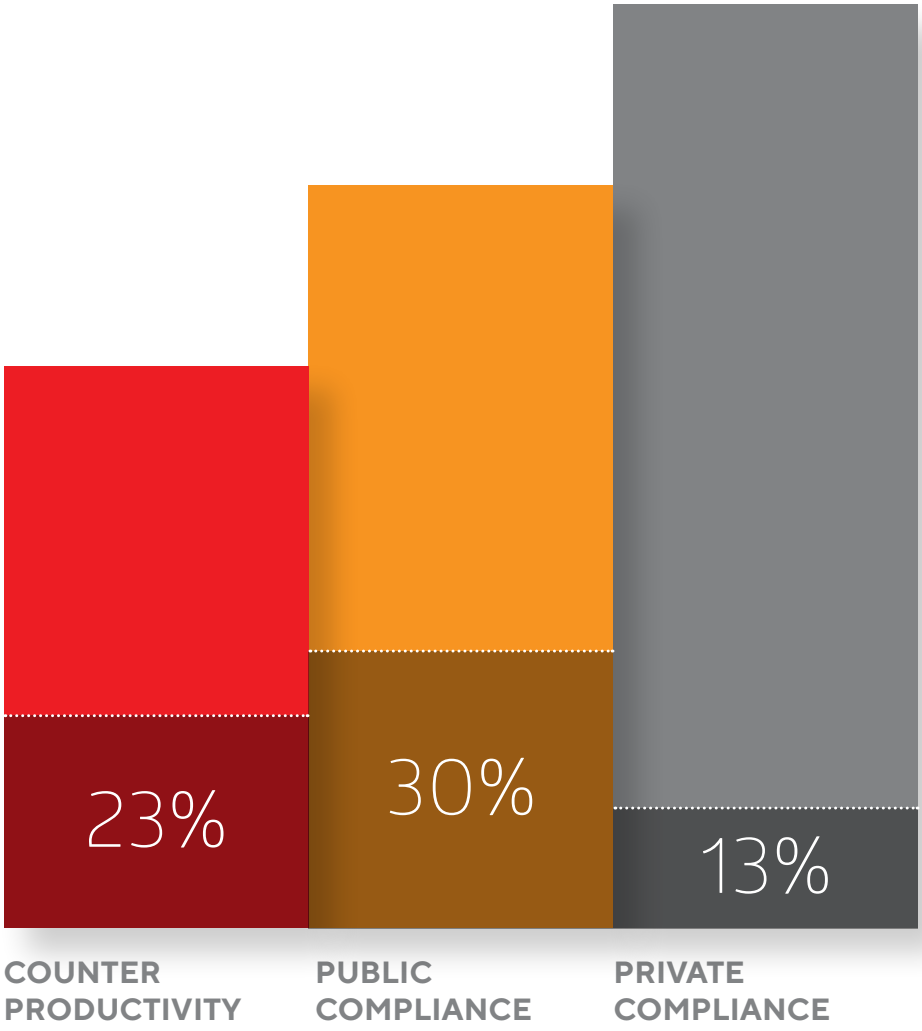
Figure 2. Examples of safety-related attitudes and behaviours associated with different levels of safety culture maturity



The extent to which employees underreport is determined by the culture they reside in. In our work with clients, we have the opportunity to better understand safety culture through employee interviews and focus groups. This allows us to benchmark safety culture against the Sentis Safety Culture Maturity Model both across and between sites. This data also allows us to determine the levels of maturity where underreporting is most prevalent.

Unsurprisingly, the results of our study indicate that the highest rates of underreporting exist within negative safety cultures. Specifically, *Counterproductive* and *Public Compliance* cultures see 23% and 30% of incidents unreported respectively. Furthermore, a notable decrease is seen when an individual is embedded within a more positive *Private Compliance* culture (see Figure 3).

Figure 3. Underreporting rates by cultural maturity



Concerningly, if you couple these findings with the fact that 76% of organisational sites sit below the *Private Compliance* level of maturity,[3] there is a strong likelihood that underreporting in your organisation is more prevalent than you think.

On the surface, it may seem surprising that *Public Compliance* has the highest underreporting rate. One would expect that as culture matures, underreporting becomes less prevalent. And while this is generally true, *Counterproductivity* is the exception. In this type of culture, engagement is low and people only look out for themselves. Employees have the perception that the company doesn't care, so only do the bare minimum to get by. They are unlikely to even realise they need to report, let alone admit when they don't—even to a confidential third-party. As a result, it is likely that the 23% underreporting rate for this level of maturity is conservative.

In contrast, the *Private Compliance* level of maturity is the key tipping point for unlocking a culture of *Citizenship* and discretionary effort in safety. As maturity progresses, employees become more focused on learning and continual improvement for the benefit of not only themselves, but also their team and wider organisation. Organisations who sit below this level of maturity simply fail to realise the benefits of a positive safety culture. Shifting attitudes towards underreporting and safety more generally is crucial for organisations seeking to improve safety performance. The first place to start is by assessing the current state of your culture. For leaders this includes taking a long, hard look in the mirror.

UNPACKING THE DATA

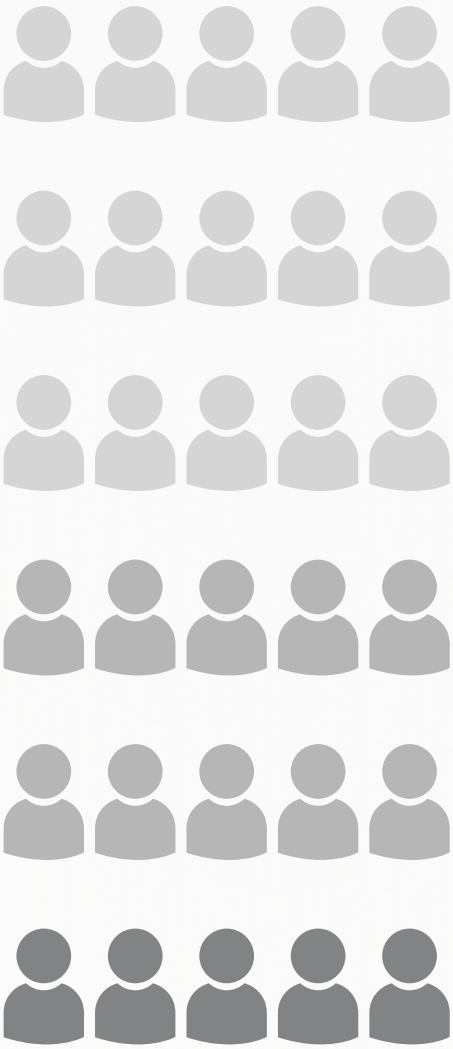
INDUSTRY-WIDE UNDERREPORTING RATE

Overall, results show that 25% of incidents go unreported, with this rate increasing to 31% when separating the Australian data. Specifically, we found that approximately half of the workers surveyed experienced an incident in the prior 12 months. Of these, 30% failed to report at least one incident. In fact, this group of workers failed to report on average 6.3 incidents over a 12-month period.

25%
globally

31%
Australia

WHAT DOES THIS LOOK LIKE IN A PRACTICE?



Consider an organisation with

3000 employees.

1500 (50%) employees

experience at least one incident over a 12-month period.

Of these,

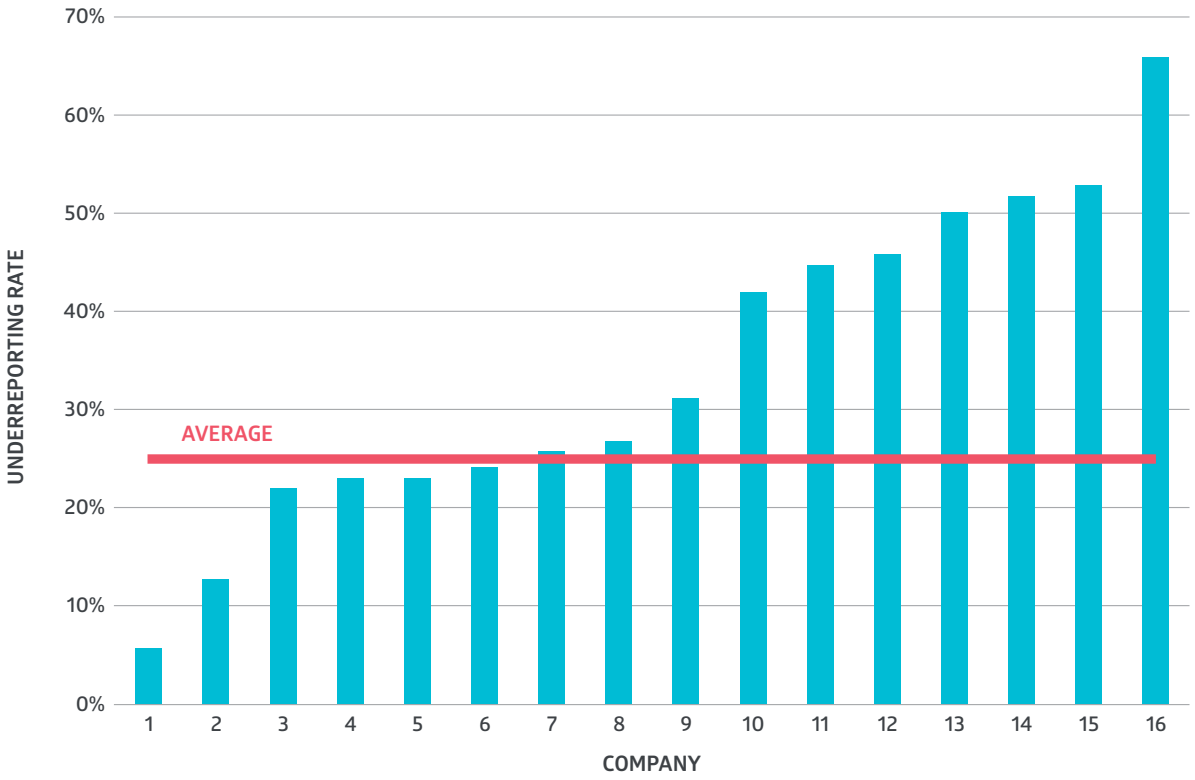
450 (30%) employees

fail to report 6.3 incidents each.

That's a staggering **2835 incidents unreported each year**. It's also 2835 missed opportunities to learn and improve to mitigate physical, social and financial risk and avoid future incidents and injury.

It's also worth noting that the 25% underreporting rate is likely to be a conservative one. In fact, 2 in 5 companies included in our quantitative sample had an underreporting rate of more than 40%, with the highest being 66% (see Figure 4).

Figure 4. Underreporting rates by company



To further understand underreporting across industry, we split the results across position, age and tenure. This allowed us to uncover potential trends and areas of opportunity for organisations seeking to address this pressing issue.

A NOTE ABOUT MEASUREMENT

From a measurement perspective, our research only captures a sample of employees from each organisation. While this is standard practice and we ensure appropriate responses rates to capture the majority, the results do not account for those who choose not to engage in the survey. This is important to understanding why the underreporting rates noted in this study are likely to be conservative. There is a chance non-participation is a sign that these individuals are less engaged in safety overall and may therefore underreport at higher rates. It is also worth noting that our data is based on self-reported recollections of the past 12 months. There is a chance that respondents less accurately recall each and every near-miss they fail to report when compared to injuries which are generally more memorable.

In addition, our research shows a general lack of understanding around what constitutes a near-miss—a key learning opportunity for organisations that is explored later in this report. As a result, people are unlikely to know they have failed to report a near-miss if they are unclear on how to recognise one in the first place. Essentially, people are likely to underreport their underreporting due to inaccurate memory recall and/or a lack of education around incident and near-miss classification.

UNDERREPORTING RATES BY POSITION

In our experience, when senior leaders discover their underreporting rate, it is common to hear statements like:

“Why is this still a problem?”

“I thought we addressed this.”

“But we’ve seen an improvement lately.”

“Why won’t they [frontline workers] just report?”

Rarely do we hear senior leaders refer to underreporting as an issue that occurs throughout all levels of the business—but the data suggests otherwise.

When split by position, the data shows an interesting trend. Underreporting of incidents and errors is not limited to frontline workers. It is an issue that permeates the entire organisation, with those in frontline leadership and management also underreporting at alarming rates. Although frontline workers do underreport the most at a rate of 32%, frontline leaders and management are not immune with 15% and 21% of incidents unreported respectively (see Figure 5).

Figure 5. Underreporting rate by position (incidents)

This is a concerning result, especially given that a key part of being an effective safety leader is to role model positive safety behaviours. By failing to report safety incidents and errors themselves, leaders inadvertently give permission for their teams to do the same.

It is important to note that this isn't just a case of a few bad leaders. If we look at the number of people rather than the number of incidents, we see that 24% of frontline leaders and managers actively choose not to report one or more incidents. Most concerningly, those at management level fail to report an average of 11 incidents per year—nearly double that of their frontline counterparts. (see Table 1).

Table 1. Detailed underreporting statistics according to position

	Sample size	People who experience an incident	People who underreport	Total incidents not reported	Average incidents not reported per person
Frontline worker	6378	3321 (52%)	1102 (33%)	6653 (32%)	6
Frontline leader	2247	1459 (65%)	354 (24%)	2127 (15%)	6
Management	1255	716 (57%)	174 (24%)	1977 (21%)	11

By failing to report safety incidents and errors themselves, leaders inadvertently give permission for their teams to do the same.

Figure 6. Underreporting behaviour by position (people)

If we consider leaders as a combined group, nearly 1 in 4 fail to report an average of 8 incidents per year. To put this into context, consider an organisation with 200 leaders across frontline and senior management. If 100 experience an incident, 24 fail to report 8 incidents each. This equates to 192 incidents unreported at a leadership level. Some leaders may try to explain away this number, but what would that prove? If we think that any number above zero is acceptable, we need to seriously consider the safety attitudes we portray to our workers. If we think it's okay for leaders not to report, what does this say about the value we *really* place on safety in our organisation?

CONSIDERATION FOR LEADERS: ROLE MODELLING SAFETY

As leaders, our teams look to us for direction and as an example of what 'good' looks like. We have a responsibility to role model exemplary safety behaviours at all times. Role modelling is a key component of safety leadership. It relates to a leader's capacity to role model safety-compliant behaviours that set the benchmark for what is expected from workers.

Consider the leader who always wears his PPE, runs safety meetings and supports his team when they raise safety concerns. It's getting close to knock off and everyone is ready for a break. A near-miss occurs—nobody is injured, but property damage could have occurred. The leader observes the incident while out in the field and raises it with his team. They tell him that it was "just an accident" because they'd been rushing and the chances of it happening again are low. The leader looks at his watch and contemplates his next move, knowing that completing the event notification paperwork will mean the team won't leave on time.

He could choose to tell the team, "Don't worry about it, start packing up and get ready for knock off." But what example would this set? In a single moment, the leader would undermine the positive safety role modelling he has previously laid down. Instead, the leader decides to stop work and report the near-miss. He wants to ensure that he not only leads by example, but also provides his team with a valuable learning opportunity that would otherwise be missed.

While demonstrating effective reporting is important, effective role modelling encompasses much more than just this. Leaders must drive a positive safety culture in all aspects of safety. Strong safety role models:

- demonstrate both safety compliance behaviours and safety citizenship behaviours
- ask subordinates and peers to keep them accountable to safety standards
- attend and actively participate in non-mandatory safety meetings
- proactively identify opportunities to influence the safety behaviour of others.

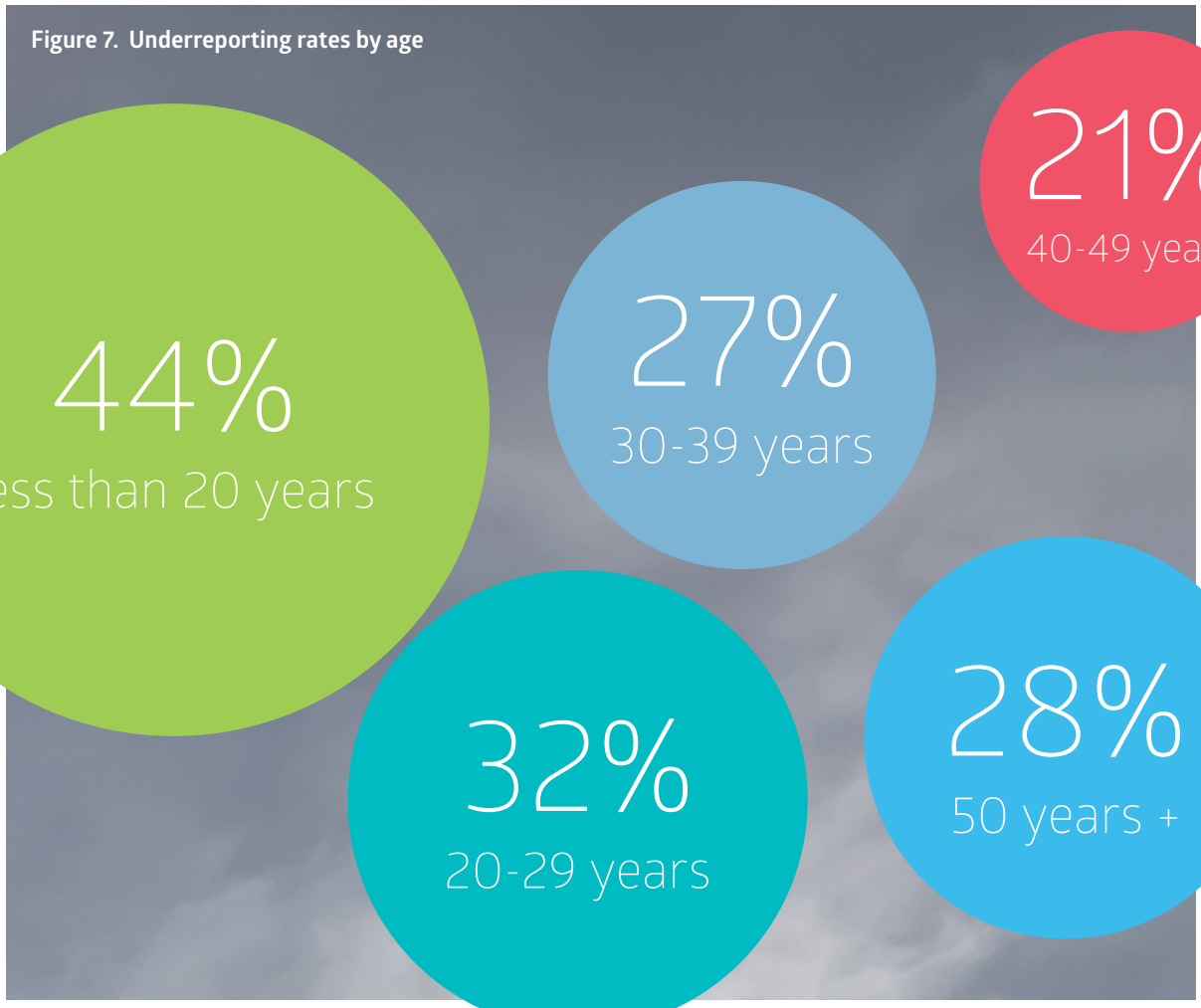
It is crucial that leaders are strong safety role models, but it is also important to consider the impact of informal leaders and peers within a team. Workers look to their peers as much as their leader for guidance and approval, particularly those with more experience. Encouraging all workers to role model effective safety behaviours, including reporting, is important to establishing a positive safety culture.

Given that only 1 in 4 leaders demonstrate strong safety leadership behaviours,[4] this represents a significant area of opportunity for organisations. A safety leadership training program, with a focus on soft-skill development and supported by a 360° assessment and coaching sessions, is recommended for organisations seeking to improve their safety leaders' ability and performance.

UNDERREPORTING RATES BY AGE AND TENURE

Does age impact likelihood to report incidents? Specifically, do younger or older workers tend to underreport more? Perhaps it's older workers who haven't always needed to report and are 'stuck in their ways'. Alternatively, maybe it's younger workers who don't understand the value of reporting, believe they are invincible, or don't want to 'rock the boat' when starting a new job.

While we can't know for sure the circumstances of each worker, we do know that overall, younger workers underreport at a greater rate. Specifically, those aged less than 20 years old (see Figure 7).



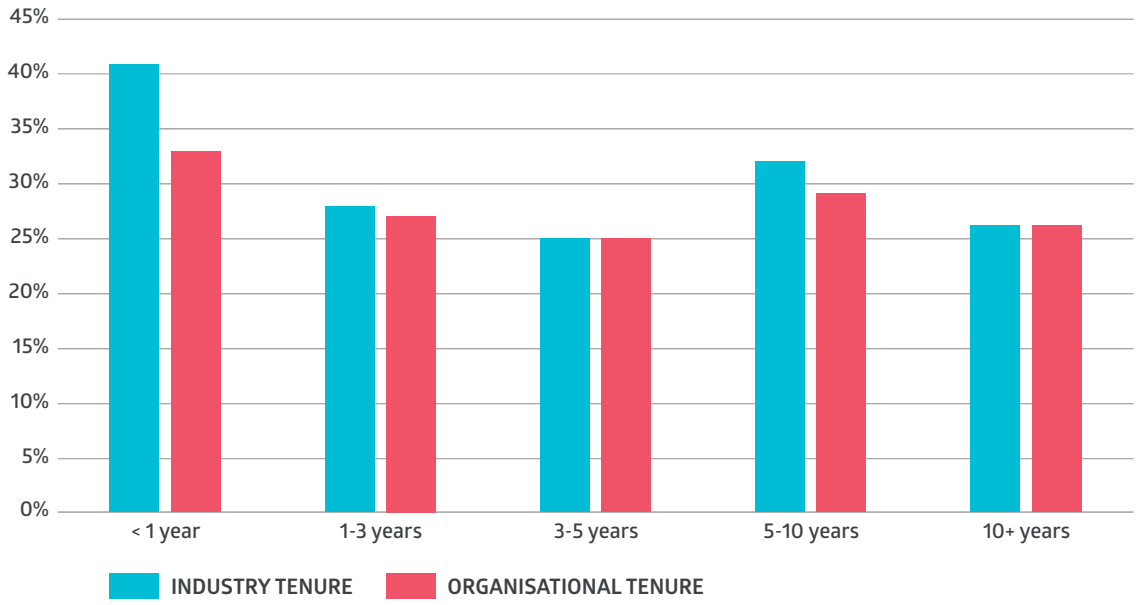
Unsurprisingly, we see similar results with tenure, with those newest to the industry and organisation underreporting at slightly higher rates. In terms of industry, this is likely a reflection of age, with those newest also likely to be younger (see Figures 8).

This highlights a key area of opportunity for organisations with regards to onboarding and role modelling. When entering the workforce or a new company, it is vital that workers are equipped with the knowledge of what, when, how and why to report, as well as the support and motivation to do so. This, coupled with positive role modelling of incident reporting by older and more experienced coworkers is crucial to improving incident reporting in this age group.

Organisations can also consider initiatives like mentoring programs that pair new starters with experienced workers who are also good safety role models. There is also opportunity to include reporting data and the sharing of learning outcomes from incidents and near-misses during safety meetings. Ensuring this from all levels of leadership will help to influence team members to consider the importance of reporting. These types of learning culture initiatives not only help to set the scene for new starters, but also re-establish expectations around reporting for all employees.

When entering the workforce or a new company, it is vital that workers are equipped with the knowledge of what, when, how and why to report, as well as the support and motivation to do so.

Figure 8. Underreporting rate according to industry and organisational tenure



CONSIDERATION FOR LEADERS: ONBOARDING AND INDUCTION

Consider how new starters are inducted into not only your company, but also your culture. When they look to see how things are done around the organisation, what do they notice? What does this look like when it comes to incident reporting? Do they see a 'she'll be right' or 'don't rock the boat' attitude? Or do they see a culture of continuous improvement that places value on reporting, without fear of negative repercussions?

Don't just consider what employees are told to do in training and inductions. Think about what *really happens* on the frontline and whether this matches up—i.e. do leaders and workers simply talk the talk, or do they walk it too? Think about how you can lead by example when it comes to not only incident reporting, but also safety more generally.

THE 3 KEY DRIVERS OF UNDERREPORTING

Why is it that people choose not to report incidents and errors? Understanding the core attitudes that drive a culture of underreporting is the first step to addressing the issue head-on in our own organisation.

Our qualitative sample allows us to explore the reasons that impact employees' willingness to report incidents and errors. In our work with clients, we use this data to provide organisation-specific insights into the challenges employees face when they decide whether or not to report an incident. Interestingly, while there are some organisation-specific nuances, we find that the core challenges employees experience overlap significantly across organisations.

Combining our two data sets allows us to pinpoint the overarching reasons why people choose to underreport.

These fall into three categories:

1

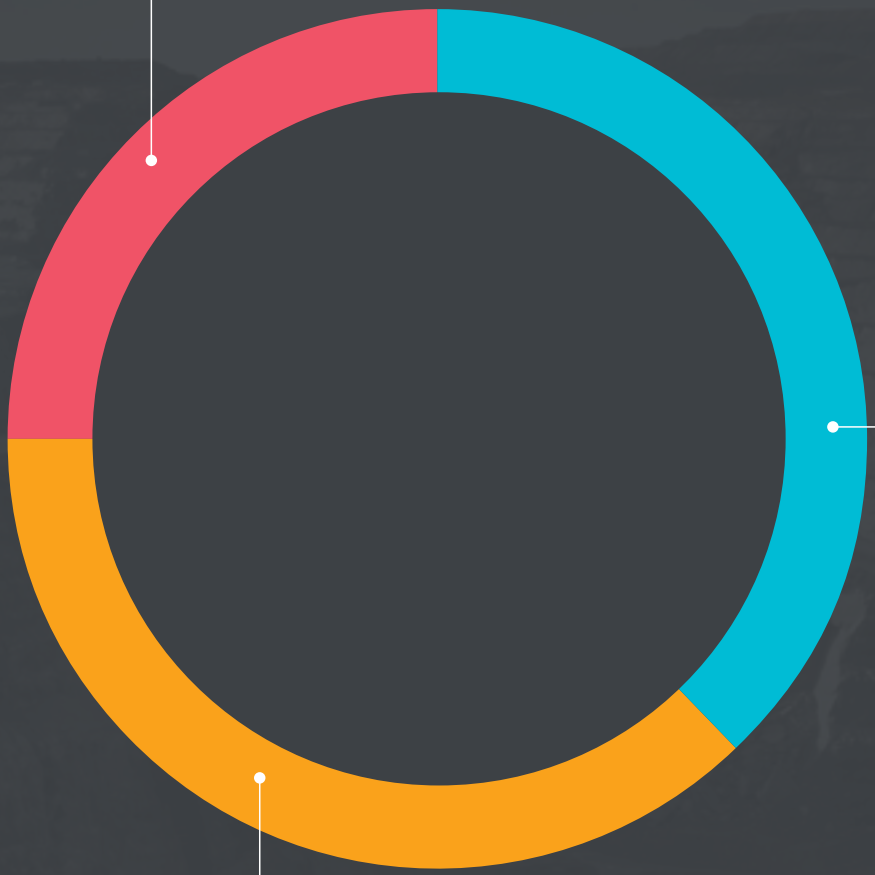
A general **underappreciation** of the benefits of reporting

2

Fear of negative repercussions

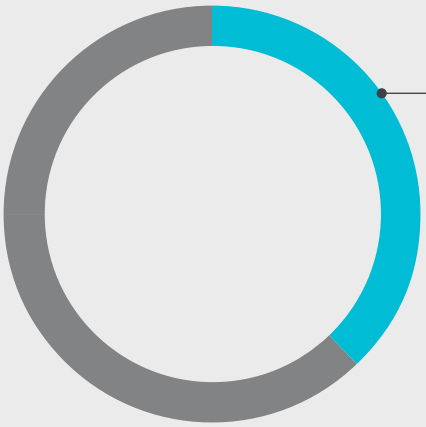
3

Issues with the **process** required to report incidents.


25%
process
38%
under
appreciation
37%
fear

DRIVER 1:
UNDERAPPRECIATION OF THE BENEFITS OF REPORTING

1



38% of workers underreport because they have a general underappreciation of the benefits of reporting.

Two common reasons for underreporting include "I took care of the problem myself" and "I didn't think it was that important". Both point to an underappreciation of the need to report a safety incident, no matter how big or small.

Interestingly, taking care of the problem oneself was consistently the top-rated reason across all demographics (position, age and tenure). On the surface, this might signal initiative and good intent. But in some cases, this may point to a deliberate effort to 'cover up' incidents in the workplace. Either way, it highlights a lack of understanding of the benefits and value of reporting. As leaders, we miss the opportunity for potential learning and improvement. Importantly, we miss the opportunity to create a safer workplace and reduce the likelihood of damage, injury or worse. If we have hundreds or even thousands of people 'taking care of problems' themselves without reporting them, our organisation has no opportunity to resolve potential systemic issues. This leads to inefficiencies and a false sense of security around the state of safety in our organisation.

If we consider that the majority of underreporting happens in cultures with a lower level of maturity, specifically *Counterproductive* and *Public Compliance* cultures, it isn't that surprising that "I did not think it was that important" also rates highly. These types of culture tend to be characterised by attitudes of indifference and behaviours of non-compliance, particularly when it comes to safety systems and processes. In fact, our findings show that an underappreciation of the value of reporting was the most prevalent reason for participants who are embedded in a *Counterproductive* safety culture.

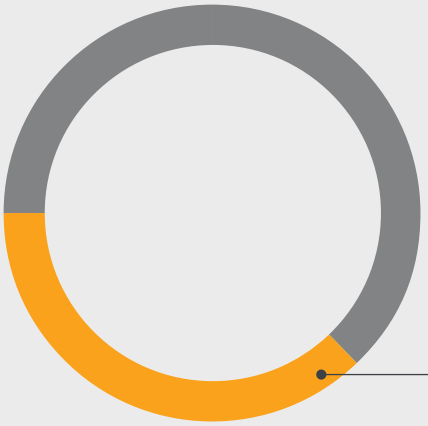
There is opportunity for organisations to provide greater clarity and education around the benefits of reporting. This might include integrating discussions about reporting and associated learning outcomes into business-as-usual activities such as prestart meetings, toolbox talks, formal safety meetings and executive communications. While it is important to verbally state the importance of reporting, a stronger case is presented if learning is disseminated in a way that employees see the benefits in action (i.e. through organisational improvement efforts and improved incident rates).

Furthermore, organisations must address a larger issue in leadership. If frontline leaders and management also believe that taking care of an incident themselves and dismissing its importance is an appropriate way to behave, what does this say about our organisation and our approach to safety? Again, leaders must actively support and role model incident reporting behaviours. If they don't, how can they expect employees to follow suit?

"In a culture where people 'take care of the problem' themselves without reporting it, organisations miss the opportunity to resolve potential systemic issues. This leads to inefficiencies and a false sense of security around safety."

DRIVER 2:
FEAR OF NEGATIVE REPERCUSSIONS

2



37% of workers underreport because they are afraid of negative repercussions.

Results show that 37% of people who underreport do so due to a fear of negative repercussions. It makes sense that an organisational culture of fear and blame will reduce employees' willingness to report incidents and errors. In this type of culture, it is not uncommon for even the prospect of reporting to strike fear into the workforce. But what exactly are employees afraid of?

Often employees are fearful of overly harsh or punitive disciplinary action and at worst losing their job. But it is also important to consider the social ramifications that deter incident reporting. Employees may be afraid of being blamed by others, the discomfort of a permanent 'blemish' on their record or being the subject of peer disapproval for the loss of a safety bonus. The list of goes on and on.

We saw the consequences of this type of fear culture play out at a recent client site. Workers identified an issue with the mobile plant vehicles but failed to report it because they were afraid of getting in trouble. As a result, the vehicles were not serviced properly and the faulty suspension created seismic vibrations when driven underground. Over time, repeated exposure to these vibrations led to several cases of driver back injuries. This inevitably cost the business more in the long run and had significant negative effects on the individuals injured.

Fear-based reasons for underreporting such as "I thought I would be labelled a troublemaker" and "I thought my crew/team members would be angry" are common. This fear leads to a mindset of "if I can hide it, I will". Unfortunately, this means that lessons aren't learned and the organisation misses a chance to reduce the risk of an incident occurring in future. Consider the following practical examples:

- The worker who wants to report a near-miss, but then realises that he and his co-worker weren't technically following procedure. If he reports the incident, he will essentially 'rat out' his teammate.
- The worker who knows the team is only weeks away from achieving a safety bonus. If he reports this incident, everyone's bonus is gone.
- The worker who is new to the team and trying to build new relationships so doesn't want to 'rock the boat'.
- The worker whose supervisor says, "if anything happens, come to me first..." and then tries to convince the worker that because nobody was hurt there's no need to report.

But where does this fear come from and what can we do about it? It may be that employees have experienced negative repercussions firsthand, but secondhand experiences can be just as powerful. Historical cases where it was perceived that an employee was treated harshly or unfairly can weave their way into the fabric of an organisation. These stories pass down from employee to employee and help to cultivate fear and distrust.

During our interviews and focus groups, we often hear of stories that continue to play a role in maintaining a fear culture. Exasperated leaders often ask us how the handling of an incident months or even years prior can still influence employee behaviour today. The research tells us this is due to a phenomenon called *negativity bias*.[5]

Negativity bias is the tendency for people to weigh negative information more heavily than positive information. In other words, people are impacted by negative events more so than positive events. Consider the following example:

John has been an exemplary employee for the past five years and has recently been promoted to frontline supervisor. John is overwhelmed by the new responsibility and when walking on site accidently forgets to put on his high-visibility jacket. He's never forgotten before in his life, but this doesn't matter. The next time John talks to his crew about safety and PPE at a toolbox talk, they're already rolling their eyes and questioning why he was promoted over them. John's previously squeaky-clean record seems to count for nothing. The one time he slipped up is all anyone onsite can talk about.

The same is true for incidents. If an incident occurs and is managed fairly (e.g. no one loses their job or is punished with 'dirty' tasks for speaking up), it isn't the story that sticks in people's minds. But the one worker who got fired for reporting a near-miss 10 years ago? That's the story that spreads like wildfire and still sticks to this day, regardless of whether the details are completely true or not.

This isn't to say that positive stories aren't important; it's quite the contrary. We just need more of them to outweigh the negative, and we need to be conscious in how we administer investigations and communicate the outcomes in a fair, transparent and open way.

THE BRAIN AND FEAR

At its core, the human brain is hardwired to keep us safe from harm. Whether the threat we face is physical or social, our brain reacts just as strongly. In fact, the same neural pathways that activate when we experience physical pain also activate when we experience a social threat. By better understanding how our employees think, we can take conscious steps to minimise threat responses and maximise reward responses when it comes to incident reporting.

Learn more at sentis.com.au/brain-animation-series

CONSIDERATION FOR LEADERS: OVERCOMING NEGATIVITY BIAS

Negativity bias explains why people pay more attention to negative stories about incident reporting than positive ones. Although people tend to put greater weighting on negative events, this doesn't mean that nothing can be done. By having more positive information regarding incident reporting, we can outweigh the effects of one negative event.

Be mindful not to take the term 'positive ' too literally. By positive information we mean the learning or outcome of an incident investigation that allows the organisation to improve and prevent an incident from reoccurring in the future. For example, if an incident involves a serious injury it can be difficult to see the 'positive' in the situation or to speak about it in a way that does not reduce the seriousness. In this scenario, the positive information employees need to hear is what the organisation has learned and what measures or actions have been put in place to ensure a similar injury does not occur in future.

The same is true for a near-miss. Acknowledging that the possible outcome could have been catastrophic, but that the organisation has addressed the issue to avoid this outcome from ever occurring, is a positive story. Remember to be specific. Simply saying an issue has been addressed doesn't strike confidence into the workforce. Provide details and tell them *how*. Is it through improvements to systems, the work environment, equipment, dedicated training or education? Specifically, what does this look like?

Organisations should also consider if any leaders in their business actively drive negative stories through unfair investigations that lack transparency or are perceived by the workforce as 'witch hunts'. If organisations are unable to help these leaders approach investigations in a non-adversarial way, they may need to re-evaluate whether these leaders are a good fit for the business and its safety goals. Otherwise, the lasting impact of these leaders' investigations on the company's culture will do more harm than good.

To summarise, if leaders do not close the feedback loop or provide lessons learned from incident reports, it is likely that employees will fail to hear any positive stories at all. To shift this negativity bias, leaders must consciously promote the good to outweigh the bad.

Here is just a small sample of the responses from our research participants when asked about incident reporting in their organisation:

> *"Some people say 'don't put my name on it'. A few years ago someone got hurt and the people there got letters. People remember written warnings."*

> *"It's almost like a witch hunt."*

> *"Usually after an incident, people are asking if they're going to keep their job. It's a legacy thing where numerous times people lost their job following an incident. People don't want to be seen as a squeaky wheel—there's a fear there."*

> *"Putting stuff into [the reporting system] can be like putting your head in a noose."*

> *"When injured they'll report it but when it's a hazard improvement or a near-miss or equipment damage is slow, people are too scared they're going to get belted for it. They think we [leaders] are a wolf in sheep's clothing. They don't trust us as history has shown they would get belted for it."*

> *"They will just find some weird clause to justify why they will sack you and change a procedure."*

> *"I'm just a contractor, they'll get rid of me."*

Clearly the fear of negative repercussions is very real in the mind of the workforce. So, how do we even begin to address this? If we consider that most underreporting occurs at the *Public Compliance* level of maturity, we start to understand the role this plays in influencing employee attitudes and behaviour.

In a culture of *Public Compliance*, leaders typically use a carrot and stick approach to motivate their staff. Unsurprisingly, fear-based reasons for underreporting are most prevalent at this level of cultural maturity. The fear of being reprimanded (the stick approach) for being involved in an incident is a driving force in an employee's decision not to report.

One of the biggest challenges in a *Public Compliance* culture is the *appearance of compliance* (i.e. it looks like workers are complying *when management is watching*). When management walks around site safety looks great, but the numbers don't add up. Behind the scenes, employees take a tick and flick approach to safety systems, see safety procedures as something that gets in the way of doing their job, cover up incidents and errors due to fear, and cut corners or turn a blind eye to safety violations during times of production pressure. This is perpetuated by the close monitoring of employee performance which encourages a culture of fear and therefore increased underreporting. Creating internal motivation to take personal ownership over safety is critical to shifting this mindset. It's why we see such a shift in cultures who progress towards a more positive safety culture and is the key difference between a culture of *Public* versus *Private Compliance*.

SHIFTING THE FEAR MINDSET: KNOW WHERE TO START

Leaders seeking to address fear-based reasons for underreporting in their organisation should:

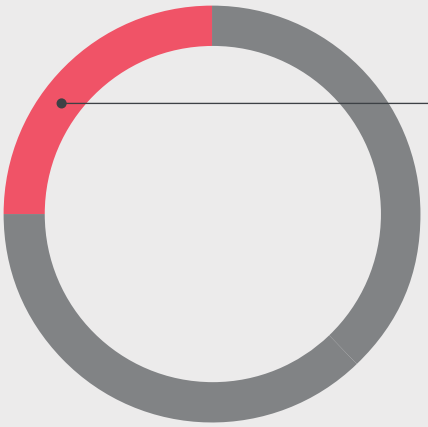
- **Develop safety leadership capabilities.** Assess leaders' strengths and opportunities, and create development programs to build skills in creating positive motivation towards safety and closing feedback loops.
- **Identify leaders who openly create a culture of fear within their teams.** Offer soft-skills training and coaching to support their improvement. Recognise that if a leader refuses to modify their behaviour and chooses to 'wield a big stick' when it comes to safety, that they may not be a good fit for your business.
- **Put in place recognition or positive feedback processes** to reward individuals who report near-miss or minor incidents that lead to improved safety outcomes/processes.
- **Create formal processes that ensure safety information is shared** with teams on a regular basis, specifically recognising how incident reporting, however minor, led to improvement.
- **Work on improving safety culture maturity overall.** Culture plays a critical role in safety attitudes, behaviour and performance at an individual, team and organisational level. Remember, underreporting is just one symptom of an underlying cultural issue.

Remember that change won't happen overnight, especially if there is a long-term culture of fear already deeply embedded within the organisation. However, with dedicated resources, time and effort, and a deliberate strategy in place, organisations can achieve positive change.

Historical cases where it was perceived that an employee was treated harshly or unfairly can weave their way into the fabric of an organisation. These stories pass down from employee to employee and help to cultivate fear and distrust.

DRIVER 3:
ISSUES WITH THE REPORTING PROCESS

3



25% of workers underreport due to issues with the process required to report incidents.

A quarter of people who underreport do so due to perceived issues with the reporting process. If the process is complex, unclear, cumbersome or time-consuming it can become too complicated, or too painful to report, and this can drive a culture of underreporting.

A common process-driven reason for underreporting is employee uncertainty of the criteria or conditions that trigger reporting. For example, workers report being unclear on what constitutes a near-miss. This can be an indicator of insufficient training around how the reporting system works, what should be reported and why it is important that all near-misses are captured. This is particularly concerning when frontline leaders or managers also admit they are unsure what needs to be reported and what doesn't.

We also found that the amount of time it takes to report an incident is a reason for failing to report. Reporting systems that are overly complex, cumbersome and difficult to use can discourage individuals from reporting. Furthermore, many workers openly admit that they hate the 'paperwork' component of their role. If reporting systems involve a significant amount of physical or digital 'paperwork', this can discourage employees from reporting minor incidents.

Our research also identified a common theme around the process that follows incident reporting. Specifically, when reporting leads to investigations that are perceived as time-consuming, unfair or lacking in transparency.

There are often stories that exist within workplace cultures about the worker who reported a near-miss and then missed out on a promotion, or the worker who supposedly reported an incident and then shortly afterwards left the business. These stories are not always based in fact but given the mystery and lack of transparency that often surrounds incident investigations, workers 'fill in the blanks' of what happened behind closed doors.

Sometimes employees hear the worker's side of the story but hear nothing from management, so have no information to challenge their thinking. This is a difficult component of incident investigations as leaders are often unable to publicise the details of an incident or near-miss. However, care must be taken to ensure at least some communication occurs from leadership. This is where clear processes regarding the communication of incident outcomes during safety meetings can ensure that team members are not left to 'fill in the blanks'.

It is also an organisation's responsibility to ensure incidents are investigated in a timely and efficient manner. When incident investigations are perceived to drag on and take up a lot of time and resources, employees may be reluctant to report minor incidents or near-misses. Organisations who hear this feedback would do well to review their investigation process and identify opportunities to streamline and improve.

A final theme identified was a history of reporting resulting in no tangible action. When an incident is reported using the appropriate process and the employee hears nothing back from management, what might that employee think? Our brains like to have an explanation for everything, so in the absence of feedback we create our own story. Typical stories we hear include "the company doesn't care about our safety", "the company doesn't value our feedback" and "what's the point of reporting anyway? Nothing ever changes around here". Think of the worker who reports a near-miss and shares it with his team. A few days pass and he hears nothing back. Then another member of the team experiences the same near-miss and reports it, also hearing nothing back. Over time the issue is reported multiple times by multiple people, yet no feedback is heard and management takes no action to rectify the issue. If you were a member of this team and experienced the same near-miss, would you bother to report it?

Here is just a small sample of the responses from our research participants when asked about incident reporting in their organisation:

"I can guarantee there are 10 near-misses a day that people don't report because they don't even know how to clarify/identify a near-miss."

"It's so much effort when you do report that you're better off not to."

"If you've ever gone to an incident investigation, you'll think twice about reporting next time."

"Paperwork can be a barrier to accurate reporting; you could spend a whole shift filling out paperwork after reporting an incident."

CONSIDERATION FOR LEADERS: REPORTING PROCESSES AND SYSTEMS

Organisations are faced with the challenge of critically reviewing their reporting process to ensure the process itself is not deterring reporting. Consider the following:

- How easy is it for workers to report an incident? Is the paperwork simple and straightforward? How long does it take your workers to complete the paperwork? Could this be a disincentive?
- How effective is your training around the reporting of safety incidents? Is it delivered during the site induction, or separately? Is the training interesting and engaging? Are people very clear after the training of what needs to be reported and how to do it?
- How efficient is your incident investigation process? Is it handled quickly or do investigations become long, drawn-out processes?
- How effective is your feedback process around incident reporting? Is every single report followed up? Does every individual who reports an incident, at the very least, receive informal verbal feedback about their report? If not, ask yourself why and consider what impact this is having on your reporting culture.

“Our brains like to have an explanation for everything, so in the absence of feedback we create our own story.”

ADDRESSING UNDERREPORTING IN THE WORKPLACE

It is clear that underreporting is a significant issue that organisations need to address, not only to avoid unnecessary financial cost, but also to prevent potentially devastating outcomes for workers and their loved ones.

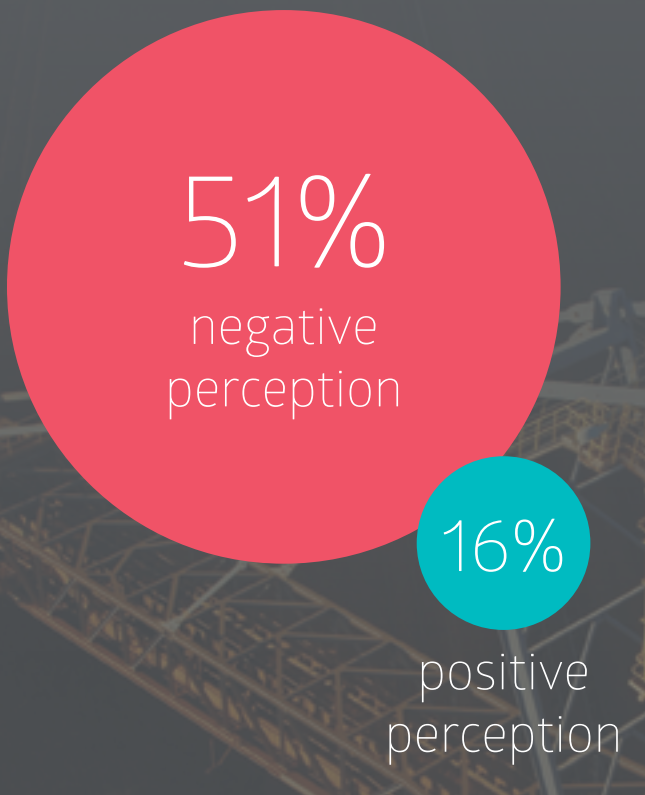
So far, we have seen that:

- underreporting is not limited to those in frontline worker positions and that employees at all levels (including management) underreport,
- at an individual level, managers underreport nearly twice as many incidents as individual workers and leaders on the frontline,
- employees that are younger or newer to the workforce underreport at a higher rate,
- employees within less mature safety cultures have the highest rates of underreporting, and
- the three key drivers of underreporting are an underappreciation of the benefits of reporting, fear of negative repercussions and process issues.

Underreporting of safety incidents is a pervasive issue that has many causes, but it is also a symptom of a much larger cultural issue. We can examine this more closely by looking to an organisation's safety climate. Think of safety climate as a 'snapshot' or the 'mood' of an organisation's safety culture at any point in time. Safety climate encompasses a broad range of dimensions from perceptions of equipment, tools and machinery, to quality of safety practices and procedures, and management safety commitment. So, it's not surprising that a safety climate has a strong relationship with underreporting.

Across all safety climate and safety-related dimensions, more positive perceptions are linked to less underreporting. Essentially, workers who have more positive perceptions of safety climate underreport less than those who have negative perceptions. Unsurprisingly, the strongest relationship is found in the 'error management climate' dimension. Individuals who underreport incidents have significantly less positive perceptions of error management climate than those who report all incidents. As seen in Figure 9, those who hold negative perceptions of error management underreport 51% of safety incidents, whereas those with positive perceptions of error management only fail to report 16%. This tells us that how an organisation reacts to and manages errors after they occur is linked to underreporting.

Figure 9. Underreporting rate comparison of those with positive versus negative perceptions of error management



ERROR MANAGEMENT CLIMATE

"Error management is an approach that does not attempt to do away with errors completely but rather attempts to deal with errors and their consequences after an error has occurred. In addition, error management ensures that errors are quickly reported and detected, that negative error consequences are effectively handled and minimised, and that learning occurs." [6]

There are five dimensions of error management climate:

1. Willingness to report errors (disclosing errors to leaders or official reporting of errors)
2. Learning from errors (identifying 'lessons learned' following an error)
3. Communicating about errors (talking to co-workers about errors)
4. Thinking further about errors (spending time understanding how/why errors occurred)
5. Effective error management (fixing errors when they occur).[4, 7]

In an organisation with a negative error management climate, employees are less willing to report incidents or errors, or discuss them with their leader and team. They are also less likely to fix the error, consider why it occurred in the first place and identify mitigating factors to reduce the likelihood of the incident occurring in the future.

ERROR MANAGEMENT PULSE CHECK

Are employees willing to report errors? ☐ Yes ☐ No ☐ Unsure

Do employees give much thought to errors and how they could have been prevented after they occur? ☐ Yes ☐ No ☐ Unsure

Do employees see errors as an opportunity to learn and improve? ☐ Yes ☐ No ☐ Unsure

Do employees actively try to fix errors immediately? ☐ Yes ☐ No ☐ Unsure

Do employees share errors with others to prevent them from occurring again in the future? ☐ Yes ☐ No ☐ Unsure

If you answered 'no' to any of these items, there is room for improvement in your error management climate. If you are 'unsure', then this is an area worth investigating further.

Of the five dimensions of error management climate, according to our research 'willingness to report errors' is the most negatively perceived dimension. Willingness to report safety incidents and errors is linked to the concept of psychological safety. Psychological safety is a term that refers to an employee's belief that he/she can freely express ideas, opinions and concerns without fear of negative repercussions.[8] In the context of error management, this belief is an expectation of how other people in the team will respond when an error is reported.

CONSIDERATION FOR LEADERS: ESTABLISHING PSYCHOLOGICAL SAFETY

Psychological safety is an essential requirement for increasing willingness to report and learning from errors. Psychological safety depends on high-quality social relationships within one's team. These relationships are characterised by mutual trust and respect, as well as shared goals and knowledge.[9] Leaders wishing to increase willingness to report within their teams must first work to establish high psychological safety.

What leaders can do:

- Encourage people to speak up and share their concerns, particularly with respect to safety.
- Eliminate unhelpful or discouraging behaviours among the team (such as criticism or ridicule).
- Actively listen to and show genuine care for team members to build high-quality, trusting relationships.
- Seek to reduce or eliminate power differentials within their teams to ensure every team member has a voice and is heard.
- Close feedback loops wherever possible and take responsibility for actively chasing up feedback from higher levels of management (if required) to provide feedback to team members.

What team members can do:

- Participate in team development activities to build positive relationships and improve communication.
- Demonstrate active care for team members by assisting them to complete a task or showing care and concern when performance deficits are noticed.
- Be willing to share personal learnings with the team to encourage a culture of openness.

KEY RECOMMENDATIONS

Underreporting is a pervasive issue that affects all levels of an organisation. When effective error management practices aren't in place, or when employees are embedded within a *Counterproductive* or *Public Compliance* culture, they underreport more. So, what can organisations do to address the issue?

There are a number of activities or changes that an organisation can implement to increase reporting. Some are simpler than others and include:

- Regularly communicate to the business the importance and value of reporting incidents. Back this up with examples of how incident reports have led to improvements.
- Celebrate individuals and teams who report an incident or error that results in an improvement.
- Reduce the complexity of reporting systems and provide employees with training in how to lodge incident reports.
- Ensure leaders are role modelling helpful attitudes towards reporting and are actively demonstrating reporting behaviours to their team. Leaders need to actively encourage reporting and support/recognise their team when they do so. Depending on the maturity of your leaders, this may require an investment in safety leadership training and soft-skill development.
- Ensure information/knowledge management systems are in place that capture and disseminate error-related learning across the organisation.
- Ensure investigation procedures are non-adversarial, transparent, help to identify root causes of errors and encourage growth through learning, rather than compliance through punishment. In the case of near-misses, also focus on which defence wasn't breached and celebrate that.
- Implement regular in-team and cross-team meetings that focus on error-related discussions and information sharing.
- Ensure leaders close the feedback loop with team members who report an incident or error to let them know of any action or improvement.

Organisations need to invest in all four overarching dimensions of safety culture (environment, practices, person and leadership) to effectively manage risk and create a strong, positive safety culture. For example, improving safety leadership by ensuring that leaders effectively role model incident reporting will not improve reporting if the systems are overly complex and time-consuming.

Remember, underreporting itself is symptomatic of a larger issue within your safety culture. While each of the above recommendations are fundamental in positively influencing the reporting of safety incidents, if done in isolation they may not have the desired impact.

Consider an organisation where the perception is that underreporting occurs due to a lack of understanding of what and how to report. Leaders put energy into revitalising their reporting process and run training for all employees to ensure everyone understands the process. This tactic works and employees soon start to report incidents and near-misses in increasing numbers; but leaders find that the process to investigate, provide feedback on and share the learnings of incidents is too time intensive. While it was a priority to begin with, leaders eventually stop providing timely feedback and the length of time it takes to close out actions creeps higher and higher. In six months' time, the underreporting rate has returned to previous rates. To effectively address underreporting make sure to review the process, but also consider the behaviour of your leaders.

To encourage a culture of reporting, leaders need to:

1. **Get people to report**

   Encourage a culture of reporting by talking openly with the team about the value of reporting all incidents (even minor ones).

2. **Address what is reported**

   Organisations should take action to address issues prior to them resulting in incident or injury. Far too often we hear stories from clients where someone has been seriously injured or killed by faulty machinery, an unsafe environment or flawed practices that had previously been reported by workers but not addressed. Whether faced with an incident, near-miss or safety concern, commit to action. Don't shift the responsibility to someone else. Instead, take ownership of the situation and ensure that, for the psychological safety and trust within your team, the issue is addressed.

3. **Close the feedback loop with the individual, team and organisation**

   What was the outcome? Share the learning and results and provide positive feedback to the team and individual involved. Help others see that you value the reporting of incidents as a method to help increase safety on site for every worker.

It is important to take a holistic approach to improving safety culture across your organisation. Investing in your safety culture more broadly leads to considerable organisational gains, beyond reporting. As safety culture improves, organisations see a decrease in unwanted safety outcomes and an increase in desired safety outcomes.

Table 2. Safety culture improvement outcomes

Unwanted Outcomes	Desired Outcomes
↓ Critical incidents	↑ Lead indicator reporting
↓ Risk of fatalities	↑ Improved willingness to report
↓ Damage to plant and machinery	↑ Organisational alignment
↓ Lost time injury frequency rate	↑ Discretionary effort in relation to both safety and production
↓ Total recordable injury frequency rate	↑ Trust and engagement
↓ Injury severity	↑ Helpful attitudes and behaviours
↓ Unhelpful attitudes and behaviours	↑ Change resilience

CONSIDERATION FOR LEADERS: MEASURING IMPROVEMENTS

In our study, leaders perceived that incident reporting was improving across 18 of 63 sites. However, the average underreporting rate for these sites was still high at 22%. At these sites, leaders truly believed they had seen a tangible improvement in reporting. This begs the question, has improvement really occurred? Or is this further evidence of underreporting as an 'unknown' issue?

Leaders looking to evaluate how their organisation is tracking in terms of reporting must be mindful. While you might appear to be seeing positive improvements on site, consider that the issue may have been larger than you first thought and is likely to still require significant attention. Engaging a third-party to conduct a cultural assessment and regular pulse-checks can help you to more accurately measure improvement and performance.

IMAGINE WHAT YOU COULD ACHIEVE...

CASE STUDY: MINING COMPANY

Operating sites across Australia, including in remote areas, this global mining company had experienced a plateau in their severe injury and recordable injury frequency rates. As a result, the senior leadership team had identified the need to address safety culture and leadership to improve safety performance across the business. While the client was aware of certain issues within their business that were proving to be barriers to change, a Safety Climate Survey (SCS) and Onsite Safety Evaluation (OSE) uncovered a significant and surprising unknown for the business: reporting.

Until undertaking an SCS/OSE diagnostic, the client held incorrect assumptions about the workforce's view on reporting. There were pre-existing beliefs that the workforce was actively hiding incidents and that they were simply too scared or too lazy to report. While the diagnostic did show a deep-seated fear of negative repercussions, this was not the only driver. A lack of feedback and education around the benefits of reporting, as well as the positive outcomes of reporting for overall safety, had cultivated a workforce who did not see the value in reporting incidents or near-misses.

The results of the diagnostic triggered the senior leadership team to closely assess their current systems, processes and communications around reporting. This lead to a significant system clean-up, the development of new metrics and targeted communications to shift the perception of reporting in the business.

Committed to achieving positive and significant long-term change, we partnered with the client to complement these system improvements with a complete safety culture intervention. In addition to the safety culture diagnostic, the client also assessed safety leadership ability and engaged in targeted training, coaching and embedding.

Over the course of a two-year period, the client not only achieved a significant improvement in reporting and injury reduction, but also a positive shift in their safety culture maturity from *Public Compliance* to *Private Compliance*. By moving from a negative to a positive safety culture the client achieved:

- ✓ 45% reduction in LTIFR
- ✓ Improved reporting, with five times more high-potential risk incidents reported post-training
- ✓ Positive shift in supervisor commitment to safety
- ✓ Improved recognition for employee safety performance
- ✓ Employees are more consistently reporting a greater willingness to exert social pressure on colleagues to comply with safe work

In terms of training and employee participant feedback:

90% indicate that they are highly motivated to apply what they learned in the program to their work

86% feel confident in their ability to apply the skills they learned in the program to their work

92% agreed the program was either 'above' or 'far above' average when compared with previous safety training received.

For this client, underreporting was a significant concern, but again was just one symptom of a broader cultural issue. By investing in leaders at all levels and putting in place a strategy and intervention that targeted employee attitudes and fostered personal motivation and ownership over safety, the client was able to shift their business to a positive safety culture. Not only did this lead to improvements in reporting, but also in safety performance and outcomes overall. Achieving positive safety culture change takes time. Dedicated to continuous improvement and achieving safety performance excellence, we continue to work the client to help them progress towards a culture of *Safety Citizenship*.

HOW TO GET STARTED

Firstly, it is important to determine the extent of underreporting in your workplace. On average, 25% of incidents go unreported in a 12-month period; 31% if your business is based in Australia. We have seen this number soar as high as 66% in some organisations. To gain an accurate understanding of how your organisation performs (or underperforms) in terms of reporting, it is best to seek third-party assistance.

Safety culture exists below the conscious awareness of leaders and employees alike, so accurate, unbiased diagnosis of an organisation's safety culture requires an expert, systematic approach. Undertaking a full safety culture diagnostic—incorporating both an Onsite Safety Evaluation and a Safety Climate Survey—is required to identify areas for potential streamlining and improvement of reporting processes and systems which may be a priority to address.

Furthermore, leaders need to be equipped with the soft-skills to better role model 'good' safety and improve their ability to manage incident reporting and investigation in a way that fosters a culture of learning and improvement. Development activities such as safety leadership training and coaching should be considered for leaders across all levels of the business. It is also important to consider team-level training to encourage your workforce to take personal ownership over safety. In doing so you can help employees understand the value of reporting and be on board to create a more positive safety culture overall.

It's important to remember that cultural change doesn't happen overnight. But with a determined and strategic focus, and a comprehensive approach, you will find your organisation making positive progress towards a culture of *Safety Citizenship*—where errors and incidents are used for learning and continuous improvement to not only prevent reoccurrence, but also improve safety for everyone.

ABOUT SENTIS

Offering safety culture assessments, training, coaching and consulting, Sentis helps organisations to break through the safety plateau and achieve positive safety culture change. As experts in applied psychology and neuroscience, we make safety personal and equip employees with the knowledge, skills and motivation to make safer choices, each and every day. This leads to safer, more engaged workplaces, as well as increased productivity, leadership capability and transformational, sustainable safety culture change. Since the introduction of our pioneering ZIP program in 2003, Sentis has empowered more than 300 companies and 150,000 individuals to think differently about safety.

If you would like to learn more about Sentis' diagnostic tools, our approach to safety culture, and how we can help you to address underreporting in your organisation, contact us at **sentis.com.au** or by calling 1**300 653 042**.

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Safety isn't about protecting you from something, but **for something.**












Empowering more than **300** companies and **150,000** people to think differently about safety since **2003**.

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