

# OPERATIONAL LEADERSHIP AND CRITICAL RISK MANAGEMENT

## THIBAUT VINCENT

Principal Consultant

 Thibault.Vincent@Sentis.com.au

 +61 427 638 088

 <https://www.linkedin.com/in/thibault-vincent-au/>



sentis.com.au

1300 653 042

A photograph of a man in a plaid shirt and jeans smiling as he holds a young girl in a yellow dress and a young boy in a blue shirt and jeans. They are standing in a doorway, looking out towards a bright, green outdoor area. A decorative dotted line in shades of blue and green arches from the left side of the image towards the family.

**To change the lives  
of individuals and  
organisations for the  
better, every day.**

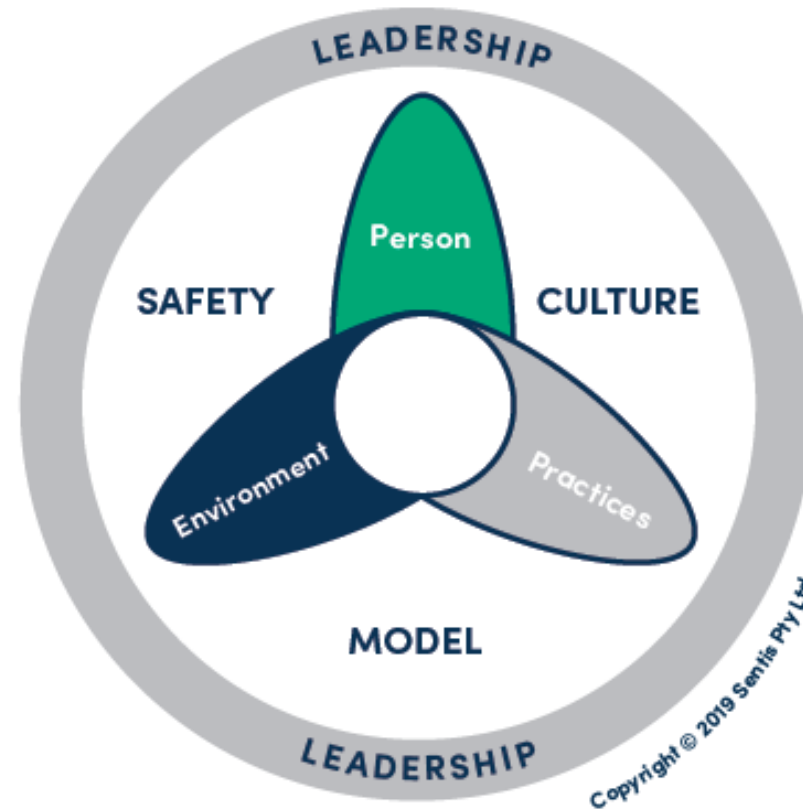
# AGENDA

- 1 CRITICAL CONTROL ASSURANCE
- 2 THE PSYCHOLOGY OF RISK
- 3 THE ROLE OF THE LEADER
- 4 PRACTICAL TIPS FOR OPERATIONAL LEADERS

A photograph of two people from behind, wearing high-visibility safety vests, standing on an airfield. The person on the left is wearing a green vest, and the person on the right is wearing a yellow vest. They are looking towards a large white aircraft in the background. The sky is clear and blue. The image has a dark blue overlay on the left side where the text is located. There are decorative dotted lines in green and white on the right side of the image.

# CRITICAL CONTROL ASSURANCE

# SAFETY CULTURE MODEL



## LEADERSHIP

- Confidence to supervise high-risk work and verify critical controls
- Ability to identify SIF potential events
- Understanding of high-risk work
- Willingness to share learnings from SIF potential events
- Executive focus on leading indicators for SIF prevention

## PERSON

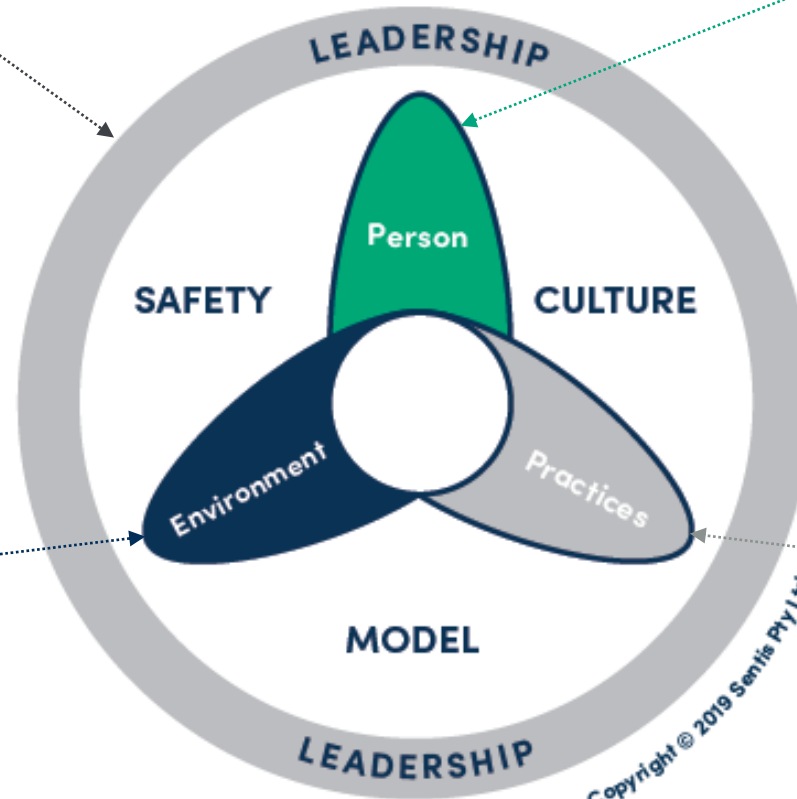
- Attitudes towards risks
- Willingness and ability to verify critical controls are enabled before commencing work
- Willingness to stop work if critical risks are not effectively controlled

## ENVIRONMENT

- Critical controls can include physical barricading, PPE, lock out mechanism, guards, exhaust ventilation

## PRACTICES

- Process to capture event data
- Mechanism to accurately classify events as SIF potential
- Process to direct investigation resources towards SIF potential events rather than minor events





**Let's take a quick poll...**

# CONSIDER THIS...



61%

of critical controls were in  
some way **difficult to  
implement** for the worker



49%

of control failures  
involved intentional  
**'workarounds'** by the  
worker

A review of 168 serious incidents\* across multiple industry sectors in 2020/2021 revealed 49% of control failures involved intentional 'workarounds' by workers.

*\*From studies performed by Incident Analytics*

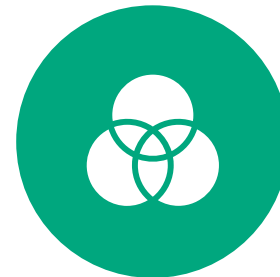


# SOME 'BRUTAL FACTS'



High risk work controls are not always **effective** or **fully enabled**.

*\*28% involved workers and/or supervisors **adjusting practices for local circumstances***



Local operational risk tolerance is often driven by **misaligned corporate systems**.

*\*32% of control failures resulted from **routine work practices that drifted over time***

*\*From studies performed by Incident Analytics*

# DRIVING A POSITIVE SAFETY CULTURE



**73**  
organisational sites  
across 8 industries



Agriculture



Construction



Government



Healthcare



Mining



Manufacturing



Oil and Gas



Utilities



**9**  
COUNTRIES  
(AFRICA, AUSTRALIA, CANADA, GERMANY,  
NEW ZEALAND, SAUDI ARABIA, UNITED STATES  
OF AMERICA, UNITED KINGDOM AND VIETNAM).



**562**  
focus groups



**597**  
hours of interviews



**5,011**  
people interviewed  
(representative of 15% of the  
population of organisations  
included in the study)



**21,711**  
surveys completed  
to validate findings



**155**  
observations made  
(pre-starts, site tours,  
inductions etc.)



**819**  
total cultural themes  
analysed

# THE BIGGEST OPPORTUNITIES

Top five **opportunity** areas identified across sites operating at *Counterproductive* and *Public Compliance* levels of safety culture maturity.

Safety Culture Dimension	Opportunity Frequency (% of Sites)
Quality of safety procedures*	56%
Management safety commitment*	51%
Internal context*	48%
Willingness to report incidents and errors	40%
Employee safety performance*	37%

\*Denotes dimensions that have a strong correlation with safety culture maturity (Pearson Correlation  $\geq 0.70$ )



**We cannot change the  
human condition,**

**But we can change the  
conditions in which people  
work.**

*James Reason*

# THE PSYCHOLOGY OF RISK



# SEEING A RISK IN THE FIRST PLACE



## Cognitive limitations

Inattentional blindness, gradual changes, short term working memory, biases.



## Skills and knowledge

Do I know what risks I should be looking for?



## Alertness

Fatigue, stress, prescription drugs, etc.



## Preparation

Rushing, habituation, distraction,

# RISK ATTITUDES

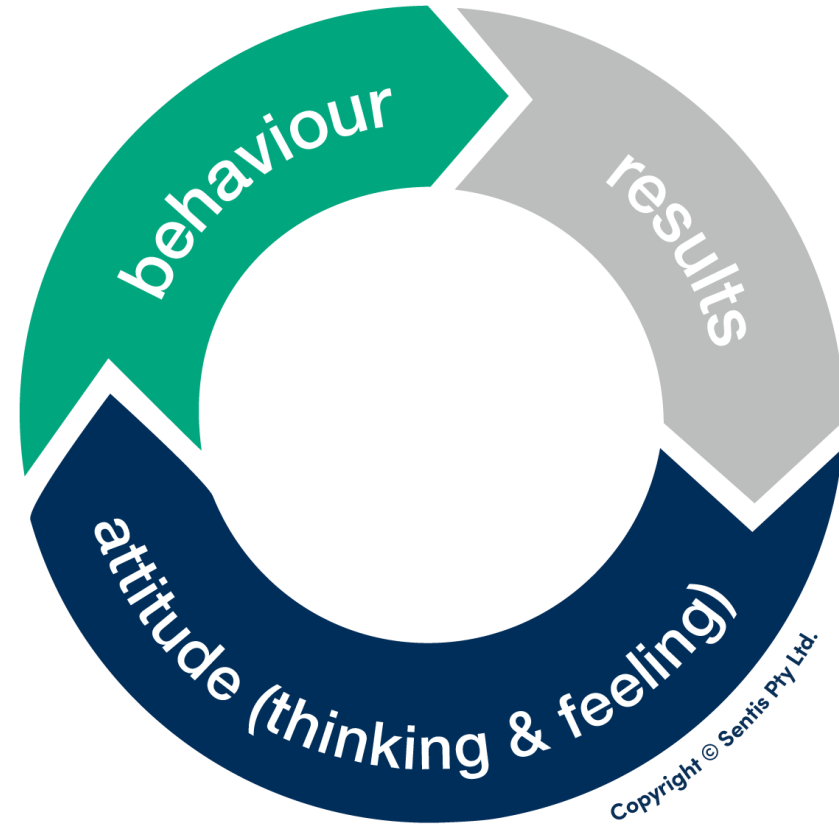


Do we have an **appreciation** and/or respect for the risks involved



Do we have a helpful **attitude** towards risk assessments and risk management tools

# OUR ATTITUDES



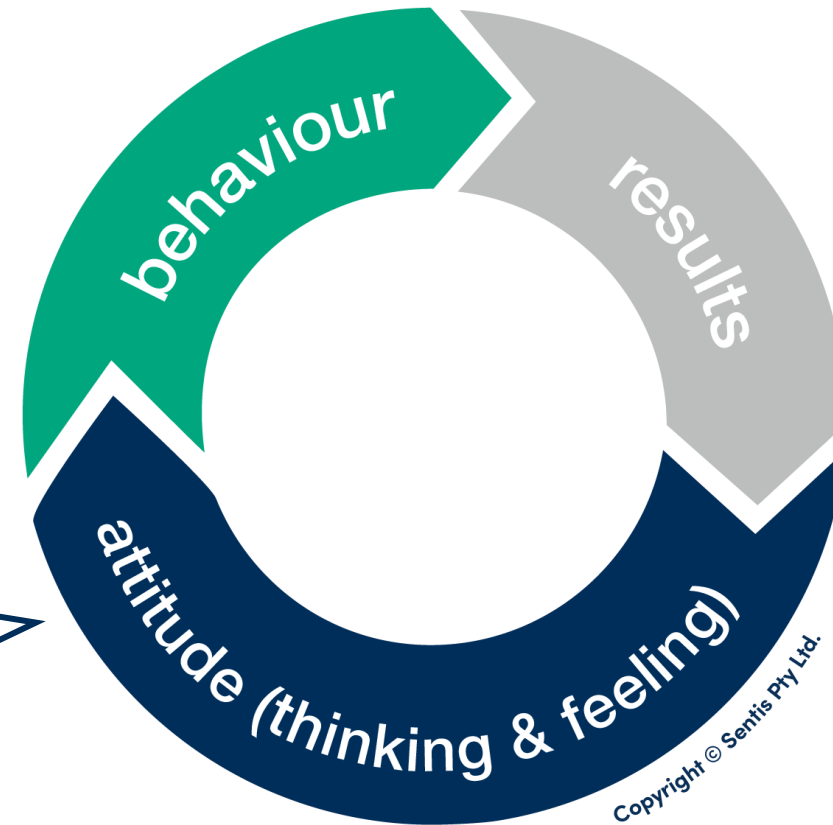


# OUR RISK ATTITUDES

'It'll be alright, it won't happen to me'

'I know what's involved and nothing has gone wrong before'

'I'm too busy to go policing my team'



**ARE  
WORKAROUNDS  
ALWAYS A BAD  
THING ?**





**Behavioural and procedural controls are here to stay. Therefore, there is a need to make sure their inherent frailty is understood...**

**This includes an increased understanding of social, psychological, organisational culture and culture change as well as an appreciation of human error/reliance.**

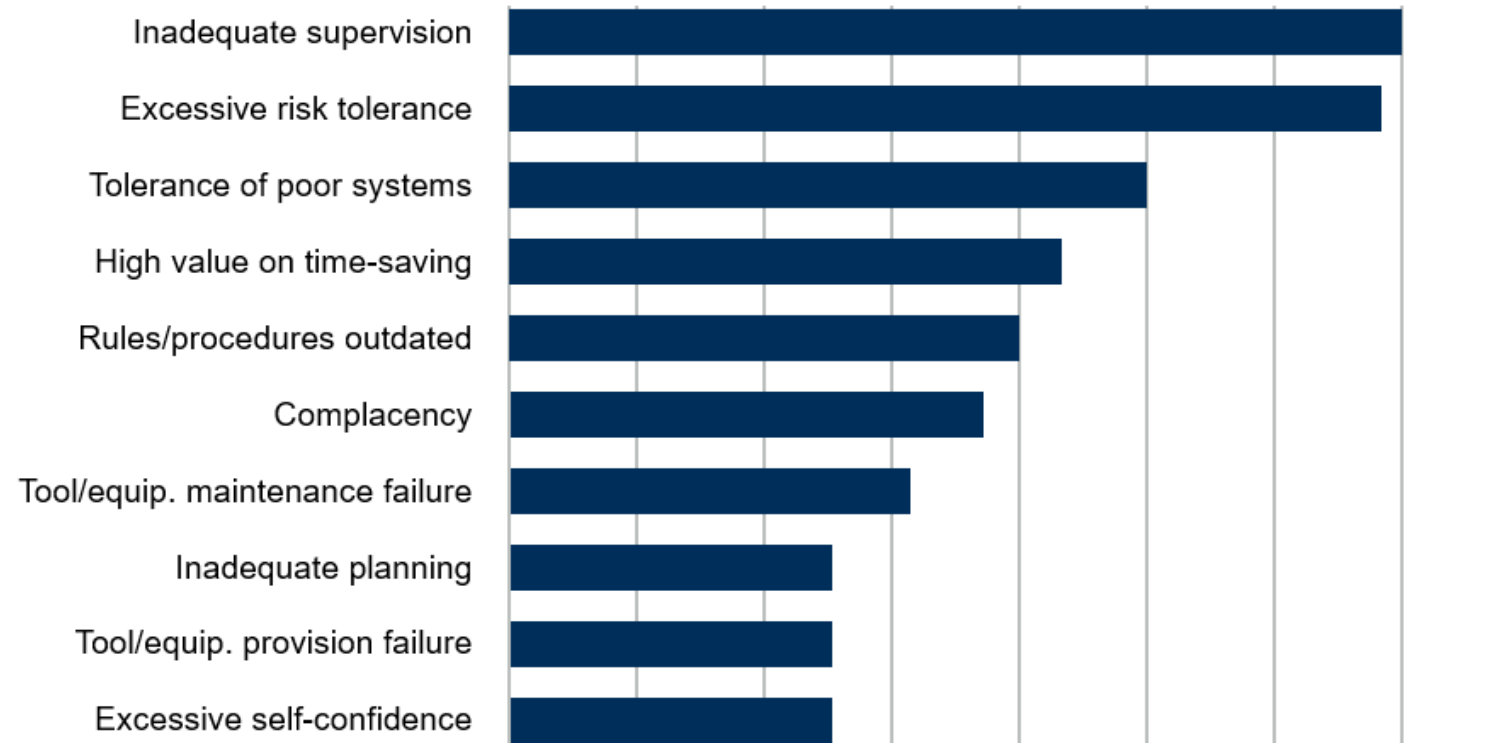
# THE ROLE OF THE LEADER





**Let's take a quick poll...**

# TOP 10 FACTORS AT A LOCAL LEVEL



# THE INFLUENCE OF THE LEADER

- Leaders set the tone and help shape the environment within which high-risk work activities are completed.
- They act as role models, define what's expected of the wider team, and influence the attitudes and behaviours of others with their actions and words.
- The quality of leadership and a leader's own tolerance to risk is essential in promoting effective critical control implementation and ownership.



# EFFECTIVE SAFETY LEADERSHIP







**Support** team members through training in critical risks and critical controls, active supervision of high-risk work and verification of critical controls.

**Recognise** and reward team members based on their demonstration of effective safety behaviour when performing high-risk work activities or choosing to stop work.

**Actively care** for the health, safety and general wellbeing of team members.

**Collaborate** or share ownership of safety with team members by asking for their active participation in safety decision-making relating to high-risk work, and empowering individuals to take personal responsibility for enabling critical controls and helping them understand how work is done.

Share a **vision** for safety and facilitate the development of team goals, targets and plans to achieve it.

**Inspire** the team to achieve the safety vision and safety excellence through motivational and encouraging communication.

**Role model** safety-compliant behaviours such as the implementation and verification of critical controls and reporting of all SIF potential and minor events that set the benchmark of what is expected from the team.

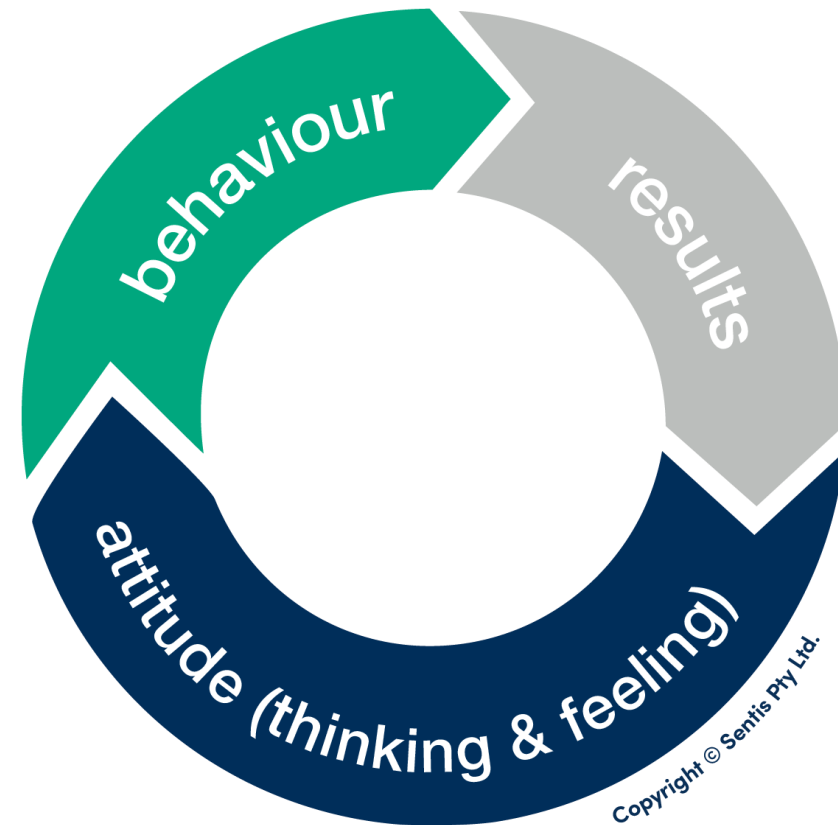
**Challenge** team members to think about how to manage high-risk work activities in ways that they might not have considered before.

# LEADERSHIP TOUCHPOINTS

- Pre-starts
- Meetings (I.e. toolbox talks)
- Formal and informal interactions (safety observations, control verifications)
- Safety communication
- Feedback loops (I.e. Hazard report close outs)
- Event notification and investigations
- Work planning



# INFLUENCING ATTITUDES



# PRACTICAL TIPS FOR OPERATIONAL LEADERS



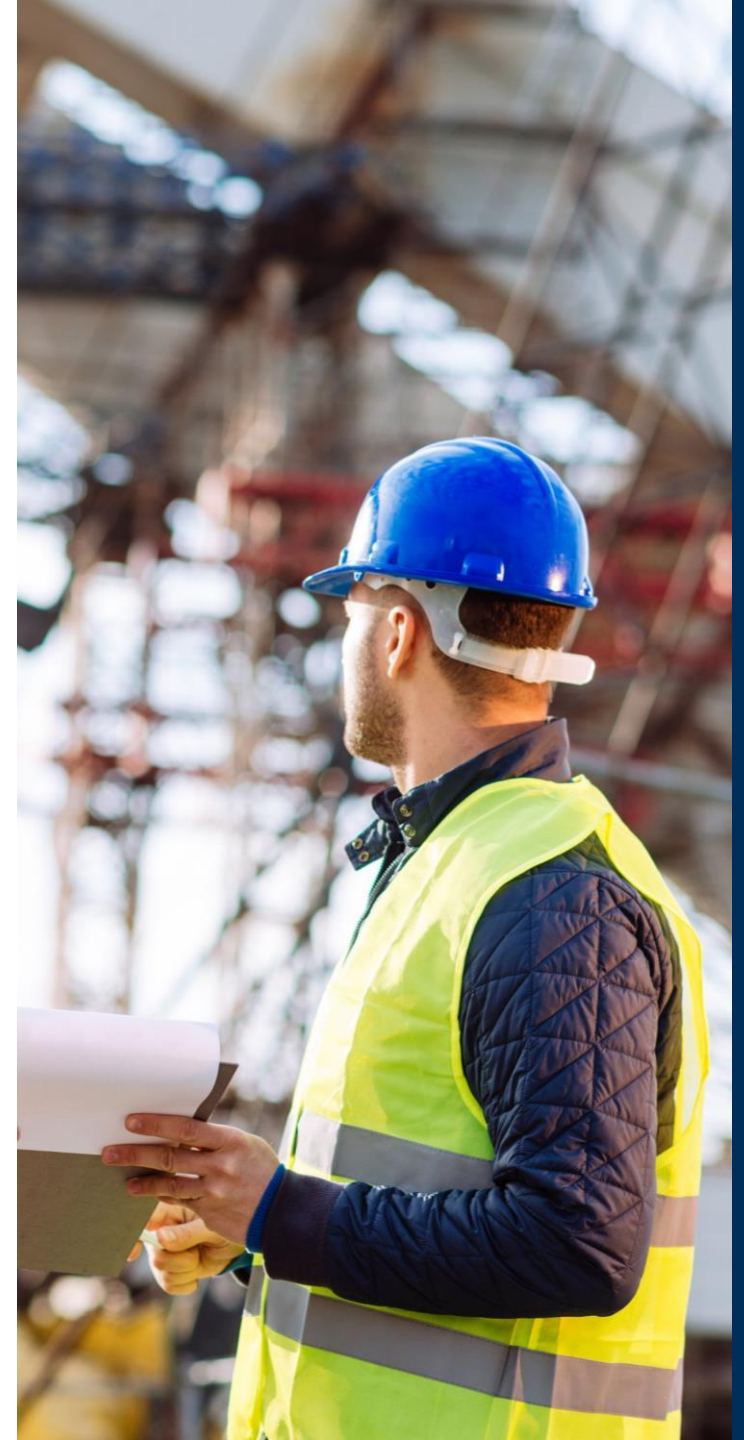
# OPERATIONAL LEADERSHIP STRATEGIES

## 1 Understand your risk profile and know your critical controls for high-risk activities

- Validate and verify the presence of controls through your infield interactions

## 2 Take the time to plan and implement the controls

- Ensure your team is enabled to implement the controls
- Encourage 'start work authority' discussions ("Are there enough controls to commence the work?")
- Incorporate feedback, learning and re-focus through pre-starts (and other mechanisms)

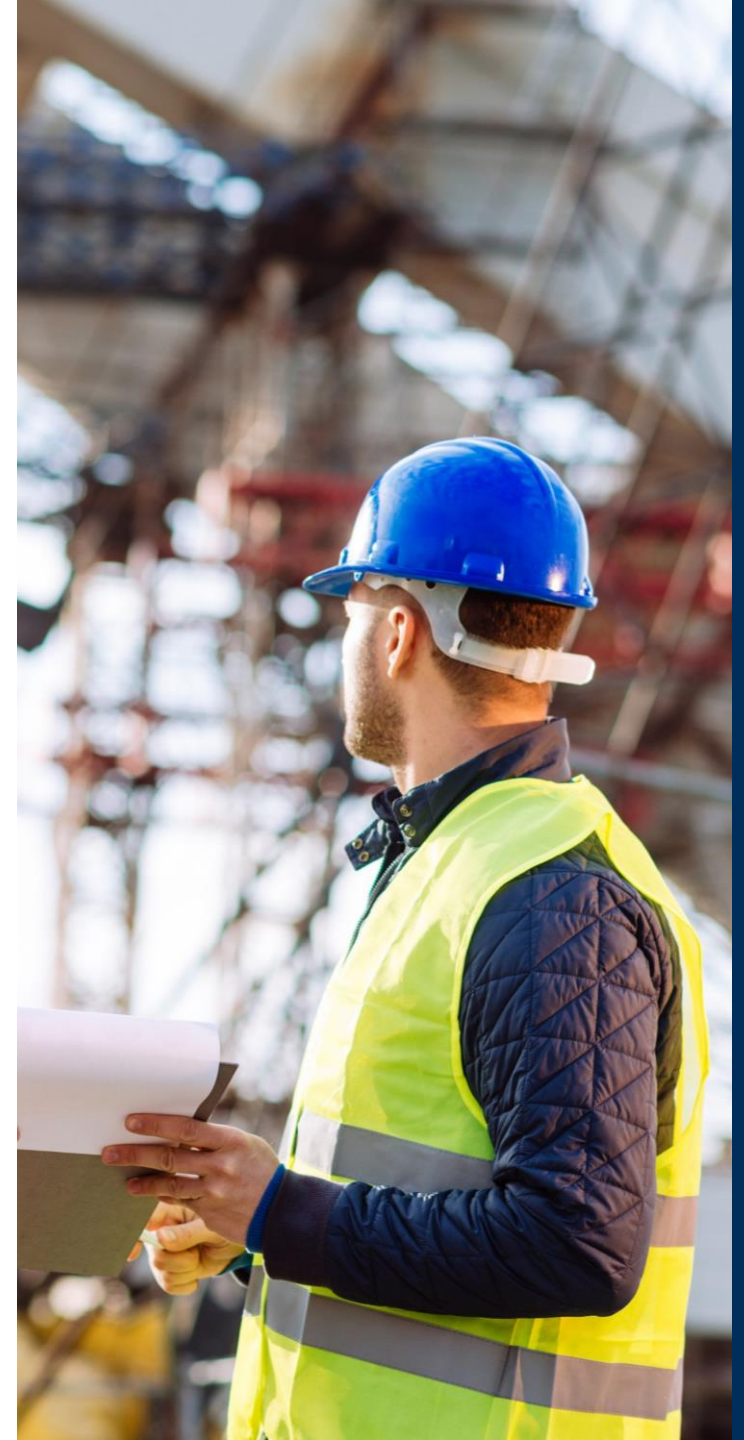


# OPERATIONAL LEADERSHIP STRATEGIES

3

## Continuous improvement

- “Early, often, ugly, it’s okay”
- Celebrate the ‘good catches’
- Be proactive: Learn your ‘weak signals’ (e.g., absent, ineffective), explore your workarounds, address the gaps
- De-identified, voluntary, anonymous safety observations (look for ‘what’s working well’)
- Look at your historical data and understand the ‘story it is telling you’



# Q&A

Over to you



DISCOVER MORE

## Safety Climate Survey (Critical Controls)



Would you like more information on Sentis' Safety Climate Survey (Critical Controls)?



Express your interest



DISCOVER MORE

## Meta Incident Analysis



Would you like more information on Senticis' Meta Incident Analysis?



Express your interest

# Get in touch

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Principal Consultant

 Thibault.Vincent@Sentis.com.au

 +61 427 638 088

 <https://www.linkedin.com/in/thibault-vincent-au/>

Join us for our next webinar:

***Understanding Culture,  
Climate and Engagement:  
Choosing the Right Survey  
for Your Business***

Date: Thursday 12<sup>th</sup> May



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