Creating a Passion for Safety
vs.
Management Oversight & Inspection

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I was disappointed with the OSHA report of the South Canyon Fire. My feelings are not the result of any need to defend my agency (USDA Forest Service). In another time and place, I thought the OSHA report following the death of Bill Martin (a smokejumper who died in a training jump) was right on target. In that instance I was disappointed with my agency's response. But that is not the case with this OSHA report. The bottom line is that the report will not help prevent future loss of life. The report is a quick fix aimed at what Argyris (1990) calls "single-loop learning" and is counterproductive to creating a passion for safety.

The OSHA report did make some good points, for example, "OSHA further supports the efforts of the agencies to address the more systemic issues of suppression preparedness, fuels management, and the wildland/urban interface. If those fundamental policy issues are not squarely addressed, the safety and health of firefighters may be placed unnecessarily at risk."

TWO PERSPECTIVES

However, there is a fundamental flaw in the OSHA report. To quote best selling author Stephen Covey (1989), "the way we see the problem is the problem." Covey talks about the difference between an inside-out approach versus an outside-in approach. Inside-out is based on the premise that between stimulus and response, people have the freedom to choose. Effective change starts with individual choice and works outward. Covey points out that the word responsibility--response-ability--is the ability to choose our response. Juxtaposed to this concept is the widespread practice in our litigious society of explaining our misery in the name of circumstance or blaming someone else's behavior.

Fritz (1989) calls these two approaches to life the creative orientation and the reactive-responsive orientation. The reactive-responsive orientation (outside-in) is a way of living in which people predominantly react or respond to circumstances that are beyond their direct control. In contrast, the process of creating is taking action to have something come into being (Fritz 1989). In the systems literature, the dichotomy has been framed as the archetypal structure of addiction (Kim 1992):

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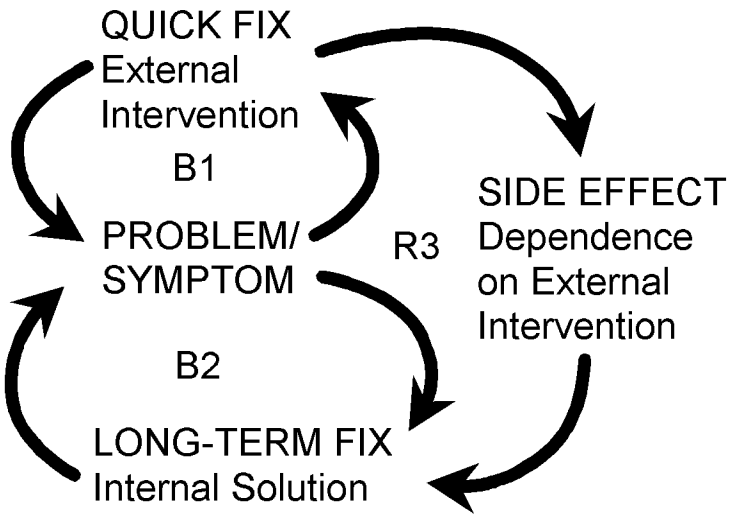

The addiction archetype is a special case of "Shifting the Burden." In both cases, a problem symptom is "solved" by applying a symptomatic solution (B1), but the solution has a side-effect which diverts attention away from the fundamental solution (B2). The side-effect (R3)--the dependence on an external intervention--eventually overwhelms the original problem. Argyris (1990) refers to a similar structure as single-loop and double-loop learning. Single loop learning (e.g. a thermostat) detects and corrects the immediate situation. Double-loop learning solves the more basic problem of why the situation developed by looking at the "master program," (also called "theories of action," or "governing values"). If actions are changed without changing the master programs individuals use to produce the actions, then the correction will either fail immediately or will not persevere (Argyris 1990).

An outside-in approach results in unhappy people who feel victimized, powerless, and immobilized, who focus on the weaknesses of other people and the circumstances they feel are responsible for their own stagnant situation. Covey's and Fritz's research argues that the inside-out (creative) approach is the most effective. Unfortunately, the OSHA report recommends an outside-in approach. That is a fundamental flaw.

This is particularly disconcerting given the head of the Department of Labor, Secretary Robert Reich. I had the opportunity to hear Secretary Reich give an inspiring address to the 6th Annual National Conference on Federal Quality, July 23, 1993. Prior to Secretary Reich's speech, Peter Scholtes (author of The Team Handbook) pointed out that our top-down, hierarchical organizations were rooted in the ideas of F.W. Taylor's "scientific management" developed in the late 1800's. The hierarchical organizational chart was designed to figure out who was at fault in train wrecks. He called such a chart the tree of blame. Secretary Reich came on to point out in great detail how such industrial-age thinking based on Taylor's "scientific management" will not work in today's information-age. Yet, here is this OSHA report that seeks to build a bureaucracy, the result of which will be the ability to assign blame for "train wrecks," but will not prevent the wreckage.

CAUSAL FACTOR

Identifying the causal factor leads us in a particular direction. The OSHA transmittal letter states, "we conclude that the primary cause leading to the deaths of the fourteen firefighters was that no one person was responsible for insuring the safety of the firefighters." Nonsense. These were not rookie firefighters who needed someone to hold their hands, baby-sit them, and "insure" their safety. These people were hotshots and smokejumpers, type 1 crews, the best of the best. As I have stated elsewhere (Dec. 94 Wildfire, p.63), the overriding causal factor was: the firefighters did not recognize the seriousness of the threat in time to take appropriate evasive action. They didn't see the danger until it was too late. By asking the question why, this causal factor leads us in the right direction. We get to start asking the questions, how do firefighters recognize a threat? How do they communicate it? How do they determine what is appropriate evasive action and when to take it? Putnam (1995) states, "we lost firefighters on Storm King Mountain because decision processes naturally degraded." By asking these questions about decision processes and investigating their answers we start to make some real improvements in firefighter safety. Stating the cause as "no one person was responsible," as OSHA did, leads us on a counterproductive search for blame that leads nowhere.

THE NINE UNSAFE CONDITIONS OR PRACTICES

The following review of the nine unsafe conditions or practices cited by OSHA turns up a common theme of individual responsibility. As Putnam (1995) states, "the goal should not be to fix blame. Rather, it should be to give people a better understanding of how stress, fear and panic combine to erode rational thinking and how to counter this process." OSHA cited the following unsafe conditions or practices that led to the catastrophe.

1) "The identity of the Incident Commander was not effectively communicated to firefighters." What does the identity of the Incident Commander have to do with safety? This information is useful for assessing blame for train wrecks, it does not prevent the wreckage.

2) "Adequate safety zones and escape routes were not established for and identified to employees." The individual firefighter has a responsibility to know their own safety zone and escape route.

3) "Available weather forecasts and expected fire behavior information were not provided to employees." The individual firefighter has a responsibility to obtain this information before stepping onto the fireline.

4) "Adequate fire lookouts were not used on the fire." Again, it is up to the individual firefighter to take the initiative to ensure there are fire lookouts.

5) "Hazardous downhill fireline construction was performed without following established safe practices." The individual firefighter has a responsibility to establish safe practices on the line.

6) "Management failed to provide the firefighters with comprehensive fire behavior information." Again, the individual firefighter has a responsibility to obtain this information before stepping onto the fireline.

7) "Management failed to ensure that the evolution of the Incident Command System was commensurate with the fire threat."

8) "Management failed to heed the safety practices contained in the Fireline Handbook pertaining to blow-up conditions.

9) "Management failed to conduct adequate workplace inspections of firefighting operations, including on-site, frontline evaluations, to ensure that established safe firefighting practices were enforced on fires of all classes." Having a separate quality control bureaucracy inspect for quality does not work. W. Edward Deming's third point of quality states, "Cease dependence on mass inspection to achieve quality." Deming reiterates the point in his eighth obstacle to quality, "quality by inspection." The details of the limitations of inspection are beyond the scope of this write-up. The interested reader can find plenty of references in the voluminous literature on quality. Suffice it to say that just as inspections won't produce quality, they won't produce safety either.

When I think about these nine conditions/practices, I am reminded of factory workers on the shop floor who have the ability to shut down the assembly line when quality is compromised. We need an analogous system whereby the individual firefighter can shut down the system when safety is compromised, not some archaic and ineffective system built around management oversight.

Safety, like quality, is everyone's job and responsibility, not something that management provides. Several quality initiatives have failed because they built a separate quality department. We can not afford the following thinking: safety? that's not my job, that's management's job, or that's the safety officer's job; quality? that's not my job, that's the quality department's job. Ultimately, the individual is responsible for their own safety. The OSHA report seeks to remove individual response-ability and replace it with a system to assess blame. Such patriarchal, patronizing systems will not work. It will only make matters worse.

OSHA's position is summed up by the concepts of management oversight and inspection: "management of both agencies failed to provide adequate oversight of the South Canyon Fire..." "To better protect firefighters and prevent catastrophes such as the South Canyon Fire from recurring, there must be an increased level of oversight on incident management."

In the agencies response to the OSHA report, there was a unanimous call for developing a passion for safety:

Mike Dombeck: "...instill a passion for safety among all agency personnel..."

Claudia Schechter: "...line managers must invest themselves in assuring that everyone shares and practices a passion for safety in all aspects of wildland fire activities."

Jack Ward Thomas: "...safety is the number one priority of our firefighters." "...every employee must internalize."

As Fritz (1989) points out, "problem solving is taking action to have something go away--the problem. Creating is taking action to have something come into being--the creation. They are two fundamentally different ways of thinking and acting. The bottom line is that the OSHA report, by taking an outside-in approach based on oversight and inspection, works against creating a passion for safety in each and every employee.

A DIFFERENT APPROACH

The OSHA report states: "A number of factors acted in cumulative fashion to create and intensify hazards to firefighters on the South Canyon Fire. Among those were a lack of adequate resources; dangerous weather, fuel and terrain; failure to ensure that safe firefighting practices, as outlined in the 10 Fire Orders, the 18 Watch Outs, and the Common Denominators were implemented; a lack of a clear chain-of-command; and a lack of effective management oversight." As Putnam states, "these tried-and-true solutions simply fail to deal with a major cause of the fatalities." We need to start looking outside the box. For examples of where we might start looking, see the following: The Collapse of Sensemaking in Organizations: The Mann Gulch Disaster (Weick 1993), Skilled Incompetence (Argyris 1986), Overcoming Organizational Defenses (Argyris 1990), Creativity in Decision Making with Value-Focused Thinking (Keeney 1994), and Dialogue: The Power of Collective Thinking (Isaacs 1993).

> "We lost firefighters on Storm King Mountain because decision processes naturally degraded. At this time we do not have training courses that give firefighters the knowledge to counter these processes. Both the Investigation Team and Review Board recommended creating a passion for safety but did not acknowledge that this passion is determined by psychological and sociological processes. The type and skill level of investigation team members and review boards (typically they include IMT personnel, a fire weather forecaster, fire behaviorist, fuels specialist, equipment specialist, but no psychologist or sociologist) predisposes them to focus on the traditional inputs, which effectively excludes other types of input, hence predetermining the outcome. This calls into question the very process and structure by which we investigate fatalities and communicate the results to the fire community. We can and ought to do better." (Putnam, in press)

If we are to make meaningful progress in improving firefighter safety we must start investing in this type of research and training. To create a passion for safety, we must learn about the creative process (Fritz 1989), effective actions (Covey 1989), meaningful dialogue (Isaacs 1993), and organizational defensive routines (Argyris 1990). Not surprisingly, all of this is at the foundation of what is increasingly becoming known as "learning organizations" (Senge 1990).

CONCLUSION

Argyris (1990) provides a succinct summary:

> It makes little sense to enact laws and rules against organizational defensive routines, fancy footwork, and malaise. The equivalents of such laws are already in place, and they do not work. The answer, as in the case of prohibition, lies in each one of us becoming self-managing and helping to create organizations that reward such self-responsible actions. p. 161

In conclusion, after relating the story of Victor Frankl, a Jewish psychiatrist imprisoned in the death camps of Nazi Germany, Stephen Covey wrote the following:

> As Eleanor Roosevelt observed, "No one can hurt you without your consent." In the words of Gandhi, "They cannot take away our self respect if we do not give it to them." It is our willing permission, our consent to what happens to us, that hurts us far more than what happens to us in the first place. I admit this is very hard to accept emotionally, especially if we have had years and years of explaining our misery in the name of circumstance or someone else's behavior. But until a person can say deeply and honestly, "I am what I am today because of the choices I made yesterday," that person cannot say, "I choose otherwise." (Covey 1989)

What's more important: assessing blame for train wrecks or choosing to act responsibly and safely? You can't mandate a passion for safety, it must come from the heart. The choice and responsibility is ours to make individually; not OSHA, not management, not a safety officer, or anyone else.

REFERENCES

Argyris, C. 1986. Skilled incompetence. Harvard Business Review, 64(5):74-79.

Argyris, C. 1990. Overcoming Organizational Defenses. Prentice Hall, Englewood Cliffs.

Covey, S.R. 1989. The Seven Habits of Highly Effective People. Simon & Schuster, New York.

Fritz, R. 1989. The Path of Least Resistance. Fawcett Columbine, New York.

Isaacs, W. 1993. Dialogue: The Power of Collective Thinking. The Systems Thinker 4(3):1-4.

Keeney, R.L. 1994. Creativity in Decision Making with Value-Focused Thinking. Sloan Management Review 35(4):33-41.

Kim, D.H. 1992. Systems archetypes. Pegasus Communications, Inc., Cambridge.

Putnam, T. 1995. The Collapse of Decision Making and Organizational Structure on Storm King Mountain. Wildfire 4(2):40-45.

Senge, P.M. 1990. The Fifth Discipline: The Art & Practice of the Learning Organization. Doubleday, New York.

Weick, K. 1993. The Collapse of Sensemaking in Organizations: The Mann Gulch Disaster. Admin. Sci. Quarterly 38:628-652.