Relationship Based Safety RBS can move your safety program beyond BBS

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Abstract

This paper addresses how Relationship Based Safety RBS is needed to move safety beyond traditional Behaviour Based Safety BBS principles. RBS provides the shift of focus from behaviours to relationships. Behaviours are NOT the causes of incidents & risks. They are the symptoms, consequences of deeper human and psychological factors.

RBS can move safety processes beyond BBS by developing risk based conversations RBCs in all workgroup interactions. Workgroup relationships are based on establishing and holding mutual trust, respect, care, credibility, encouragement, and appreciation of joint beliefs, values, shared solutions of challenges and issues. Relationships are in turn dependent on the nature and quality of the communication between the members of the group, and ultimately they depend on the nature and characteristics of the language used in that communication.

All informal, formal, day-to-day safety meetings, discussions, and personal behavioural choices need to benefit from incorporating clear, concise, accurate, defined, risk based language RBL into participative risk based conversations RBCs. Real examples of practical RBL and a sample RBS Card used in effective RBCs are described. Risk based conversations and interactions are at the core of establishing and sustaining RBS. RBS is shown as the means of making evolutionary improvements to BBS programs.

Part 1. What is a BBS Safety Program?

In 2015, the terms Behaviours Based Safety BBS and Behaviour Modification BM programs are still being used and applied to a wide range of different safety programs. When people are arguing about BBS they are often not talking about the same thing. This paper is not about arguing for complete abandoning of all aspects of existing BBS programs. Moving up and beyond the negative characteristics, as shown in Table 1, should involve evolutionary, not revolutionary, safety improvement, as measured by both positive prospective leading process indicators (e.g., risk management based factors) and negative retrospective lagging outcome measures (e.g., injury statistics).

1.	Behaviours/errors are labelled as causes - not seen as consequences of deeper underlying root causes.
2.	Assumes all *wrong* behaviours should be changed into *correct* sub-conscious *habits/routines.*
3.	Relies on Consequence Reinforcement / Operant Conditioning models of behaviour change.
4.	Ignores all or most principles of cognitive, affective and social neurosciences.
5.	Does not recognise importance of influence of personal relationships on behaviours.
6.	Training does not cover breadth of psychological bases for understanding behaviour.
7.	Observations are mostly directed at physical visible conditions and actions in the workplace and leads to concentration on wearing PPE, etc.
8.	Minimal or no verbal face-to-face interaction or dialogue and feedback between observer and observed.
9.	Any verbal interaction uses subjective undefined language such as *safe* and *at-risk.*
10.	Emphasis on non-predictive numbers – count what can be counted and only what doesn't really count.
11.	Problematic Selection Criteria for Check Lists of Critical Behaviours.
12.	Pocket record cards for Observations that are often "pencil-whipped" – *see Appendix 2 for Sample of New RBS Card for those who still want cards.*
13.	Mainly target behaviours of front-line workers - not senior and middle managers.
14.	Inverse Interpretation of the *Hierarchy of Risk Controls* – focus on behaviours.
15.	Often only peer-to-peer observations, sometimes top-down, but rarely bottom-up.
16.	Many do not have a mix of announced and unannounced observations/interactions.
17.	Sometimes observations are covert.
18.	Observations can be confused with, and even replace supervision, inspections and audits.

Table 1. Negative Characteristics of Original and Some Current BBS programs

Original behaviour observation programs were narrowly based on *reinforcement theory* and were designed to encourage behavioural change by always providing *soon, positive and consistent* consequences to condition desired behaviours and *soon, negative and consistent* consequences to discourage undesired behaviours.

There has been reports of BBS benefits by researchers (Marsick, 2004; Mettert, 2006;) as well as consultants (Krause, Seymour & Sloat, 1999; DePasquale & Geller, 1999). In Krause, et al. (1999), there was no direct evidence that observations could be entirely responsible for the positive results because the program encompassed multiple elements, including leadership involvement and an emphasis on communication. Throughout the safety profession, there are many versions of BBS using combinations of varied techniques, explanations, and theories. Many BBS programs often ignore the fact that safety risk management is not primarily a technical or behavioural problem: It is primarily a social or cultural problem. (Carrillo, 2012).

Despite this, many BBS users claim success solely on the basis of actual and apparent improvements in injury statistics. This could be explained by research conducted to identify key success factors in successfully implemented programs. The elements found in successful programs that did have lowered injury statistics included a strong emphasis on frequent high-quality communications, training in basic psychology of interpersonal interactions, including care for each other, and visible signs of genuine management commitment and leadership. These elements appear to result in increased trust, respect and care, as expressed between management and coworkers (DePasquale & Geller, 1999; Geller, 2014). This is not surprising when it is noted that, without calling it RBS, they are using a number of the foundational tenets of Relationship Based Safety.

With scientific backing, RBS recognises that how we feel about our leaders and our peers (mutual respect , trust, care) strongly influences whether we affect each other's behaviours.

Many contemporary behaviour modification programs still focus primarily on promoting *safe* behaviour among operators and frontline staff only. These programs exclude a large proportion of the behaviours that can also be involved in safety performance. Behaviour modification techniques could be used more effectively by expanding their application to include risk control behaviours (e.g., participating in risk identification processes such as system audits, reviews, incident investigations, design reviews and planning) Management behaviours (e.g., demonstrating health and safety leadership) need to be included as well.

Some organisations can demonstrate that observations or better interactions based on Critical Behaviour Lists are effective. Risk Assessments provide an objective basis for risk calculation and evaluation to allow meaningful selection, construction and interpretation of their Lists. Using risk based conversations gives the descriptor "*at risk"* some interpretable meaning. Even following a procedure involves some risk. A successful behaviour-based program needs to provide all participants with at least one method of calculating risk and hence provide an objective basis for understanding, prioritisation and assessment of workplace risks and corresponding Critical Behaviour Lists. The old traditional term "*at risk"* has no objective basis and worse no objective criteria for evaluating and agreeing on the level of risk tolerability to allow classification as *safe*. If an organisation introduces a BBS program that involves extensive training on BBS techniques and have the management leaders demonstrate commitment and inspiration in launching the initiative, then they are very likely the reasons for some success in behavioural change, not because of any observations techniques.

The communication interaction aspects of workgroup conversations need a structure, a framework and a language to achieve success. Risk management, risk language, and applications of a broad range of psychological principles can provide the links (Figure 1) between positive interpersonal relationships in a workgroup and the willingness to engage fully in safety programs.

Behavioural psychology was and is an extreme ideology that considers only observable physical phenomena – behaviour – observable stimulus and response. *Behaviourism* is a philosophical approach whereby nothing else matters except stimulus and response (Strahlendorf, 2013). Behaviourism emphasises consequences of previous behaviours as the predominant even only Antecedents/Activators of Behaviour, the A of the original ABC model of behaviour. There is little or no recognition of other factors which prompt, cue or influence behaviour. They include "forbidden" cognitive terms such as *beliefs, values, culture, attitudes, morality, judgment, emotions, logic, rationality, persuasion, memory, ethics, courage, creativity …* (Strahlendorf, 2013).

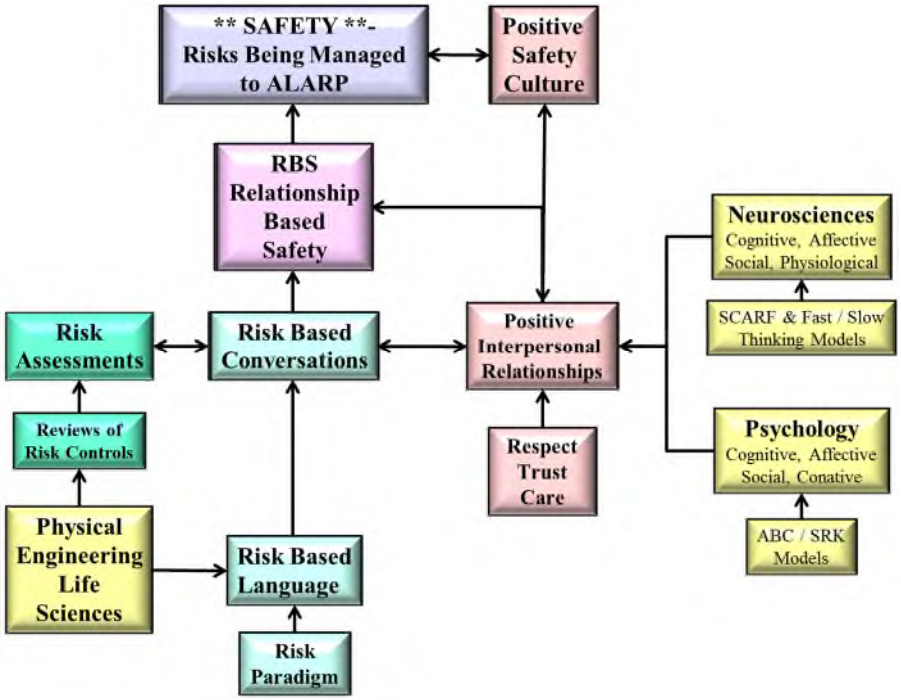


Figure 1. Logical interconnections of RBS with Risk Assessments, Language, Conversations

Part 2. Risk Based Conversations and BBS Observations

In traditional behavioural safety, the focus on the physical and observable is a major issue. A much greater emphasis should be placed on psychological and cultural factors such as relationships. The skill in safety conversations is not only observing the obvious but also listening for *what is said and not said* as indicators of ***what co-workers believe based on what they feel trust, respect and care for each other***. If the safety conversations are enriched by using more rigorous, objective risk based principles and language, then the resulting risk based conversations are more likely to influence behavioural choices. Risk Based Conversations can facilitate the evolutionary transition Figure 2 from BBS to RBS.

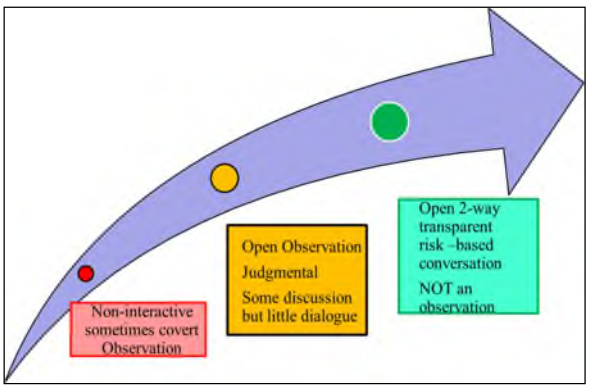


Figure 2. Evolutionary Change from Observations to Conversations

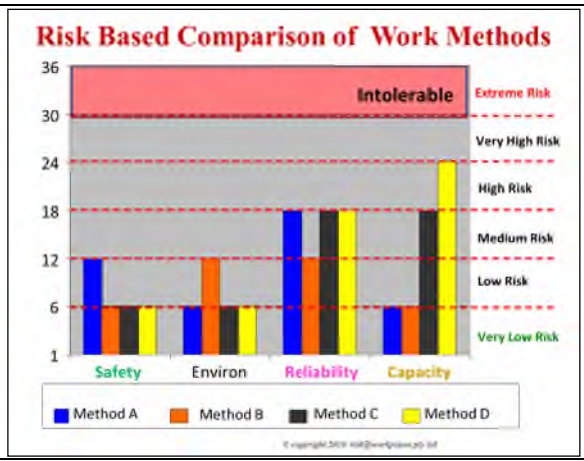


Figure 3. Risk Based Comparisons for Making Decisions the BEST Way

A **risk based conversation** is a respectful, open, focused, dialogue between members of a group engaging in a safety risk related analysis leading to a process of deciding the BEST way of planning and executing a business activity or job. As in all risk contexts, there is always uncertainty in predictable outcomes/causes for the different options being considered and decided. In the face of uncertainty, the likelihoods of the risk factors need to be estimated and discussed. A risk based conversation involves comparisons of the estimates of relative likelihoods of costs and benefits of exposures involved in each option for alternative courses of action (Figure 3). These comparisons provide more objective data to assist in ensuring the decision-making process is as objective, consensual and reliable as possible. The ultimate decision is based on selecting the option which has a greater likelihood and quantum of positive benefits that outweighs the likelihood and quantum of negative costs, more than for any of the other options. *Simply, which option has the highest chance of benefit and the lowest chance of harm?*

A **risk based conversation** helps establish and sustain positive intragroup relationships that are built on principles of mutual respect, trust and care. The rationale for adopting an RBS approach is based on the use of risk based conversations in developing positive relationships and vice versa. Noninteractive observations need to be converted to conversations to allow the exploitation of RBS principles. Shared beliefs are based on conversations with people they trust. Trust is hard to establish and even harder to sustain.

There are significant differences in the scientific basis for, and actual conduct of, Risk Based Conversations RBC and BBS type Observations. Observation processes in BBS programs usually involve only finding the physical, visible and hence observable signs of people doing the wrong things, *the ill-defined unsafe act or at-risk behaviour*. One significant difference is that RBS does not require an observation or other trigger for an interaction. The nature of the observation process varies. Common features are outlined in Table 2.

1. Who is responsible for observations? Who is observed? Peer-to-peer, up-down, down-up?
2. Is there any verbal exchange? 1-way/2-way? Discussion/Dialogue? Objective risk-based? Many BBS programs including the four reviewed by the HSE 2001 recognised the need for immediate verbal face-to-face interaction, conversation and/or feedback between observer to observed.
3. Prior announcement or 'warning' of observation – either undeclared or surreptitious (can be furtive, secret, sly, covert, underhand…)
4. Prepared checklist of Target and/or Critical Behaviours. Number on checklist?
5. How is checklist obtained? What is included or excluded?
6. Types and nature of Target/Critical Behaviours. Visible only or visible indications.
7. Focus on Positive Compliance or Negative Non-Compliance with Agreed Behaviours.
8. Nature of recording/scoring of Results of Observations – Some use Pocket Cards.
9. What else is measured and recorded besides the number of cards/person?
10. Setting quotas and rewards/incentives/awards for set numbers of completed observation cards is usually contentious & counter-productive. Quotas often lead to fictitious 'pencil-whipped' cards being submitted.
11. Different Policies for intervention or not if observer perceives an immediate intolerable risk is present.
12. What triggers an observation?
13. Inverse Interpretation of the Hierarchy of Risk Controls – focus on behaviours.

Table 2. Common elements of BBS Programs

BBS programs need to de-emphasise the 'observation' aspect and focus more on the relationship between people and conversation involved in the interaction between co-workers in all circumstances, not just some structured safety program called BBS. A negative perception that being observed is a form of 'spying' on each other, can commonly arise. ***Focus has to be on conversations re the underlying human factors of the behaviours not the behaviours themselves.*** The HSE (2001) review of BBS programs found that interpersonal skills (e.g., non-threatening productive dialogue & conversation techniques) of observer and observed need to be developed in order for any behaviour programs to be effective. It was noted that although some proprietary programs do not include interpersonal skills training, employees still require these skills to ensure program effectiveness.

Part 3. Risk Based Conversations and Language

Risk based language is the verbal communication tool that uses informal and formal risk terminology and concepts to better express and discuss risk management processes such as scoping, identifying, analysing, evaluating, treating, recording, monitoring, reviewing, and communicating risks. Sometimes there is unfounded criticism that some people cannot discuss risk with sophisticated concepts and terminology such as *randomness, uncertainty*, and *probability*. Risk-based language can use terms that are appropriate to any level of risk literacy and familiar comprehension. Table 3 shows how to match the language to that of the participants in the risk conversation.

Risk based language provides better descriptions and explanations of safety concepts than traditional absolute safety/zero risk models and beliefs. Poorly structured and unplanned risk based conversations can be subject to the same issues as those involved in any potentially confrontational person to person interaction. Without *mutual respect, trust and care*, the nature and context of communication between the participants can be negative, passive, and even antagonistic. Humans can be very sensitive to any comments or questions that can be taken as critical judgments or even personal attacks. The usual response is to immediately set up defensive non-communicative responses, and possibly even anger, resulting in the closing down of risk conversations.

Suggestions for what to say in Risk Based Conversations are given in Table 3 and Appendix 1. Training can improve conversational skills. Some other examples of positive non-threatening feedback and responses include:

- *"Thanks for that information / explanation, now I understand the issues better."*
- *"Thanks, now I have a better understanding of what needs to be done /avoided when….."*
- *"Until you explained that to me I never really appreciated what is involved in……"*
- *"Now I can appreciate / understand that some people could reasonably think like that ……"*

Traditional Safety Terminology	Preferred & Recommended Risk based Language
Loss Control / Loss Prevention	Safety Risk Management – profits as well as losses – enabling positive outcomes as well as preventing negatives – maximizing the chances of gains, profits, benefits – Safety is about a focus on *maximizing chances of gains* NOT *minimizing chances of losses*
Safety - as absence of harm – double negative	Safety - as presence of well-being – double positive
Safe Acts / Conditions	Standard, Agreed Acts / Conditions
Prevent, Stop, Eliminate	Absolute, false confidence words – better to use simple realistic terms *"manage"* or *"control"*
Unsafe Acts, Conditions *At-risk* Behaviours, Conditions	Nonstandard, Non- agreed Behaviours / Conditions
To accept a risk Acceptable Risk	To tolerate a Risk– working with, never passively accepting always uncomfortable – looking for how make the risk ALARP Tolerable Risk
Safe	Risk is ALARP - As Low As Reasonably Practicable
Safer / Safest	Lower risk / Lowest risk
Event / Scenario	If used interchangeably creates confusion e.g. The expression: 1. The same event can lead to different consequences is valid but 2. The same scenario can lead to different consequences is NOT valid ! Reserve the term ***event*** for each discrete happening / action and ***scenario*** for all the events and circumstances needed to describe How / When / Where / Who / What
If safety is involved, money doesn't count !	Sounds like a good caring philosophy but it is an untrue unbelievable statement which corrodes credibility, trust and respect. Better to use expressions such as: WHEN a risk exceeds our defined intolerable threshold level, and IF continued exposure to the risk is needed or desirable for legal, moral or commercial reasons there is no limit to time money effort needed to reduce the risk below the intolerable threshold. The reduced risk then also needs to be shown as always being managed to ALARP – not just at one point in time. *Tolerable* means BOTH below intolerable and ALARP
Alertness Vigilance	Situational Awareness, and Mindfulness
Violation, Breach, Failure, Negligent, Reckless	Use non-judgmental terms - *Variation, Alternative, Deviation, Work-around* Always look for root causes of variations
Shortcut	Smarter way of doing a job which can be *an approved variation* but only after a formal authorization / approval process involving qualitative or Semi-Quantitative risk assessments. (Whiting, 2014) - Always distinguish between - finding a shortcut (*smart)* and - taking a shortcut without risk assessment *(dumb)*
Safety Measures, Preventative Measures, Safeguards, Barriers, Layers of Protection Mitigating Factors, Corrective Actions,	Use the single term **Risk Controls** for all of them
Causes of Incidents & Risks	All causes are missing or ineffective risk controls due to deeper underlying root causes based on systemic, physical and work environment factors
Behavioural causes	Behaviours are Consequences of deeper underlying root causes NOT seen as causes in themselves
Human Error	Use term **Human Factor** in preference to **Human Error** to emphasize that Error is not a cause of an incident or a risk of an incident. It is a consequence of the underlying human factors mismatches between a job's requirements and the person's capabilities and limitations. The mismatches are usually created or due to systemic, physical, and work environmental factors
Possible, **Probable,** **Potential** used interchangeably and hence confusingly	**Possible** = absolute YES / NO black / white – it is or it isn't - has no range of values – cannot be used to express a level of Likelihood – cannot use meaningless terms *Quite Possible* or *Remotely Possible*
	Probable = relative not absolute – use *likely, chances, odds* – always has a range of values – can be used to express a level of likelihood
	Potential = confusing - It can be used to express either *Possible* or *Probable.* See further description of *Potential* after this Exhibit 3
Probability	**Likelihood, Chances, Odds** are risk terms preferred for non-quantitative users
Likelihood can be expressed as either a **Frequency** Or a **Probability**	**Frequency** can be used *retrospectively* to indicate how often an actual incident has been occurring in the past AND ALSO It can be used *prospectively* to predict how often the risk of an incident may occur in the future.
	Likelihood, Chances, odds can be used ONLY prospectively to express predictive estimate of how likely the risk will occur.
	Often better to use the terms "chance" or "odds" NOT decimal 0.001 or unfamiliar exponential 1E-03 notation e.g. 1 chance in 100 ladder climbs 1 chance in 10,000 valve operations The odds are 1 in 1,000 holes drilled
	Avoid using fractions of % - hard to interpret e.g. use 1 chance in 1000 rather than 0.1%
	Always question any assessor's perception that 1% or 1 chance in 100 is a small likelihood. It is a large likelihood.
Exposure	How often & How long exposed *(In financial RM it is $ quantum)*
Frequency of Exposure	How often e.g. Exposed to noise daily (or yearly or every shift)
Duration of Exposure	How long e.g. Exposed to asbestos 3 hours / shift (or 100 hours p.a.)

Table 3 Better Terminology and Language for Risk Based Conversations

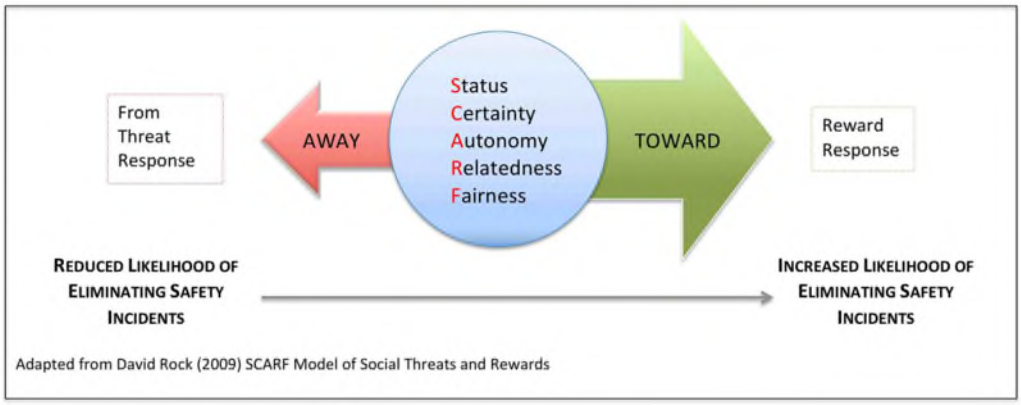
Part 4. Principles of Neurosciences & Behavioural Change

Neuroscience explores the various layers of the mind that are crucial to shaping and sustaining positive attitudes to, and belief in, safety. This is critical to RBS and safety risk management as the more we understand about the brain and its impact on behaviour, the more able we are to tailor safety strategies to overcome barriers to safety performance and achieve a positive safety culture. Of the four domains of neuroscience (see Table 4), social neuroscience investigates the critical role that social needs - and hence relationships - have in shaping behaviour.

Domain	Involves
Cognitive	Beliefs, judgment, perception, attention, memory, language, problem-solving, reasoning, and decision-making.
Affective	Feelings or emotional processes/states, motivation/reward/consequences, prediction.
Physiological	Flight vs. fight, or arousal.
Social	The domain of the greatest interest to RBS Relationship Based Safety • How we relate to each other; and • How this influences our choices and behaviour.

Table 4. The Four Domains of Neuroscience

Humans are highly social beings who require interaction with others. Neurosciences looks at how the brain functions using a variety of functional and imaging techniques such biochemical analysis of brains, functional MRI and functional EEG. Such studies show that the brain treats social requirements in a similar fashion to that of core basic needs, such as eating, drinking and sleeping. Our interactions in the workplace are fundamental to our safety attitudes and performance and attending to these social needs is vital to achieving and maintaining a positive safety culture. Figure 5 describes the SCARF model (Rock, 2009), a model developed within social neuroscience that explains the core drivers of social behaviour. These are necessary for building, sustaining and embedding behaviour change, and ultimately a more positive safety culture. The SCARF model shows how important inter-personal relationships are to the behavioural change.



Threat	Reward
• Reduced working memory • Reduced field of view/attention • Generalising or amplification of threat • Err on the side of pessimism	• More cognitive resources • More insights • More ideas for action • Few perceptual errors • A wider field of view/attention • Better judgment, lower-risk decision-making and behaviour.

Status – Our relative importance to others
Certainty – Our ability to predict the future, our confidence that things are consistent and stable
Autonomy – Our sense of control and influence over the course and consequences of events.
Relatedness – Our sense of safety with others are you friend or foe? In-group or out-group?
Fairness – Our perception of fair exchanges between people

Figure 4. Rock's (2008) SCARF Model

Neuroscience can broaden aspects of all safety programs. For example BBS models can be extended to consider all types of Activators in the Activator-Behaviour-Consequence (ABC) model, not just consequence reinforcement. Focus on how the *Value/Immediacy/Frequency* characteristics of the Consequence of a Behaviour affects the strength of its reinforcement is still valid and useful in describing effective methods of behavioural change. Neuroscience adds the powerful extra dimension of explaining how

brain function is involved. In any evolutionary advancement of understanding of behavioural change, it is still beneficial to retain the useful classification and differentiation of types of behaviour in the Skills-Rules-Knowledge (SRK) model (Rasmussen, 1983) that explains the varying degrees of conscious decision-making and automated actions involved in various workplace behaviours. But again, neuroscience goes deeper and helps us better understand why safety procedures, Job Safety Analyses (JSA's) and rules are so often forgotten or disregarded. Similarly, many of the principles of the Fast / Slow Thinking or Systems 1 and 2 Models (Kahneman, 2011) can still be used with other neuroscience models to identify and exploit behavioural change factors.

An organisation is people in constant communication and dynamic interaction, influencing each other and changing outcomes sometimes in ways that are not always obvious and predictable. Personal individual motivation determines what aspects of our lives we pay attention to. If existing rules, policies or procedures are processed by an individual's brain as *irrelevant, unnecessary, involving unfavorable cost-benefit perception, lacking credibility and hence ownership*, this triggers a response in the brain that strongly motivates the person away from those rules, policies or procedures**.**

***Research in social neuroscience has revealed that our need for belonging and acceptance is as strong an influencer on our choices and actions as our need for food*.**

Extrapolating this to organisations, the social life of an organisation enables it to build shared knowledge and commitment to safety processes designed to keep people safe and build sustainable positive safety outcomes. Organisations need to extend beyond BBS programs in an evolutionary not a revolutionary way so that hard-won and still valid processes are not abandoned. The application of neuroscience principles allows organisations to break through their safety plateaus, pre-empt and respond more effectively to unexpected 'left-field' risks and incidents, and build on gains of existing programs to embed a strong positive safety program. Behaviour modification techniques could be more effective if they focused on techniques of measuring *the effectiveness of identified and implemented risk controls* as evidence of behaviour management. Inadequate and even incompetent decision making re selection and resourcing risk controls by supervisory and managerial staff is usually latent and not easily observable. It is the faulty decision-making not the behaviour itself that is still heavily involved in risk and incident causation.

The evidence from research suggests that *involved, decentralised and participative leadership styles* will encourage more positive behaviours at supervisory levels. In particular supervisors who feel they are *allowed some decision making latitude* within their own role are more likely to develop participative relationships, horizontally and vertically up/down.

Monitoring whether risk controls are in place and measuring their effectiveness can provide objective evaluation of the quality of the decision-making behind their selection and implementation. This is analogous to the old expression that Corrective Actions generated from all kinds of investigations and reviews need Verification and Validation checks. This V & V checking can be the actual observation or interaction process and will definitely require and benefit from risk based conversations during it.

One of the many other interesting neuroscience research findings is the existence of ***mirror neurons*** and how we influence each other in developing a group safety culture. Researchers have found that when people observe the actions of others, their brains unconsciously mirror (or mimic) their emotions, intentions and behaviours as if they were their own. For mirroring to occur, there needs to be a relationship between *intentions* and *actual* behaviour. Daalmans (2013) states that people do not mirror behaviour without an underlying intention. So, even if a safety leader espouses safety messages, mimicking will only occur if their underlying intention is genuine. We have all heard the statement that *safety is our number one priority*, yet seen that safety decisions have been based largely on financial or economic factors. Employees see through the façade and fail to mirror the safety message. Within a safety context, the mirror process has the potential to create a powerful platform for learning appropriate or desirable safety intentions and behaviours from others. Within organisations and teams, mirroring processes are active between all members in the group and serve to enhance relatedness (as per Rock's model), disseminate desirable safety intentions and behaviours, while eliminating or defusing more destructive patterns that erode safety culture and performance.

Part 5. Summary – Using RM and RBS to Move Beyond BBS

The trend toward scientific approaches to safety, including applying risk management, risk engineering and neuroscience, has proven beneficial and sustainable. In many programs, people are now being given the option to think more clearly about risk criteria such as tolerable risk, and managing risk to ALARP – which are more realistic and fundamental features of successful safety risk management. As well, neuroscience pushes our understanding of behaviour and safety models beyond the traditional cognitive-behavioural, social, and affective theories of decision-making, motivation, risk perception, and risk taking in safety (see Figure 1).

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Appendix 1. Suggestions re Risk Conversations © Soteris 2013

(Suggestions only – develop your own sincere style)

Consider- What are the differences between a risk conversation and a BBS observation, and an interview / instruction / inspection / audit?

1A Some suggestions for conversational openers/ice-breakers

- *How **often** is this …(job)… done?*
- *What is the really **challenging** part of this …(job)…?*
- *How do people know when that …(job)… is **completed / finished** properly?*
- *How **many** of …(widgets) … are produced / processed / answered …. per …..day / year?*
- *Does it take long to get **proficient / competent / experienced /comfortable** at…(job)?*
- *Is it possible to build any **variety** into the process?*
- *What are the greatest **distractions**?*
- *Do people have **favourite ways** of doing ..(job)…?*

1B General Advice re Risk Conversations including Leaders' 'walk-arounds'

1. Introduce yourself casually without rigid formalities and show an immediate interest in an individual's name and position / role in the organisation.
2. Be alert for cues (body language etc.) of any unease at interacting with you and respond quickly.
3. Listen carefully for the tone of all answers and adjust your responses / prompts accordingly. ***In fact, always try to listen more than talk.***
4. Often OK to use humour if you feel the reaction is / will be appropriate. For example, *What do you do around here? and I don't expect that the answer "as little as possible".*
5. Always open with words that are NOT going to be taken as "know-all", or confrontational or critical. For example, *That seems to be an interesting job. What aspects are interesting?*
6. Inquire **first** about what he/she regards as the **positive aspects of specific tasks** NOT negative aspects of their job as a whole.
7. Let them – not you - introduce negative aspects and engage fully with them to get a clear explicit summary of their concerns with guarantees of:
   - *I will look into that and definitely get back to you;*
   - *If I can, I would like to join you and your team in doing the comparative risk assessments of the options / alternatives you have suggested*; and/or
   - *I will be very interested in getting the results of the comparative risk assessments by your team of the options/alternatives you have suggested.*
8. When appropriate, ask what are good aspects of the task? For example,
   - *What gives people the most satisfaction doing this task?*

1C Suggestions for what to do if you observe someone who is apparently doing something YOU may perceive as wrong and maybe taking a risk that is not ALARP

1. If the local supervisor/line manager is not accompanying you, take care not to say anything that appears to undermine his/her authority.
2. Remember to be careful of making rash judgments of apparent risk-taking that is not ALARP.
3. Again, avoid commencing with words that are going to be taken as 'know-all' or confrontational.
   - *Do people around here do that job in different Ways? Tools? Positions? Speeds?*
   - *What work method/sequence have the people around here sorted out and agreed is the best way of doing this job?*
   - *Were there many different choices for working out the best way of doing this job?*
   - *Who has a part to play in the development of, and making any changes to the rule / procedure?*
   - *What still limits people from doing this job in that best way?*
4. De-personalise and avoid any accusatory-type language in any of your questions/comments by NOT using the word *"you"* say *"people around here".*
5. If appropriate, ask:
   - *Do any rules/procedures ever need to be varied or changed sometimes?*
   - *What risk circumstances that were not expected when the rule/procedure was written, agreed and learned can require users to vary the rule or procedure normally needed?*
   - *If risk-justified, what is the approved process for varying a rule or procedure?*
6. Avoid jumping to unfounded conclusions by using negative, emotive, judgmental words. For example, *violation / breach / reckless / negligent / failed*.
7. Obtain agreement of expectations and clarify the nature of any promised or necessary follow-up to the conversation / interaction.
8. Indicate only the nature and timing of any follow-up that you know you can deliver.
9. Express sincere thanks for the 2-way risk conversation / dialogue and how much you learned.

1D Recognising and Endorsing Apparently "Good Work"

1. Always balance, looking for problems, with recognition of successful work being done.
2. Involve the doers in deciding how a job will be judged as having been done well. For example, *How do you know when the job has been done well?*
3. Involve the doers in choosing an appropriate form of recognition to enhance sense of autonomy and sense of reward. For example, *What would be the best way for recognition of successful achievement?*
4. Verbal praise and recognition is best provided at both group and individual levels.
5. Involve the site supervisor or line manager in the recognition process to improve team relatedness.

Appendix 2. Sample New RBS Record Card

(for RBS users who require them)

RELATIONSHIP BASED SAFETY

Risk-based Conversation/Interaction

1. **Location**: _____
2. **Activity/Job No.**: _____
3. **Date**: _____
4. **Shift**: _____
5. **Recorder's Name:** (optional)

6. Please place a tick in the correct key (see below).

KEY		What triggered the risk-based conversation?
◇	❑	Actions/inactions?
◇	❑	Near miss?
◇	❑	Work methods?
◇	❑	Tools/equipment?

Key codes:

◇ *Standard/positive/agreed* OR ❑ *Substandard/not agreed*

7. **Participants in conversation**:
   - a. More than 2 people YES / NO
   - b. Leader involved YES / NO
   - c. People outside of group YES / NO

8. **Which risk *factors or hazards* where discussed?**

   Which checklist was used?
   What was different, abnormal, changed, unusual or unexpected? (*Please comment below*).

   a. _____
   b. _____
   c. _____
   d. _____

9. **Which risk *controls* were discussed?**
   Which risk control(s) was used?
   What was different, abnormal, changed, unusual or unexpected? (*Please comment below*).

   a. _____
   b. _____
   c. _____
   d. _____

9a. **Did any changed conditions create new risks that required a unique procedure variation or workaround?**

YES / NO (*if no, jump to Q10*)

9b. **Were alternative variations risk assessed and the '*lowest way*' then agreed as '*best*' way?**

YES / NO

9c. **Which risk assessment methods were used?**

- ❑ Qualitative only
- ❑ Plus semi-Q (matrix)
- ❑ Other: _____

9d. **Which risk (as well as safety) were discussed to reach agreement on the 'best' way?**

- ❑ Commercial/financial
- ❑ PR/Reputation
- ❑ Environmental
- ❑ Quality
- ❑ Legal
- ❑ Other:_____

10. **During the risk conversation indicate the presence of the following:**
    a. **Objective listening & willingness to change personal biases/risk perceptions**:
       - ❑ HIGHLY – noticeable & appreciated by all
       - ❑ MODERATE – reasonable but improving
       - ❑ LOW – needs significant improvement

    b. **Levels of mutual respect and care**:
       - ❑ HIGHLY – noticeable & appreciated by all
       - ❑ MODERATE – reasonable but improving
       - ❑ LOW – needs significant improvement

11. **Recommended follow-ups (when and where)?**

_____