NON-PUNITIVE CLOSE-CALL REPORTING;
Learning from the Mistakes of Others Prior to Disaster
2002

GREFS

INTRODUCTORY COMMENTS:

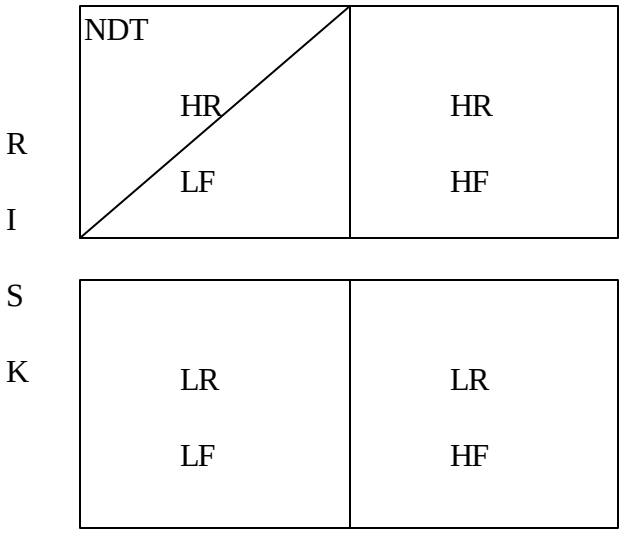
Thanks for inviting me back to San Jose to speak to you regarding your profession, the American Fire Service. Today, I will have just 90 minutes this morning to talk to you about a topic near and dear to my heart, Firefighter Safety. My goal with respect to your noble profession is a simple one: **NO MORE FIREFIGHTER DEATHS**. Before you dismiss this as the ramblings of a psycho Chippie trying to fill 90 minutes, let me ask you a question. Why can we not eliminate Firefighter deaths? Identifiable risks are manageable risks. We know what the risks are in your dangerous job. At other venues, I have addressed the issues that are over represented in your fatal summaries; heart attacks, vehicle operations, and risk assessment on the fireground prior to going into any involved structure. I think we can put a severe dent into firefighter fatalities if these three issues were forcefully addressed. Today, I want to put the icing on the cake with some thoughts on **NPCCR**, a system for learning of mistakes prior to their ending in disaster. I do not get the opportunity to speak to you often, so these handouts are more inclusive than the advertised topic. Some things I will cover quickly, but you can read these handouts at your leisure. First, some opening thoughts on the discipline of Risk Management.

Over the years, I have stressed the importance of true Risk Management. So many people, both inside and outside of the Fire Service, don't get the concept. Webster takes a stab at defining risk as the possibility of meeting danger or suffering a harm or loss, or exposure to harm or loss. As a follow then, **Risk Management is any activity that involves the evaluation of or comparison of risks and the development of approaches that change, reduce or eliminate the probability or the consequences of a harmful action.** Or more simply stated, Risk Management is the identification and evaluation of risks as well as the identification, selection and implementation of control measures that might alter risks. I like to divide risks and the management of risks into two types. First, the big picture, organizational risk management, or how to manage the overall risks of your fire department. This big system contains a number of sub systems, **PEOPLE**, **POLICY**, **TRAINING**, **SUPERVISION**, **DISCIPLINE**, and when they all work together in concert, things end up going right. Second, the smaller picture, operational risk management, or how to manage the risk of a specific event or incident, for example, a specific fire, disaster, fast water rescue or similar single event. Both of these involve the proper development and full implementation of systems. Theme Two for the day is the concept of Systems, and what this word means to you in management, supervision and in your respective line operations. Systems, when properly **DESIGNED**, kept **UP TO DATE**, and fully **IMPLEMENTED** will never let you down.

Systems. The word gets thrown around a lot but what does it mean. According to Webster – "an organized or established procedure" or "an accumulation of processes". When you check under process and procedure, you will find "a particular way of accomplishing something" and also "a series of steps followed in a regular definite order". I am a huge fan of "systems", and have been for most of my life. My "hard drive" (more on this and other thoughts regarding NLP, RPDM and learned behaviors later) was loaded by my Dad early on in life. How many times did I hear this? "There are multiple ways to do any task, and some are better than others. But there is always a best way to do anything". Make this the commitment of your organization. 99% is not good enough, particularly in the arena of Firefighter safety.

I am here to tell you today that it is does not matter why the system was not implemented, but if good systems are not properly implemented, you are in route to disaster. Challenger, Waco, Ruby Ridge, TMI, Chernobyl, Worchester, the Sadler Fire, Jack in the Box, NYPD, LAPD, Los Alamos, Singapore Air, the Soviet Submarine Kursk, the Submarine mess off the coast of Hawaii, the e-coli mess in Canada and the FBI McVeigh mess are all examples of organizations and incidents where systems were lacking, not up to date or not fully implemented. By the way, there are other concurrent themes, Customer Service, Accountability and Integrity, but these are not our lecture for today.

Here is my take on your profession. Each of your job descriptions in your fire department is a series of incidents. We want things done right. Doing things right is the key for eliminating liability, maximizing customer service, and protecting your personnel. Most incidents you encounter in the fire service end up going right. Everything goes right, no one gets hurt and everyone goes home at EOW. Why this occurs is pretty simple. Take a look at this chart.



This is the classic risk/frequency analysis. Everything we do can be put into one of the above four boxes. I have no worries when you get involved in HF events, as **RPDM** kicks in. RPDM is your friend and will be of great assistance to you.

The principals of **RPDM** are as follows. Consider your mind as a "hard drive", or for those of you over 50, a slide tray. Your daily experiences help load this drive. This process started when you were born, and some argue it commenced before you were born. Everything you do and experience is loaded into your hard drive. When you get involved in any task or incident, your magnificent brain quickly scans your hard drive and looks for a close match. Here is a great story from the August 13, 2001 LA Times.

> Chess Grandmasters Use Different Parts of Brain – Whether they're thinking about castling or attempting a four-pawns attack, grandmaster chess players and amateurs use different parts of their brain, reports the journal Nature.
>
> In the study, scientists at the University of Konstanz in Germany imaged the brains of 20 experienced chess players while they played against a computer. For the 10 amateurs, playing chess activated brain regions involved in processing new memories – as if the amateurs were intensely analyzing unusual new moves.
>
> The 10 grandmaster brains, however, were more active in regions storing older memories. The scientists conclude that grandmasters have memorized many more moves and positions and can recognize key elements in problem situations far more quickly.

My instant response when I read this was "DUH!!!" Ladies and Gentleman, this is **RPDM** in action. **RPDM** allows good people with experience to do things right. However, if you have not experienced the task you have now encountered, or do not experience it on a regular basis, then your brain cannot quickly locate a match. Without a match, you are in route to problems. HF events do not cause us problems. It is the Low Frequency events that cause us grief.

I do not get worried when you get involved in LF/LR events, as quite frankly, the consequences are not that severe. I get very worried when you get involved in incidents that fall into the top left box. This is where problems occur. Please note that this top left box has been split into two triangles, the DT and NDT tasks. Some have time to think through, and others need to be done now. Some examples are necessary.

Please remember; when you or your people get involved in a low frequency event think it through so that it will be done right the first time. This may include utilizing your DT - discretionary time (if available) to ask someone who does the task at a higher frequency (and that may mean only once more than you) how to do it so it gets done right. Fire Service operations can be very complex. However, **many** of the incidents you get involved in are **total**

discretionary time. Employment law is 100% DT. Report writing is total DT. Discipline (after stopping unsafe conduct observed) is total DT. And, many of your fireground operations have at least some DT. There are plenty of people in your profession who have done the involved task before, and they know how to do it correctly. Asking questions up front is not a sign of stupidity. Failure to slow down and ask questions when time allows on a low frequency event is a sign of stupidity. I have been preaching this for the last 20 years. Ask me any question. Any question at all in any discipline. Give me 5 hours and 5 phone calls, and I will give you the answer. Individually, you know a lot about your job. Collectively, this group present today knows a lot more than any one individual. Slow down and think before you act. If no one knows how to handle a situation (this is doubtful), then fall back on your organizational mission statement and follow the guidance therein. With all this in mind, we really need to focus on the HR/LF?NDT family of tasks. These can be identified, and once identified can be addressed through some serious training specific to the task. That was the purpose of my **SROVT** program I introduced to you in years past. Every day is a training day specific to the HR/LF/NDT's in each job description.

All of the above is the foundation for the next system, **NPCCR**. I learned this in 1975 from Chaytor Mason. He enlightened me to the writings of H.W. Heinrich, the great risk management guru of the '30's. If you get the chance, run his name through your search engine. This thoughts of the 1930's are still being discussed today, and if you take the time to read the sites that speak of him, he was extremely controversial. He developed some thinking called "BBS" of Behavior Based Safety. Since he was with the Traveler's Insurance Company, it was his belief that most accidents were caused by the worker. The company could do no wrong. He studied tens of thousands of accident reports (mostly prepared by supervisors) and concluded that 88% of them were caused by worker error.

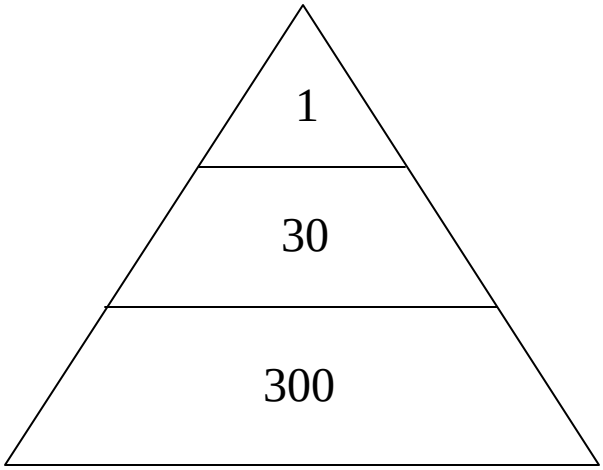
This theory inflamed some people, who blamed the work environment for the problems, not the individual worker. Unions were particularly upset with his "research' and over the years many continue to assault his theories. I have some problems with his BBS theory also, specifically when it addresses single site factory jobs. It is my belief that most of the injuries there are caused by the environment of the workplace, not the worker. If people are regularly getting hurt doing the same tasks in a controlled setting, there is something wrong with the working environment. The workplaces should be designed with safety in mind, and even if a worker gets careless, this should not result in an injury.

However, when you move out of the single factory site into the complex real world of fire service operations (freeway ops, burning buildings, hazmat incidents, and the like) Management, Supervision, Unions and the Worker must accept more responsibility for being safe. The complex, continually changing dynamics of your job require that workers regularly access their "loaded hard drive" to stay safe and avoid problems up front. Over time, your individual hard drive will load up with the experiences you have in the fire service. Some of the experiences involve "close calls" in which you almost got hurt or worse. You learned a lesson from this incident, one that you will never forget. Your hard drive is permanently loaded. Who did you share this new information with? Probably no one, because of fear of embarrassment or discipline. This is sad. Had you killed yourself or lost a leg, then everyone learns from your

tragedy. Here is a Chaytor Mason (the great Risk Manager of the 60's and 70's) quote for you.

"The only time you learn from the mistakes of another is when they end in tragedy."

This is unacceptable. Waiting for people to die so we can learn a lesson from the death is simply Un-American. Heinrich had a theory on how mistakes end up in tragedy. Capsulizing what he said regarding people, activities and mistakes, here is my take on his work. Give me a group of people doing the same or similar task. When the group makes 300 mistakes, 30 will end up in a mishap and one will end up in the "big one". We all learn from the mistakes of a fire service professional if they are seriously injured or killed. This is a <u>good</u> idea. The <u>better</u> idea is to learn when it was just a mishap. The <u>best</u> idea is to learn when it was just a mistake. What is the answer? This Triangle of Probability will be of some benefit to you. Here it is. Please take a look at it and we can fill in some information together.



Developing a non-punitive close call reporting system allows others to learn from the non disastrous mistakes of another prior to the death or injury. This program can work within your Department, or within a group of Departments so we can take advantage of the greater volume of mistakes. Optimally, we can learn from the whole group, i.e. all firefighters in America. How can we collect this data on a national level? Here are a couple of thoughts.

Take a look at Firehouse magazine (every issue since August 2001). In this Cygnus Publication, you will find an article every month focusing on "Close Calls". One of the authors of this is Chief Billy Goldfeder from Ohio. He has been around for a while and has a lot of

friends in the fire service. He has them telling him about their close calls, which he repeats in the magazine. Take the time to study these, as they have happened to people in your line of work and you can learn from their mistakes. Additionally, you can go to this web site www.firefighterclosecall.com. Firing this site up every now and then and clicking on your area of concern will allow you to read what is going on with others. And most importantly, if you have a close call of your own, you can share it with Firehouse Magazine or the webmaster. Further, sharing this information through an **SROVT** program within your own department will benefit all as we can learn vicariously from the close calls of others who are in the same line of work. And now you know the rest of the story.

Finally, Firefighter safety is an important issue for all of us. Here is Graham's Rules for Enhancing Firefighter Safety (**GREFS)** for your use and information.

GREFS 1. People are the most critical element of the safety process. Without good people, all of your subsequent efforts are for naught. Safety problems are directly caused by the lifestyle, behavior and actions of your people. People provide the solutions to safety problems and challenges. Therefore, before you hire someone, check them out as much as your laws allow. The public deserves firefighters who have the strength, skill, integrity and fitness to do this most complex and dangerous job. Not everybody is qualified to be a firefighter. The best predictor of future behavior is past behavior, and if you hire those who are unwilling or unable to live and work safely, you will pay for it downstream. Finally, since the majority of firefighter deaths are caused by heart attacks and traffic accidents, you should closely scrutinize applicants and screen out those with a history of serious medical conditions and inappropriate vehicle operations. By just doing this you can reduce the number of deaths by half. Predictable is Preventable.

GREFS 2. Management (that is you) has leadership responsibility for preventing injuries. After hiring good people who are ready, willing and able to work safely, you must give them guidance on how to do so. Developing and maintaining a policy manual consistent with worker safety is essential. The rules and protocols must be kept up to date. Good policies give different firefighters on different shifts in different locations with different supervisors the ability to encounter an incident and do it safely. Color coding the policy manual regarding HR/LF tasks is a good idea as it identifies those incidents that have a higher probability of causing the greatest problems. Since too many injuries and fatalities occur within structures on the fireground, it is essential that you have workable accountability systems in place.

GREFS 3. Employees must be continuously trained to work safely. Awareness of safety issues does not come naturally. After initial hiring, there must be immediate training regarding safety in the new employees job description. This is essential, but it is not enough. Real training is more than having a piece of paper saying they went to a safety seminar some time ago. Every day must be a training day. The principles of risk management apply here. Develop an **SROVT** program so that every worker gets an update everyday on how to continue to work safely. Emphasis should be placed on those behaviors that regularly cause injury, and HR/LF tasks in each job description. We must all teach our people to think things through when time allows. Additionally, when mistakes happen that do not end in disaster, we must have system to allow this learned knowledge to be shared with all. **NPCCR** is an excellent tool in this regard. Learning from mistakes prior to disaster is a great idea. It is your obligation to ensure that every employee has a loaded "hard drive" prior to arrival on scene.

GREFS 4. Safety is a condition of employment. Every firefighter has to recognize they have an ongoing obligation to work safely. Regular oversight and monitoring of safety performance in the workplace is essential. Supervisors must be doing their job, whether in station, or on the scene of an incident. **MBWA** and **SBWA** are essential components in this process. Walk around and look for deviations from the rules. The good news is that most of what you see will be people doing their job right on a regular basis. When you make these observations, document good performance. Good men and women will rise and fall to your level of expectations. Set the high standards, and you will get a higher level of performance. The role of on scene Safety Officers is essential. They must be trained, and free to make the tough calls relating to on scene safety issues. Finally, supervisors and managers must set the proper example. Personnel will never follow safety rules unless and until they are being followed by supervisory and management personnel.

GREFS 5. When safety rules are not followed, someone must step up to the plate and address the issue involved with prompt fair and impartial discipline. Discipline is not a function of consequence, but rather a function of behavior. If you notice a deviation from established safety policy and procedure, that deviation must be addressed. Level of discipline may well be a function of consequence, but the initiation of discipline is dependent on deviation from the rules.

GREFS 6. Most operating exposures that could result in injuries or occupational illnesses can be controlled. An essential question that must be asked on every fireground is "Does the benefit of fighting this fire justify the risks involved in fighting this fire". This goes against the grain of thinking for many people, but if the building owner did not care enough to prevent the fire, then why are we risking our lives to save a structure. Again, **MBWA** and **SBWA** are essential. Not only do we need to be watching the performance of our people, but also the continuing changing work environment in which our good people work. If you see a condition is screaming "watch out", then you should consider shutting down the operation. This behavior will send a very powerful message to all your employees. Safety deficiencies that are identified must be promptly corrected.

GREFS 7. There is a link between worker safety and productivity. Women and men who work safe are more likely to be productive. Go back to all of those early management studies in the 50's. When workers know you are concerned about their well being, you will be rewarded with a higher level of performance. Again, every day should be a training day, and firefighter safety should be a component of this training. People are our most important asset, and we must protect them.

GREFS 8. Safety extends beyond the job to be part of every person's life. It does not click on and off at the threshold of the workplace. Develop programs for your good people that they can take home with them, again focusing on the HR/LF incidents that occur outside of working hours. Recreational activities, natural disasters, vehicle operations and third party violence all need to be addressed on a regular basis. Again, **SROVT** is an excellent tool for getting this information out to your good people.

GREFS 9. Safety is a business responsibility. Ethically, all management teams have an affirmative obligation to make sure that firefighter safety is being taken seriously. You have an obligation to your "shareholders" whoever they might be. We cannot achieve our goals if firefighter safety is given the bum's rush and is a paperwork exercise only, or if safety is only discussed after someone is hurt. Finally, taking this all seriously will lessen the chance of getting hit with a serious and willful issue downstream in Court. Take it seriously.

GREFS 10. Finally, most things that go wrong in life are highly predictable. This is also true with workplace safety incidents. Most injuries and accidents are preventable. Do the job today. Recognize the five pillars of a good organization. People, Policy, Training, Supervision and Discipline. Take one of these away, and disaster is sure to result. Preventing problems is easy. It all starts with you!!!!!

Well, that sums it up for our morning together, and I thank you for your attention. Truly, you have a complex, important and rewarding job. Hopefully, the Five Concurrent Themes I spoke of early this morning will be of some benefit to you. Every task done needs to be analyzed using these Five Themes: Risk Management, Systems, Customer Service, Accountability and Integrity will better assure that things get done right.

In summary, remember it takes a good person to be a good fire service professional! But being a good person is not enough. In order to be thoroughly ethical and professional, all fire service professionals must have a good, workable policy manual that allows good people to know how to act in a given situation. Additionally, good people still have got to be fully trained to perform every aspect of their rightful work. Training is an everyday event, and it must focus on the HR/LF/NDT's. Supervisors and managers must be accountable to ensure that things are being done right, and when they are not, that needs to be addressed, not because of consequences, but because of deviation from policy. Encountering assigned incidents, getting them done right the first time while treating all with dignity and respect should be the goal for each of our employees. You as a supervisor or manager are the one who has the daily obligation to make sure this is all happening. Doing so will maximize customer service, minimize civil liability, maximize the safety of our environment, maximize the safety of our personnel, and it is the right thing to do.

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