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Continued Professional Training

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Creating and Maintaining the High Reliability Organization

Thanks so much for again inviting me to Oregon to speak to you regarding your chosen professions. I fondly recall past visits to this conference over the past two decades and I hope that my comments over the next three hours or so allow you to go back to your department and further improve your operations.

My past experiences tell me that I have a mixed group of attendees here this morning. My guess is I have a lot of people on the Fire/EMS business, some law enforcement people, some people from the 9-1-1 world, some people from other government agencies and some of you are from high-risk occupations on the private sector side of things.

Let me start with some thoughts for the law enforcement people here today – but if you think about it, these words apply to everyone, just in a different way. Recently I was asked to give some comments on the state of law enforcement operations in America – specifically all the national efforts to reform law enforcement agencies. At that conference, I presented a set of handouts I prepared in the early 1980s providing strategies and tactics that law enforcement leaders could use to improve the quality of their operations. The handouts were still relevant, 40 years later, because too many organizations did not heed those recommendations from over 40 years ago.

All the holes in the Swiss Cheese lined up recently in Minneapolis, Kentucky, Georgia, Oregon, and other states – and you are all aware of the outcomes. As I talk to law enforcement people from around America I listen to their complaints: "the fault is with Black Lives Matter, Antifa, the anti-police news media, progressive district attorneys, and the city council that is out of control, and stupid judges and ignorant legislators" and the list goes on and on about all the problems caused by these external groups.

I recognize and appreciate all the external issues, but I think that we need to take a hard look in the mirror – because too many of the problems we have today are self-generated! This is my 43rd year lecturing to public safety personnel on what WE need to do up front to prevent tragedies from occurring – and as I look at the major law enforcement tragedies in the news today – many of which has led to this national interest in our operations – my frustration has turned to anger. There are so many things that we need to do to create and maintain a high reliability organization.

As I mentioned, while the above comments are law enforcement specific, we all need to recognize that in so many organizations – private and public sector – mediocrity has replaced accountability – and for many organizations the house of cards is starting to collapse.

In my past programs, I told you that I spend a lot of my life studying tragedies including those caused by errors, mistakes, lapses or omissions – and looking for the cause of the tragedy. I continue to do that every day. All too often, when people search for cause, they default to the event that immediately preceded the tragedy and somehow that event is given the title of cause.

Here is a primer on risk management. The event that instantly preceded the tragedy can be identified the proximate cause. Real risk managers like to go back in time and search for Root Cause or conditions or cultures within the organization – issues that really caused the tragedy.

When you do this analysis conscientiously, oftentimes you will find problems lying in wait that people knew about or should have known about and no one did anything about it. And to conclude this thought when you identify root cause you can then put appropriate control measures in place to help prevent a similar tragedy from occurring again. Please do not leave this program thinking bad things are just going to happen and there is nothing we can do about it.

Allow you to give you some thoughts on Black Swans and Gray Rhinos. By the end of our time together I want you to know that there are very few Black Swans in our world – but scores of Gray Rhinos – and we need to know how to address these events proactively.

To be fair, not all tragedies can be prevented. If some idiot is bent on shooting a cop or a firefighter today here in Oregon (like we have witnessed recently around America), he (or possibly she) is going to pull it off. It is very difficult to prevent intentional misconduct.

But almost all of your tragedies (injuries to personnel, death of personnel, lawsuits and organizational embarrassments) are caused by internal error and thus can be addressed proactively – and you have a key role here in going back to your respective organizations and establishing appropriate control measures to address the real risks you face. How can this be done in your high-risk and very complex profession?

What can be done to address the voluminous risks and increasing complexity of our jobs? Almost 13 years ago we witnessed all of the problems that Japan faced with their nuclear power plant that failed after the earthquake and subsequent tsunami.

That ongoing event has caused me to recall a name from graduate school – a man who was attempting a very complex and risky assignment and who faced tremendous obstacles. His name was Admiral Hyman Rickover, known to many of you as the father of the U.S. nuclear navy.

I was fortunate enough to be introduced to his work when I was a young kid in grad school in the mid ‘70s – and as I was impressed with what this immigrant to the U.S. in 1906 was able to do for our nation in the ‘50s, ‘60s, and ‘70s.

The end of the story is that he directed the building of a nuclear fleet that has not only protected our country and the rest of the free world, but that simultaneously has achieved an outstanding safety record. This impressive safety and reliability record is the result of a lot of hard work by Admiral Rickover and his staff.

He developed some rules to achieve success (read – safe operations and deployment ready) known colloquially as the Seven Rules of Rickover. One of the goals of the graduate program I was in was to learn how his rules could be made applicable to other branches of the U.S. Military. As I sat there in night school at USC 49 years ago, I was wondering if these rules applied to my complex, high-risk job in CHP operations.

As you read these, ask how many of them apply to the complex high-risk organizations that you work in. Let’s take a look at each of these rules and explore the possibilities.

Rule 1. You must have a rising standard of quality over time and well beyond what is required by any minimum standard.

We have to get better and better at what we do. Minimum standards are just that – minimum standards. Our profession deserves better than minimum standards. The communities you serve deserve better than minimum standards. Our personnel deserve better than minimum standards. The people you have in-custody deserve better than minimum standards.

We must be constantly looking for a better way to do things. Status Quo – we have always done it this way – is no longer acceptable. And sadly, I see a lot of status quo in public safety agencies around this great nation.

Continuous improvement has got to be part of the way we do business. Anything you can quantify and anything we can measure has to be identified and we must be constantly searching for the next best way. And when we find the next best way must commence the search for the *next* next best way. And I am not talking about change for change's sake – but a bona fide effort to continually improve the way we do business.

Strategic Hints for Your Consideration:

- What is the level of accuracy in translations in your dispatch center?
- What is the lost time injury rate in each unit of your organization and what control measures can you put in place to reduce this injury rate?
- What are the fleet maintenance costs throughout your department and what can be done to reduce these expenditures without increasing response time?
- What is your fleet mileage and what can be done to increase that number?
- What is your turnaround time on investigations and what can be done to lower that time?
- What is your response time to a call for assistance from a citizen and what can be done to decrease that time?
- When was the last time your people were trained and tested on their core critical tasks? If you don't get anything else out of my three hours with you – please take this back to your organization.

Rule 2. People running complex systems should be highly capable.

Successful high-risk operations require people who know how to think. Fifty years ago, you did not need to be all that sharp to be a cop, dispatcher, or firefighter. Back then you had to be competent and a hard worker.

While the above attributes are still important, we must recognize that things have changed. Technology, equipment, strategies, and tactics involved in providing services to our community and protecting our citizenry have all changed. This is an extremely complex job, and if you hire people who can't think things through, you are en route to disaster.

If you allow the hiring of idiots, they will not disappoint you – they will always be idiots. In view of the consequences that can occur when things do not go right in your complex, high-risk job, this may end up being

the cause of a future tragedy. We have learned this lesson time and time again, but somehow seem to forget it all too often.

And please don't tell me that you have nothing to do with the hiring process. Each of you has a role in recruitment and each of you has a role in the probationary process of each employee. More on this throughout our time together, but you have got to take your role in these processes seriously.

I could tell you stories from now until tomorrow about organizations – including organizations just like yours – from around America who failed to weed out a loser and paid the price. Every nickel you spend in weeding out losers up front has the potential to save you a million dollars. If you get bored tonight just Google "Annie Dookhan" and see how much grief one bad employee can do. If you have some extra time – take a look at "Sonja Farak." If you want to be scared – check out the "Fort Dix Six." When will we ever learn?

Strategic Hints for Your Consideration:

- Does your workforce reflect the relevant workforce of the community you protect and serve?
- After date of hire, when is the next time you do a background investigation on your personnel?
- Do you have a process to assure that the probationary period is being taken seriously?
- If I were to audit two years' worth of performance evaluations, what would I find?

Rule 3. Supervisors have to face bad news when it comes and take problems to a level high enough to fix those problems.

When you take an honest look at tragedies in any aspect of high-risk operations, from the lawsuits to the injuries, deaths, embarrassments, internal investigations, and even the rare criminal filing against our own personnel, so many of them get down to supervisors not behaving like supervisors. The primary mission of a supervisor is systems implementation.

If you promote people who either can't or won't enforce policy, you are in route to tragedy. To be sure, the transition from line employee to supervisor is a difficult one, but the people you choose to be supervisors have to understand the importance of their job.

Sadly, we have too many people who call themselves supervisors who have never made a successful transition from buddy to boss. Not to beat this point to death, but you show me a tragedy in any high-risk operation – including some in the news today – and I will show you the fingerprints of a supervisor not behaving like a supervisor – or a supervisor who tried to do his/her job and was not supported by management.

Strategic Hints for Your Consideration:

- What is the process you have in place to promote people? Is there a better way?
- Do you have a formal training program prior to their being promoted?
- Do you have a formal mentoring program to assist them in this transition?

- Do you analyze events after occurrence to assure that supervisors were doing their jobs? This is a trick question – please reread it before you think of an answer!

- Have you considered bringing back the best of the best to help train and mentor your new supervisors? I really like this idea and I know it can work for you. One of my legacy projects (that's always a morbid thought) is entitled Your Black Swan is Someone Else's Gray Rhino – just because it is new to you does not mean it is new to your agency or profession. Archiving and sharing institutional knowledge is absolutely essential!

Rule 4. You must have a healthy respect for the dangers and risks of your particular job.

All your jobs are high risk in nature, and the consequences for not doing things (tasks, incidents, events) right can be dramatic. Remember the basic rules of Risk Management: **RPM** - Recognize, Prioritize, Mobilize. Later in the program we will discuss (in detail) the importance of the risk assessment process – and you have a key role in recognizing the real risks you and your personnel face.

You must recognize the risks you face. You must then prioritize them in terms of frequency, severity, potential of occurrence, and time to think. Then you must mobilize - act - to prevent the identified problem from occurring. Also, you must fully understand that the job you have chosen is filled with risk and that there is always a potential for the unthinkable (take a look at a great book by Amanda Ripley – *Unthinkable*) event to occur in our workplace.

Strategic Hints for Your Consideration:

- Have you done a risk assessment on each job description in your organization? In your job description, how do personnel get killed, hurt, sued, fired, embarrassed, or indicted? We will discuss this in detail, but you must know this information for your specific job description.

- Do not limit your assessment to the past history in your organization. There are scores of other high-risk just like yours around America and we need to learn from their tragedies. There is also value in learning from tragedies in other high-risk occupations.

- Have you developed a protocol for prioritizing these high-risk tasks?

- Have you developed systems (aka policies) to fully and properly address the risks your department and personnel face?

- The value of **www.police1.com** and **www.firerescue1.com** When I was active I looked at sites like this every morning and found a tragedy that occurred in some law enforcement agency. I then asked this question: What control measures do we have in place in the CHP to prevent that from happening here? You need to be doing this daily!

- Do you have a process in place to identify emerging Core Critical Tasks?

Rule 5. Training must be constant and rigorous.

Every day must be a training day! We must focus the training on the tasks in every job description that has the highest probability of causing us grief. These are the High Risk, Low Frequency, Non-Discretionary time

events: shoot, don't shoot; jail fires, two in-two out, tail rotor failure, AED usage or workplace violence events – that are considered core critical tasks. These are very risky, done rarely, with no time to think.

Every job description in your operations has these core critical tasks. These have to be addressed seriously. We must ensure that all personnel are fully and adequately trained to address the tasks that give them no time to think, and that they understand the value of thinking things through when time allows.

Strategic Hints for Your Consideration:

- Do you have a daily training program that focuses on core critical tasks?
- Do you have a process to assure that the training is being taken seriously?

Rule 6. Audits and inspections of all aspects of your operations are essential.

Audits and inspections are an important part of your job as a leader in high-risk operations. We cannot assume that all is going well. We must have control measures in place to assure things are being done right. This is not micro-management – it is called doing your job. We need a feedback loop in every organization.

And while I am ignorant regarding the internal workings of your specific operations – I've looked at too many public sector organizations in detail – audits are either non-existent or a joke. I call these the "lip service audits" where we are very concerned about having a piece of paper in place saying we are all squared away, when in reality that is not true.

If you do not have the audits (formal and informal) in place, you will not know about problems until they become consequences, and then you are in the domain of lawyers. Then it is too late for action, as all you can do at that point is address the consequences.

And if you take the time to study the life of Admiral Rickover, you will quickly learn that he was widely despised in the navy because of his insistence on using the audit process as a tool to hold people accountable. And with the recent scams going on regarding COMPSTAT and NCLB – (if we have time I will get into this) – we need to take a close look at these issues.

Strategic Hints for Your Consideration:

1. Policy/Procedure manual – are they properly designed and up to date?
2. Evidence/Property room – recognize they are ticking time bombs.
3. Training records and compliance – is your organization in full compliance?
4. Performance evaluations – are they problems lying in wait?
5. Financial – everything dealing with money is filled with risk.
6. Confidential computer access/E-mail/MDT
7. Case clearance and informant issues

8. Background investigations – initial and ongoing considerations.

9. Crime laboratory – hopefully you have a state crime lab in place.

10. Crime analysis – what are you learning from the collected data?

Rule 7. The organization and members thereof must have the ability and willingness to learn from mistakes of the past.

Analysis of past data is the foundation for almost all risk management. All of us in public safety are making the same mistakes over and over again.

As I read the lawsuits, injuries and deaths, organizational embarrassments, internal investigations and even the rare criminal filing against your personnel I know that we can learn so much by studying the mistakes we have made in the past. It all gets down to risk management.

Here are three statements that have guided me through most of my risk management life. First is a quotation, albeit paraphrased, from the great risk management guru of the '40s, Archand Zeller:

> The human does not change. During the period of recorded history, there is little evidence to indicate that man has changed in any major respect. Because the man does not change, the kinds of errors he commits remain constant. The errors that he will make can be predicted from the errors he has made.

What does this mean? We have not figured out any new ways to screw things up. We are making the same mistakes over and over again. Mines have figured out no new ways to collapse. Ships have figured out no new ways to sink.

Refineries have not figured out any new ways to blow up. Restaurants have not figured out any new ways to kill people. Planes have not figured out any new ways to crash. Firefighters have figured out no new ways to die. Cops have figured out no new ways to get in trouble.

Please do not give me that nonsense that bad things just happen and there is nothing you can do about it. I am sick of hearing that faulty "poor me" refrain.

I can show you organizations in every high-risk profession that are underrepresented in problems because they understand the principles of risk management starting with the reality that there are no new ways to get in trouble.

To be fair, there are variations on a theme, but in reality, it is the same stuff over and over again. Let me jump ahead in the lecture.

IDENTIFIABLE RISKS ARE MANAGEABLE RISKS

The second statement important in my life thus far came from my mentor, professor, and friend Chaytor Mason. He was a risk management guru in the '60s. Here is a capsulized version of his response when I accused him of being the smartest person who ever lived:

The smartest person in the world is the woman or man who
finds the fifteenth way to hold two pieces of paper together.

My instant response when I first heard this was confusion, but then I figured it out. While there are no new ways to screw things up (Zeller) there are always new ways to fine tune and revisit our existing systems to prevent bad things from happening and simultaneously making us more efficient.

We too must be looking for new and improved ways of doing this most complex job, and you are the ones who can do that. There are better ways to hire personnel, and there are better ways to train them. There are better ways of doing performance evaluations, and there are better ways to track personnel to identify future problems.

Status quo (we have always done it that way – we have never done it that way) does not work. There is a better way of doing business, the 15th way, and we must constantly be looking for it. My third belief in life is a summary of the above two thoughts.

PREDICTABLE IS PREVENTABLE!

Well, that wraps it up for our brief time together. My program today was a broad discussion of risk management concepts.

I do not undertake to provide specific recommendations as to best practices in a particular scenario, and nothing in this presentation should be construed as legal advice or a recommendation by me to follow a specific course of conduct when presented with a particular risk or situation.

Please recognize that any hypotheticals or examples provided in the program today are to encourage understanding of broad risk topics, and are not to be interpreted as any recommendation to modify the existing practice you have in your operations.

Before you make any changes to the way you currently do your job, please contact your organization's attorney. Thanks for your attention today and for all you do to make things better in our world.

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