



Heat Injuries: We Talk About Prevention, But Are We Practicing What We Preach?

A tragic loss of life and a recent industry safety conference are reminders that recognizing a hazard is only the first step. What we do to prepare for it can make all the difference.

Heat Risk: Why Knowing Better Doesn't Always Mean Doing Better

Most of those in the safety profession understand the dangers of excessive heat exposure. We know that heat illness can develop rapidly, with potentially fatal consequences, and that effective prevention requires more than simply reminding people to drink water. Yet serious heat-related illnesses continue to occur, sometimes in organizations with considerable safety expertise and established prevention programs. Why doesn't our understanding of the hazard translate into management of risk?

Two Experiences, One Important Question

Two recent experiences prompted reflection on this question. The first involved the tragic death of a young man participating in a demanding military training exercise in extreme heat. He reportedly became severely disoriented during a long-distance run, and difficulties obtaining emergency assistance delayed medical treatment. Despite intensive hospital care, he subsequently died. We do not know enough about the circumstances to judge the arrangements or decisions involved, but the incident raises valid questions about anticipating and preparing for medical emergencies.

The second experience was much less serious. At a safety industry

conference in Texas, exhibitors transported equipment considerable distances in exceptionally hot weather. Cooling arrangements were initially inadequate, and dismantling exhibits required further physical activity during the hottest part of the day. At least one attendee developed symptoms of heat illness and withdrew. Fortunately, the consequences were limited, but the experience illustrates how even safety-focused organizations can encounter difficulties managing familiar hazards.



The circumstances and consequences were very different, but both events raise the same question: *How do organizations that recognize a hazard find themselves inadequately prepared for the conditions in which people encounter it?*

The Gap Between Planning and Reality

Organizations make assumptions when planning activities. They anticipate the conditions, make estimates about physical demands, identify applicable resources, and establish arrangements they believe will be adequate. These decisions are generally made by capable

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people working with the information and constraints available to them. However, the conditions people actually experience may differ considerably from those anticipated.

A short walk becomes demanding when carrying equipment in extreme heat. A temporary workspace becomes hazardous with cooling arrangements that prove inadequate. A demanding physical activity becomes a medical emergency when someone develops a heat-related illness.

The tenets of Human and Organizational Performance (HOP) encourage us to understand how work actually happens, rather than relying exclusively on how we expect it to happen.

When incidents occur, identifying what should have been done differently is relatively easy. Understanding why the original arrangements initially appeared reasonable is more challenging and potentially more valuable. What assumptions influenced planning? What operational or financial constraints shaped decisions? Were there opportunities to recognize and respond to changing conditions?

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Responsibility, Accountability and Culpability: Safety's Problem with Words

When something bad happens in the workplace co-workers, supervisors and managers historically would have most likely blamed the person who was involved and exacted some sort of punitive measure. With the introduction of HOP (Blame fixes nothing; Human error is normal), leaders may still succumb to the natural tendency to respond along the lines of "that guy who messed up may have had a slip or a lapse but still needs to be held accountable for the consequences". But do we know what they actually mean?

Safety practitioners use a variety of definitions that purport to separate responsibility from accountability in the workplace. Distinguishing between these words and their near synonym "culpability" is particularly useful in a HOP context to avoid organizations collapsing them into "who gets blamed?", which is the antithesis of HOP soundbite #1 "blame fixes nothing".

There is considerable overlap in everyday English, which is exactly why discussions about "accountability" in HOP can become muddled. The three words occupy overlapping territory, but they are not synonymous. The Merriam-Webster definition of responsibility exposes the linguistic problem rather neatly: the ordinary meanings of responsibility and accountability are genuinely entangled, and "take responsibility for the incident" can mean at least three different things:

Duty: "This was mine to manage."

Answerability: "I am the person who must account for what happened."

Culpability: "I accept that I was at fault."

HOP does not require us to abandon responsibility or accountability. People still have responsibilities, and they should be answerable for how those responsibilities are fulfilled. The difficulty begins when accountability quietly becomes a synonym for culpability; when being answerable for an outcome becomes being

blameworthy for it. HOP asks us to resist that leap and first understand why actions made sense in the circumstances in which they occurred.

Here's what we mean when we use these words...

Responsibility is about the work a person or role is expected to perform, such as completing a task, following a process, making a decision, or raising a concern.



Accountability is about being answerable for how a responsibility was fulfilled. This includes both the quality of its execution by the worker and the work context provided by the organization: the systems, conditions,

and adequacy of support surrounding the work that allow the responsibility to be fulfilled well. Ultimately this means that leaders are accountable for managing risk.

Culpability is different: it concerns blame or fault, and should not be treated as the automatic result of an unwanted outcome.

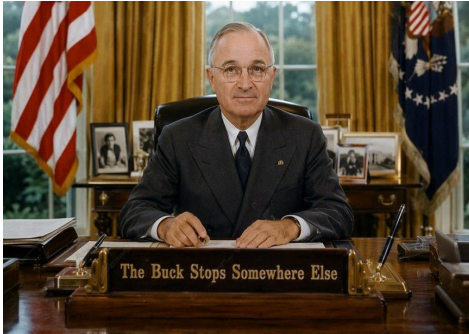
In HOP terms, this distinction matters because responsibility may sit close to the task, while accountability often extends upward to the leaders and systems that shape how the task is performed. A worker may be responsible for operating equipment, but leadership remains accountable for whether that equipment, training, procedures, staffing, and work environment are reasonably designed and maintained.

That means accountability can operate in both directions. Workers may be accountable for participating honestly in learning, raising concerns, and working within reasonable expectations. Leaders are

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	Core everyday meaning	Implies fault?	Implies consequences?
Responsibility	Something is yours to do, manage, or take care of	Not necessarily	Not necessarily
Accountability	You are answerable for what was done or what happened	Sometimes	Often
Culpability	You are blameworthy for something that went wrong	Yes	Usually

Safety Starts With - Who?



Recently, during a safety industry presentation on holding effective Learning Teams events for the Energy Corridor Section of ASSP Gulf Coast Chapter, a vPSI Consultant presented this AI-generated image following a previous slide with an employee looking into a mirror that had a sticker "Safety Starts with You!"

Our consultant asked the group three questions:

1. Who is the person?
2. What is wrong with the picture?

3. Why does the misstatement matter when talking about leadership taking action after a Learning Teams event?

For those who aren't aware, US President Harry Truman famously had a plaque on his desk that stated, "The Buck Stops Here." Setting aside the concept of three co-equal branches of government, the inference of this saying is that the final decision, and therefore Accountability, rests with him.

The third question was intended to initiate a debate about the "Safety Starts with You" versus "The Buck Stops Here" contrast in safety leadership. If we can agree that the context, culture, and conditions of the work are established by leadership, then should we think about where that sticker on the mirror should really be placed? Should it be in the leadership meeting rooms and locker rooms? If so, what could

replace the sticker (or do we really even need one) in the front-line employee area?

Maybe something like "Safety is the outcome of all the decisions made prior to today, and how do you adapt?" A bit wordy but it sends a better message.

When conducting Learning Teams, it is imperative that organizational leadership review and act on recommendations coming out of the event. This will help shape the work environment and reduce risk.

One element of #Riskwashing, and antithetical to HOP, is to say to the employee safety starts with them. They are on the receiving end of what the organization gives them.

Side note about AI: it was used to generate the picture but not for writing this article.

Responsibility, Accountability and Culpability: Safety's Problem with Words

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accountable for the systems, resources, priorities, trade-offs, and organizational conditions within which people work and, critically in the HOP context, for doing something with what the organization learns.

The problem arises when an unwanted outcome causes these three ideas to collapse into one another. Someone had responsibility for the work; therefore they are held accountable for the outcome; therefore they are considered culpable. Each step can feel perfectly reasonable, particularly with the benefit of hindsight, but none necessarily follows from the one before it. Having a responsibility does not mean that every

outcome associated with it was within the person's control, and being required to account for an action does not establish that the action was blameworthy.

So, the next time someone says, "People still need to be held accountable," perhaps the appropriate response isn't to agree or disagree. It is simply to ask: "What do you mean by accountable?"

HOP does not remove responsibility or accountability. It asks us to be much more careful before turning either into culpability.



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These questions help us understand the organizational conditions that influence decisions and identify the real opportunities for improvement without just attributing shortcomings to individuals.

From Hazard Awareness to Operational Capability

Familiarity can also influence how organizations perceive risk. In many parts of the world, extreme heat is a routine feature of working life. People develop effective ways to adapt, but familiarity can also encourage acceptance of exposures that might attract greater attention elsewhere.

Organizations may apply rigorous heat management arrangements to their primary operations while overlooking supporting activities such as training, maintenance, travel, or temporary events. The hazard remains the same, but the arrangements for managing it may be very different.



Effective heat risk management therefore requires more than written procedures. Organizations need the capability to anticipate the exposures, recognize changing conditions, arrange and provide effective emergency arrangements, and adapt activities when necessary. Importantly, heat illness can impair judgment, making it dangerous to rely entirely on individuals to recognize their own symptoms and seek assistance.

People must also have the resources, authority, and confidence to modify or stop activities when conditions warrant.

The Real Test

The distinction between knowing about hazards and managing them effectively extends far beyond heat illness. Existing risks routinely interact with changing conditions, competing demands, imperfect information, and people's assumptions that prove unreliable.

Rather than asking only whether people followed the plan, we should examine whether the plan reflected the realities of the work and whether people could actually recognize and respond to emerging difficulties.

Perhaps the most useful question isn't "Why didn't they know better?"

It's "What would have helped them do better?"

Ask about our upcoming *Learning From Incidents including Human Performance Factors* workshop in Houston, Texas, scheduled for December 1-2, 2026.

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