



### Silo Busting

All organizations aspire to continuous improvement. The most effective and sustainable improvements have long term impact and are applied broadly across an organization. Unfortunately, this is often easier said than done.

Particularly in larger entities, Construction is counted as successful if projects are completed on time and within budget, the Safety function's success is based on fewer injuries, the Risk Management group is successful when insurance costs (including workers' compensation) are low and Human Resources celebrate when wage costs are trimmed. It is easy to see how conflicting goals, and any compensation tied to those goals, can create a win / lose decision environment and ultimately silo behavior.



Haughley Silo Demolition, photo by Bob Jones

Dictionaries define a "silo" as a tall, cylindrical structure, usually in an agricultural setting, in which fodder or crops are stored. In current management-speak, an organizational silo is a department that has a specific function within the company. In theory, these silos work with each other for the greater good of the company, however the term "silo" is almost always used negatively in the business context.

Adverse business consequences of silo-ing include reduced (or absent) cross functional cooperation, withholding of information, failure to share improvement opportunities, power struggles and turf battles, lowered organizational efficiency, and diminished productivity. The organization is rigidly hierarchical, with little communication between functions except at managerial levels. Bureaucracy is rampant; getting something done may necessitate going up one silo to management, then down another silo to the level of implementation.

Accepting the premise that getting work done safely is the same thing as getting it done right, one of the most important inter-functional relationships is clearly the connection between Safety and Production / Operations. If present, silo behavior between these two functions can be detected in the way the organization responds to problems such as incidents:

- Incident investigation and development of corrective actions (or

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recommendations) is the responsibility of safety personnel, while implementation can only be approved and completed by the operations function.

- Two or more functions conduct separate investigations into the same event.
- The scope of investigations is limited to the organizational element directly involved in the incident and does not examine how business processes in other silos may have caused or allowed the problem to arise. In reality, the cause and effect trail often leads back to acts or decisions made far from the immediate scene.
- Barriers between functions get in the way of determining where a problem originated within the organization.
- Placement of corrective actions is limited to processes within the business unit involved in the incident. The optimum home for a

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corrective action may be in a management system “owned” by another silo, such as modifying a procurement specification to resolve an operational problem.

- Recommendations or corrective actions are developed that look good within the Safety function, but which will have no effect in an operational reality.
- It is difficult to take full advantage of the learning opportunity afforded by an incident by applying it broadly across the organization.

The segregation of the Safety function from the remainder of the business enterprise has been driven to some extent by regulatory authorities and the current performance measurement scheme of simply counting the number of employee injuries. To other functions, such accounting may appear to be a completely separate issue from getting work done, and thus a silo is born. It is too much to expect a scheme devised over 100 years ago for workers’ compensation purposes, and further impeded by hundreds of pages of bureaucratic interpretation of work relatedness, to still be a suitable yardstick of success given the huge enterprises and massive projects our current economy demands.

It is easy to say that loss prevention is the responsibility of every department and position, but in reality, the Safety function is often specifically tasked with addressing such issues. In some companies it is still the Safety Person’s job to make sure that no one gets hurt while the rest of the organization gets on with its business. In contrast, real continuous improvement demands cooperation and collaboration across functional boundaries; it requires bridges to be built between silos or that the silos be torn down. Several recent catastrophic losses have revealed organizational factors as dominant causes, leaving little doubt of the importance of creating coherent and logical interdependence between the occupants of each silo.

Many of our readers have safety in their job title or job description, or have the financial, legal or, at a minimum, moral responsibility to protect the enterprise’s assets. Being involved whenever things go wrong, the Safety function can play a uniquely useful facilitating role in this, if given the appropriate tools and permitted to do so. Many silo leaders do not fully understand the benefits this can offer in sustainable improvement across functional barriers.

The Safety function can deploy several tools and techniques to initiate, and get functions in the habit of, working collaboratively towards broadly optimized improvement in their organization.

- Allow those directly involved in the incident to propose corrective actions for logically simple incidents, independent of the consequences. In general, those

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Remains of the Spiller’s Silo, photo by Andy Beecroft

### Twitter

Do you have a Twitter account? Follow us on Twitter @vPSIGroupLLC. Here are a few examples of what you will see!

Chew on this: vague phrases such as "making #safety a priority" & "creating a #safetyculture" have little meaning. Agree/Disagree?

Corporate Schizophrenia: many maintain that all accidents are preventable yet accept an unavoidable level of risk in their operations.

“Should” statements are symptoms of implementation impotence.

There’s a fine line between business process and bureaucracy. Which side of the line is your company on?

Eliminating a known exposure  $\neq$  eliminating a future incident. Even if you do nothing, it’s possible the future event won’t happen.

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local to the event know what happened, why it happened, and how to prevent it from happening again.

- Assess proposed corrective actions on the basis of their real-life effectiveness instead of some theoretical ideal world. This requires confronting some difficult truths since many of the standard responses to unplanned events have little impact in reality.
- Integrate the incident investigation process with implementation of corrective actions. Until something has actually been done that impacts future probabilities, the objective of the investigation has not been achieved.
- Measure the integrated process with a single Key Performance Indicator (KPI). Aligned and interdependent metrics that reflect the efforts of more than one silo force alignment, communication, and collaboration.
- Put in place a formal mechanism for sharing and implementing high quality corrective actions across business units and functional groups.

## Combining Business with Pleasure



The duckmaster and his raft of ducks at the Peabody Hotel.

In early February, two of our consultants were in Arkansas for training at Southwestern Energy (SWN). They stayed at the Peabody Hotel in downtown Little Rock and were delighted to encounter the renowned Peabody Ducks. Since the 1930s, the Peabody Hotel has had a

twice-daily march of ducks through its lobby, complete with a red carpet and a Duckmaster of ceremonies.

March saw vPSI consultants doing our first vPSI training in the Marcellus shale area in Scranton, Pennsylvania (the fictional home of the US version of the popular comedy, *The Office*). Our consultants heartily recommend Carl Von Luger's Steak & Seafood restaurant.

As sustainability and continuous-improvement concepts are adopted more generally, senior management is reaching a broader acceptance that “safety” is not something done outside the core operation of the business. Optimized asset protection across functions naturally leads to continuous improvement at the enterprise level. Although tearing down organizational silos seems an obvious recommendation to make, it is unrealistic to expect that this is achievable in real life. We can, however, build more effective bridges between silos given the right integration machinery. Such a mechanism already exists: the vPSI System™.

## Upcoming Training Classes

**Fundamentals of vPSI Problem Solving and Accident Prevention** is vPSI Group's core class. It provides attendees with the tools necessary to do a critical analysis of their corrective actions and problem solving efforts.

We currently have one workshop scheduled in Alaska on April 12th and two workshops scheduled in Houston: May 15th and July 11th. For more information, visit our Eventbrite page or contact us.

While in Pennsylvania, our consultants were able to visit the Tunkhannock Viaduct (also known as the Nicholson Bridge), which was the largest concrete bridge in the United States for 50 years after its construction in 1915.



Norman Ritchie of vPSI Group and Josh Harvey of SWN, preparing to ski down Elk Mountain.

To round out their time in Pennsylvania, our consultants and SWN's two newly-certified vPSI System Trainers were brave enough to try night skiing at Elk Mountain. You'll be relieved to know that they did survive the trip.

More vPSI travel photos can be found on our Facebook page.



## Reasons We Are Not Getting to Zero

For many years now, it has been popular for organizations and industries to set the lofty goal of “Zero Accidents.” The Oil and Gas Exploration and Production (E&P) Industry is among those who have set this noble aspiration.



Our organization is in the somewhat unique position of being able to review a large number of incident and accident reports from a variety of E&P companies, which has enabled us to see commonalities that contribute to the inability to reach that highest of ambitions.

Norman Ritchie of vPSI Group will address this topic at the SPE/APPEA International Conference on Health, Safety & Environment in Oil and Gas Exploration and Production in Perth, Australia in September 2012.

## Another Reason to Review Your Safety Incentive Scheme

When an employee stubbing their toe has the same weight in safety performance measurement as a critical system deviation leading to a serious burn victim, both industry and regulators eventually begin to recognize that something more sophisticated is needed. You can see a hint of retreat in recent “official” high consequence event investigation reports, with the differentiating terms “personal safety” and “process safety” a great deal more commonly in vogue of late.

To be fair, in the USA OSHA has been attempting for some time to reduce the use of injury based metrics beyond their original design intent of industry to industry comparison. Their latest salvo is directed squarely at safety bonus incentive schemes based on injury rates. Although the drawbacks of such incentives have been well known for many years by the safety profession, their use has continued unabated, in part because viable alternatives are not yet firmly established.

On March 12th, 2012 OSHA issued a new memorandum entitled “Employer Safety Incentive and Disincentive Policies and Practices”. Based on Section 11(c) of the OSH Act, and by way of whistleblower protection, this memo takes a swing at the potential for safety incentive schemes to discourage reporting of injuries. In particular, it states: “if the incentive is great enough that its loss dissuades reasonable workers from reporting injuries” such a program may constitute a violation.

You have been warned.

## Number Crunching

Under normal circumstances, for every million man hours worked:

- Those involved will make an estimated **5 to 10 million\*** mistakes or errors. In vPSI parlance, this equates to 5 to 10 million undesired Acts of People.
- Working under the assumption that nothing goes wrong as a result of 99.99% of these mistakes, **500 to 1,000** Unplanned Events could be expected to occur (either with or without consequential loss).
- Based on the Minor Incident Metric of one outstanding vPSI System™ user company, it is reasonable to state that for every loss event there are approximately 100 no loss, or near miss, events. As a result, you can expect **5 to 10** loss events to occur for every million hours worked as a result of mistakes made by those involved.
- These losses will be some unpredictable degree and combination of injury, asset damage, business interruption, environmental, quality, legal, regulatory and / or reputational harm.

In stressful, emergency, or other unusual situations, the numbers can be expected to be even higher.

\*Amalberti, R. (1996). La Conduite des Systemes a Risques. Paris: Presses Universitaires de France.

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