

Beyond The Cab

The only safety management newsletter dedicated exclusively to addressing injury prevention and workers' compensation cost control for trucking companies.



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Lessons from Columbia

A few weeks ago (August 26, 2003), the official report was released addressing the Space Shuttle Columbia tragedy in which 7 astronauts lost their lives. The report indicated that a piece of foam insulation peeled from the external fuel tank during launch, struck the wing at a high speed and damaged one of the wing's heat shields. When Columbia re-entered the atmosphere, superheated air penetrated the wing and melted it from the inside, causing the spacecraft to break apart. In four simple words, "The foam did it."

But the 248-page report didn't end there. Instead, it went on to indicate that deficiencies within the safety culture of NASA permitted this scenario to occur. Furthermore, the report warned that NASA's "broken safety culture" would (not could) lead to tragedy again unless fundamental changes are made.

So far this probably doesn't sound too much like a safety management newsletter directed at the trucking industry. However, there are at least four facts that are important for managers within the trucking industry to take from the Space Shuttle Columbia investigation.

They Kept Digging

It wasn't too deep into the investigation that the foam insulation was pegged as the proximate cause of the Columbia tragedy. But the investigators didn't stop there. Over a 7-month period, they examined more than 30,000 documents, conducted more than 200 formal interviews, heard testimony from dozens of expert witnesses, and reviewed more than 3,000 inputs from the general public. The investigators kept digging, kept asking "why" and didn't stop until they exhausted their intellectual resources. They didn't stop when they identified the most obvious cause. They kept digging until they identified the root of the problem.

It happens far too often that safety directors within any industry, including the trucking industry, are made aware of an injury, gather the

facts and then immediately (perhaps intuitively) peg the cause of the injury. Whether the "cause" of the injury is failure to follow procedures, carelessness, or a slippery running board, the investigation far too often ends there. The root of the problem has not been identified, only a symptom of the problem.

To be effective in preventing future similar injuries, you must keep digging and keep asking "why" until you've exhausted your intellectual resources and have identified the root of the problem.

They Used a Team Approach

An investigation team of 13, with a staff of more than 120 and some 400 NASA engineers were used to get to the bottom of the Columbia tragedy. Obviously, the task that lay before them was ominous, and hardly analogous to analyzing an incident in which a driver was injured while sliding his trailer tandems. Nevertheless, the principal is applicable to any injury investigations.

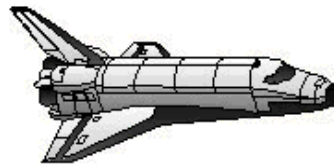
You probably heard it from someone with a healthy dose of common sense, "Two heads are better than one." With respect to injury investigations, this simply implies that you will have more experiences from which to draw and more diverse insights when a team approach to analyzing why the incident occurred, and what can be done to prevent it in the future. At a minimum, you should be soliciting the input from one or two other drivers when analyzing an injury that involves a driver.

You may know the operation better than anyone else. You may even be the founder, owner and president. But none of that guarantees that you will have the best solutions to the problems, nor does it mean that you will even be effective in identifying what the real problems are.

Not Satisfied with a Single-Cause Theory

The investigation of the Columbia tragedy could have placed all of the focus upon the piece of foam which peeled-off and struck the left wing.

The investigation could have pegged the "broken safety culture" as the sole underlying cause for the disaster. But instead of attempting to arrive at a single cause for explaining what happened, the investigation identified a multitude of issues that combined to permit the series of events that are now an unfortunate part of American history.



As managers responsible for the safety of employees within your own company, you can learn from the example of the Columbia investigation. Instead of

being content with identifying one thing that appears to have caused the incident, search for more.

A "Safety Culture" Exists

One of the fundamental flaws that lead to the Columbia tragedy is a broken "safety culture" within NASA.

Regardless of whether an organization is a multi-billion dollar space program or a trucking company with 3 drivers, there is a culture within the organization. For better or for worse, the safety culture within your company can have a profound impact upon the presence or absence of accidents, the morale of employees, the rate of employee turnover and so much more.

Although evaluating the employees' perception of your company's safety culture will be a topic that will be addressed in a future *Beyond the Cab* newsletter, consider the following statements as a self evaluation.

Our injuries are not that serious just lots of little things

Accidents are the nature of the job or the business"

Most safety stuff is just common sense

Accidents are just bad luck

If you or members of your company's management team can relate to these comments, your company's safety culture is likely broken too.