Safety Leadership

Behaviour and Safety

A business issue

In all areas of business performance it is now widely accepted that one of the key differentiators between high and low performance is how people behave. As human beings we are prone to error, and these errors have an impact on performance. High performing organisations focus on creating the conditions that create high reliability behaviour.

When the focus is on health and safety, the picture is no different although the motivation to improve current performance has wider considerations. Whilst health and safety performance can and does have a direct impact on the bottom line (poor health and safety costs money) it is also an ethical / moral issue. In these days of corporate citizenship and business ethics, looking after the health and safety of employees and of those who come into contact with the company is no longer an option. UK and EU legislation provides a further factor - the emphasis on legal responsibility is one that should focus the minds of those who occupy responsible positions. We live in an age of corporate social responsibility.

Why is behaviour important?

What this means is that health and safety is for many organisations an increasingly serious business. A poor safety record can make a difference between profitability and insolvency, can seriously damage an organisation's reputation, increases exposure to litigation and action by the HSE, and increasingly is regarded as being morally indefensible. Most importantly, poor safety ruins people's lives!

Most organisations now appreciate that a good safety record makes good business sense and so aspire to achieving the highest levels of performance. Just one incident or accident is now held to be one too many! However, even

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those organisations that have developed the most advanced and comprehensive safety management systems are finding it hard to achieve levels of safety performance that matches their aspirations. Why?

The answer lies in how people perform, how they act, ***how they behave***.

What causes accidents?

People don't cause accidents! But what people do / don't do contributes to what goes right and what goes wrong. What we need to seek to understand is what causes people to act in such ways.

As human beings we are all fallible - we make mistakes and suffer from slips and lapses of attention. All of these have the potential to produce an unplanned event and subsequent loss. Such **errors** can emanate out of poor design of the job or the workplace, or they can be the result of inadequate training. They can also result from inattentivity, mood, personality and current circumstance.

Of at least equal significance is the human tendency to find and take the path of least effort. With respect to safety this becomes manifest in incidences of unnecessary risk taking. In other words, we have a tendency to **violate** systems, procedures and safety rules. None of us are exempt – we all do it, and as such it could be regarded as "normal behaviour". (For example, how many of us at times exceed the speed limit?). And we do it for what at the time seems good reasons to us! (We believe by ignoring the speed limit we will get to our destination quicker). Like human error, unnecessary risk taking can and does contribute to the occurrence of incidents and accidents – but this is not the same as saying that behaviour causes accidents!

Whose responsibility?

In many businesses it is now established that health and safety must be a line management responsibility. This means that the responsibility for driving

health and safety performance is vested in the line and that other agencies are there to provide support and advice.

In addition to this, the benefit to be gained from worker support and involvement in driving safety performance is also recognised. In this respect the key message is that safety must be everybody's responsibility. Nevertheless, it remains a management responsibility to establish the conditions such that this is most likely to be the case. A company has to earn the right to the level of effort required by its workforce to achieve the highest levels of performance. This may seem a strange proposition given that it would appear sensible to presume that no one wants to get hurt.

The problem is that people do not always see the connection between their behaviour and the possibility that they might get hurt. Risk perception typically is subjective and people are at times more inclined to take a risk than choose to act conservatively. Our past experience tells us that it is both OK and beneficial to take risks. This means that we cannot assume that safety will result from simply telling people to act safely. There is a key role for management in how they behave to create the culture and context within which the workforce is more likely to act safely. Safety leadership must be a key area of interest for those organisations that aspire to achieve the highest levels of safety performance.

Improving performance - getting to zero?

"The target is zero"; "No accidents, no incidents, no harm to the environment"; "Zero harm". These are slogans taken from various large companies and serve to describe their intent with respect to health and safety. Most would argue that positioning safety as the highest priority and aiming to eradicate all accidents is an important if not the only acceptable aim to have with respect to safety performance.

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In this context there are some that argue that “all accidents are preventable” and getting to “zero” is not only desirable but also possible. There is some evidence that this can be achieved. Du Pont is well known as an organisation that publicise highly impressive data with respect to accident free performance in some of their plants. The operational sites of other organisations too are known to have gone for protracted periods without a significant safety incident.

However, others argue that, given the inevitability of human fallibility, achieving a situation in which accidents will not happen is unrealistic. Given what we know about human failure and its predictability, we would find it difficult to argue against this point of view. However, the key issue is one of expectation and aspiration. Aim high and you are likely to achieve high! Thus, it is important to aspire to the highest levels of performance but in so doing the need is to take the workforce with you – for them to adopt the same aspiration. Too often what happens is that declarations of “zero accident” targets are made which in the eyes of others is unrealistic and only serves to diminish confidence in the health and safety strategy. Often, too, such messages fly in the face of other perceptions based on actual everyday experience – a highly important rhetoric-reality gap.

In summary, there is a strong business case for eradicating the accident / incident risk. Good safety is good business. Good safety is also a moral responsibility. However achieving the conditions that will minimise risk associated with human behaviour is a complex challenge and one that requires serious consideration if an organisation is to optimise its performance. The focus needs to go deep and wide – improving performance for those organisations that take safety seriously often means that the “easy hits” have already been tackled. The challenge is often a cultural change one – where culture is the deep patterns of behaviour that reflect the collective mindset of the organisation. Safety leaders have an important role to play but what they face is a significant challenge.

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(The focus in the document is often directed at managing safety, it is important to stress however that the issues and ideas are equally relevant with respect to promoting health and caring for the environment).

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The Leadership Challenge

Individual incidents

Injuries that individuals experience and that result from their own behaviour are responsible for the majority of the statistics. Slips, trips and falls, contact with machinery and manual handling are consistently cited as the most common events that result in people getting hurt. The outcomes from such events range from minor cuts and bruises, to serious injury and even fatalities. Such outcomes are often said to result from "carelessness" or inattentivity although poor risk perception and unnecessary risk taking are also often involved.

Organisational incidents

Organisational incidents tend to affect more people, often include serious injury and, in the most unfortunate cases, multiple fatalities. As such they attract national and international media interest and result in wide-ranging enquiries. The explanation for such incidents is nevertheless often behavioural with the focus extending to behaviours and common practice failures in the management of health and safety within the organisation and beyond. This provides further emphasis on the need to extend the focus not just to *front line* behaviours but also to those behaviours that are intended to support and promote safety and good practice.

It also suggests that whilst we are right to focus on behaviours associated with incidents such as slips, trips and falls, we must also focus on behaviours that have the potential to cause much bigger incidents. These may include failures to follow safety critical systems and procedures, design decisions, and inadequate approaches to integrity management. This can often take us up to the highest levels of responsibility in an organisation. Decisions and actions taken at such high levels can result in widespread influence. This is now

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reflected in the emphasis on corporate responsibility and the potential for legal action to be taken against senior managers and directors.

A further important point to be made is that the difference between individual and organisational accidents is often made with reference to the outcome, whereas the acts that lead to such accidents are often little or no different. In both cases, the trigger for the events that lead to people getting hurt is someone doing something they shouldn't (commission), or not doing something they should (omission). The tendency is, however, to see individual and organisational incidents as quite different, thinking influenced by the differences in the scale of the outcomes. However, closer analysis emphasises the instrumentality of behaviour in all incidents and therefore the need for a focus on behaviour if we are to prevent all such events from happening.

A "normal" problem

There can be a tendency to see the problem in terms of "poor safety attitude / bad behaviour". This may not be helpful (promoting defensiveness) or even accurate ("good people" are not immune from having accidents). As we have already indicated few, if any, of us are perfect. We all make mistakes, suffer slips and lapses, and can be tempted to take short cuts. In effect, what we are dealing with is a normal human being problem – a problem which if we ignore will mean that accidents will happen and people will get hurt. The conclusion is that we need to tackle this "normal problem" – we cannot just accept it as a "fact of life".

A complex problem

It is also a complex problem. What causes incidents rarely is straightforward – and even those situations where this does seem to be the case we ought to be suspicious that we have not identified all of the factors. The fact that accidents happen infrequently does not mean that the conditions for them to occur only occur infrequently. Accidents tend to happen when a number of existing risks

come together in a particular configuration. This phenomenon is often described with reference to "Swiss cheese" following the work of Professor James Reason. The concept here is that the various layers of defence we introduce so as to manage risk are imperfect (they have holes in them like Swiss cheese). Accidents happen when the holes in the various defences line up.

Active and latent conditions

Accidents often result when somebody does something or omits to do something. These could be regarded as "active failures". But these active failures do not happen in a vacuum – they happen within a context. Within this context can be a wide variety of variables that all play a part in making the active failure more or less likely. These typically are referred to as the latent conditions and of course they are as important as the active failures. The problem is that they are not always exposed or detected and so go unchallenged. If we are to improve safety then we need to become very interested in the latent conditions as well as the active behaviours.

Risk perception / complacency

The manner in which people will calculate risk will be affected by how familiar they are with the situation. Generally, our level of risk perception decreases with exposure to situations. We tend to refer to this as "complacency". Again it should be seen that this is a "normal" problem and not a reflection of poor attitude. In many work situations, given that we seek to standardise what people do in many areas of activity, the conditions exist for people to become increasingly complacent. We should expect this to be the case and as a result respond accordingly to keep people focused. Once more this is not straightforward and needs careful consideration. A strong safety culture is a vigilant and suspicious one and leaders have a significant role to play in creating such conditions.

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The control paradigm

One response to this challenge is to control the problem by exerting high levels of control over what people do. This is achieved by prescribing what people should do in all situations through having a detailed set of procedures. The problem with this is that it can be overdone such that people disengage – none of us like to be treated as robots. We therefore need to be sensitive to this tendency and so not over-emphasise such an approach – we also need to focus on winning hearts and minds, to keep people focused and actively involved, to keep people thinking and discriminating so that they are able to identify the dynamic risks and react appropriately. Leaders need to get the balance right and understand that managing safety cannot be simply a case of providing a set of controls and telling people that they must follow them. The leadership challenge is a significant one.

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Understanding Behaviour

If leaders are going to maximise their effectiveness then it is of high importance that they have an understanding of why people do things that increase risk.

Errors & violations

The HSE has produced a very useful booklet "Reducing Error and Influencing Behaviour" (HSG48). This provides a good summary and consideration of the issues that follow and should be regarded as an essential read for those interested in the subject.

Errors are concerned with a lack of knowledge, poor information processing, and lapses in attention. Errors are unintentional.

In contrast, violations are intentional, result from personal choice and risk-taking or reflect some common accepted practice. Violations are unnecessary risks and result from either conscious choices to act in a way that is contrary to that prescribed or regarded as best practice, or over time they have developed into custom and practice and so may be less conscious acts.

The distinction between error and violation is not always as clear as the definitions suggest. This is because behaviour rarely occurs as a discrete event, but mostly occurs within a context and as a chain of events. Thus, whilst an error might result from inattentivity, the choice to engage in social chit-chat at the workface when engaged in a routine and very familiar task rather than to maintain a strong focus could be regarded as a violation. Similarly, a lack of focus in one area of operation can lead to mistakes being made elsewhere. What this leads us to is the conclusion that behaviour is rarely simple although the tendency often is to search for the single and personal reason why someone chose to act as they did.

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Can / Can't vs Will / Won't

Another way of expressing the difference between errors and violations is by relating the first to competence and capability (can or can't) whilst violations are more to do with motivation and preferences (will or won't). Errors typically are viewed as unwanted but reasonable transgressions whilst violations are not. What this can mean is that failures / incidents are more likely to be explained by a person involved in terms of human error rather than procedures being violated. Such an explanation is not only more preferable for the person directly involved, it can also be more preferable for those responsible for that person's behaviour and for the organisation. This defensive tendency can lead to the wrong focus and the suppression of learning and as such can mean that root cause(s) go unidentified and reoccurrence remains a possibility.

Human error

Information processing

None of us are perfect – we are all prone to slips, lapses and mistakes. As noted above, these are unintentional. Errors are associated with information processing and cognitive limitations. Aspects of our environment can make errors more likely to occur – we refer to these as *performance shaping factors*. Eradicating the risk of error and enhancing human reliability is a specialist area and is often associated with human factors expertise and areas of study such as ergonomics, reliability engineering and workplace design. Nevertheless, there is an argument for all those who have an interest in promoting safety to have an understanding of error types and error causation if they are to play a part in promoting continuous improvement.

Error types

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There are various types of error. Understanding the type of error is important in incident investigation if we are to introduce the most appropriate corrective action and more generally in our attempts to prevent error.

> **Mistakes** result when people act on insufficient knowledge (knowledge-based errors) or when they make the wrong connections through poor problem solving (if-then judgments – referred to as rule-based errors).
>
> **Slips and lapses** are more concerned with variations in attention or memory deficits and occur during routine and very familiar activity. These are referred to as skill-based errors.

Error and risk perception

The incidence of skill-based errors can be associated with levels of risk perception. Our assessment of risk lessens over time as we become familiar with activities, events and the experiences we associate with them (such as absence of near miss or injury). This means we have a tendency to regard the risk levels associated with common activities as being lower than they actually are and as a result may be less focused on the risks than we need to be. For many daily tasks, we may not even consider the risks involved (such as going up and down stairs). And yet, such activities can be associated with serious injury and even fatalities. In short, we can become complacent.

Our risk perception is often based on our past experience and even when we hear that other people have been hurt doing the same thing we tend to see these events as relatively unique and feel that "it won't happen to me". Risk perception can result in a lack of focus but it can also lead us to deviate from how we know we ought to behave – in such situations the associated behaviours are violations rather errors.

Violations

Choice

The decision-making that leads us to make certain choices as to how we will behave is influenced by a variety of factors and is dependent upon what we value and our previous experiences. Put another way, we tend to select behaviours that we know will produce for us certain desirable outcomes or consequences. Our choice is a function of these consequences.

Our differing interests and values mean that we all have preferred and non-preferred behaviours – experiences we like and those we don’t like. Whilst we all differ in terms of our personal preferences, there also exists considerable commonality in how we approach situations. In particular as human beings we tend to search for **the path of least effort**. Put another way, we like to be economic in how we behave and this can result in us searching for short cuts and the avoidance of additional effort. We also tend to avoid behaviours that we associate with short-term negative consequences, such as discomfort, even though bearing the discomfort may be associated with reduced risk.

Subjective risk assessment

The result is that we have a tendency to choose behaviours that make sense to us at the time in terms of meeting our needs even though the choice may not be the lowest (safety) risk option. This begins to explain why we have a tendency to violate rules and procedures. We are not naturally compliant, and are likely to violate when we see this as being advantageous to us. In the context of health and safety, our thinking and subsequent choice of behaviour typically proceeds along the following lines:

1. I really would like to behave in this manner because my experience tells me that there are positive outcomes for me behaving in this way
2. The negative outcomes (getting caught or getting hurt) are, in my experience, much less likely to occur (its never happened to me before)

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3. Therefore I will choose the riskier (relatively unsafe) option

Our risk assessment in such situations is subjective in that we base it on our past experience, and we tend to favour the violating behaviour because that will produce here and now positive benefits. Typically, if we really want to do something, we will usually find the evidence to justify that it is safe enough to do so and we are quite capable of being highly selective in our selection of the data.

Interactions and peer influence

Interactions and peer influence are further factors that have some bearing on the explanation for incidences of violating behaviour. Mostly we behave in social situations and the interactions we have with others are a source of influence over how we behave. Peers can encourage us to behave like them so as to gain social approval. This can be the source of custom and practice or routine violations – and where evident can be seen as evidence of a relative weak safety culture.

We also have a tendency to react adversely if we are just told how to behave, especially if we have a lack of respect for the person who is telling us. There are important implications here for role modelling, group processes and for how leaders and managers seek to exert influence. It may seem perverse, but people can choose to ignore safety rules not because they have no interest in safety but because they have a lack of respect for how it is being managed or are dissatisfied with how they are being treated.

Explanation, Cause and Remediation

Safe and unsafe people

One approach to the problem that is sometimes raised concerns differentiating between individuals, on the basis of certain measurable characteristics, such that they are deemed to be safe or unsafe. From this

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unsafe characters can be excluded from the work situation. Unfortunately, there are a number of problems with such an approach. The first is a focus on the individual will only at best partially explain what went wrong. Secondly, producing a reliable and valid measure that could differentiate between safe and unsafe individuals is very problematic. Finally, and importantly, it is evident that people generally regarded as careful and safe experience accidents. In effect, no one seems immune.

Whose fault?

Our interest in incidents and accidents lies in what we need to do to prevent them happening. The focus on human agency in this context is an appropriate one given the part played by our actions in triggering unplanned events. The tendency can be however to seek "neat and tidy" explanations as this can help us feel more secure in our thoughts about preventing reoccurrence. Linked with this is a social need to hold individuals responsible – especially other individuals. In so doing the motivation can be that we promote our own self-interest by removing ourselves from being part of the problem.

However, as we have already emphasised, behaviour is rarely explained in simple terms. Both errors and violations are often circumstantial – the context in which people behave is important in influencing that behaviour. Despite this, there is a human tendency to seek to attribute responsibility for events to a person or persons close to the incident when a more accurate and helpful explanation would focus more widely. This tendency has a term – the *fundamental attribution error* and comes from an area of research and study referred to as attribution theory (see next paragraph). The implication is that we need to be aware of the tendency to view events at face value and to place more emphasis on system or situational explanations.

Social pressures

In our social world, having our failings exposed is something that we tend to try and avoid. What this means is that we have a tendency to be inclined to be

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economic with the truth if we suspect that owning up is likely to lead to embarrassment or worse. In contrast, if there is good news around we like to be associated with it and for others to understand that we have been responsible for creating it. This is **attribution theory** – one of the basic tenets being that we tend to seek to blame others or some external factor when things go wrong for us, but behave in the opposite way when results are good.

In the context of health and safety, this can serve to explain the tendency to under-report incidents or when reporting to more likely emphasis a system induced error rather than incapability or violation.

Organisation, Job and Individual

The emphasis on contextual or system explanations for incidences of error or violation should widen our focus to consider organisational and job influences on human behaviour. This does not mean that we should ignore individual agency – we need to include a focus on individual characteristics as well. For any one incident the likelihood is that contributory factors will be found at the organisation, the job and the individual level. This is not just true with respect to human error, in many cases people choose to violate for *good* reasons (such as wanting to get an urgent job completed). Behaviour is indeed complex!

A key conclusion is therefore that we ought to adopt a focus on

- Organisational issues and job factors
- Individual behaviour

Influencing and Changing Behaviour

Behaviour and safety

In the above paragraphs we have been concerned with highlighting both the extent and complexity of the "behavioural problem". It should come therefore as no surprise to find that a simple solution probably does not exist. The important issues fall into two distinct areas for consideration.

1. There are those that are **technical** in nature and require a specific focus on issues such as **capability, job design and work organisation** and are more concerned with the elimination of error.
2. Secondly, there are those that are more concerned with **culture, management and motivation** and are more to do with best practice, promoting a sustained focus on safety and on eliminating violations.

Behavioural Theory

Behaviour is largely learnt

Much of our behaviour is learned behaviour. Indeed, through the socialisation process we learn how to behave safely. This process leads to the development of what we might call normal behaviour, underpinned by what our wider culture determines is important. This of course changes with time as our cultural expectations change and develop. In the world of work, many companies now expect standards of behaviour that are beyond those that are deemed normal within the wider culture. To achieve this, the need is to help the workforce acquire new habits. A key question to address therefore is how do we learn the behaviours that we typically exhibit.

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In this section we provide a brief overview of a number of theories or approaches that all play a part in the process through which we learn behaviour. This is not intended to be a comprehensive review, but an introduction to theories that seem particularly appropriate in the context of improving safe behaviour.

Creating safe habits

Our goal is the creation of safe habits – or what is sometimes referred to as unconscious competence. There exist many examples of safe habits that we have learned over the years – getting dressed in the morning is a learned behaviour, so is the routine act of putting on a car seat belt for most of us. The question is how have we learned these behaviours given that they are not instinctual – we weren't born doing them, they have had to be learned.

It is possible to define the key steps involved in creating new habits. For much behaviour, the learning process takes time, and occurs relatively naturally through our socialisation as individuals. However, there are situations where we contrive to take on new behaviours – either voluntarily or because someone or something demands that we do so. In such situations, the learning process becomes speeded up. For organisations wanting to eradicate unsafe behaviour, the problem is often one of unlearning old (bad, unsafe) habits, and the learning of new (safe) ones. To achieve this, the following steps are required.

- People need to know what it is that is required
- They need to have both the ability and capability to carry out the behaviour
- Frequent opportunity to practise the behaviour is required
- Frequent and specific performance feedback is essential
- An important outcome for the individual must be the result if repeat efforts are to follow

Given that people may have already developed bad and unsafe habits, we should not expect the process to be quick and easy. Consider how easy it is for yourself to change some of your more automatic and preferred behaviour.

Intrinsic and extrinsic motivation

In the above series of steps it is the last bullet that often holds the key – without repeats of the behaviour, learning is unlikely to occur. This highlights the importance of motivation in the process of learning how to behave. In the context of violating behaviours the problem often is one of motivation. Unsafe acts are typically associated with less effort, saving time, avoiding discomfort etc. In understanding these issues it is important to make the distinction between **intrinsic and extrinsic motivation**.

Our end game is where people sub-consciously choose to act safely – safe behaviour becomes the habit. In such cases, the behaviour becomes highly learned and is driven by the internal satisfaction we associate with feelings that result from doing the right thing. In such cases, our behaviour is being driven by intrinsic motivation.

However, rarely do we take on new behaviours just like that. We need to go through the behaviour learning process as described above, and we need to experience some value for making the effort to engage in the new behaviour. To get us to expend the extra effort when we have yet to internalise the behaviour into our normal repertoire requires us to experience some value for making the effort. This usually takes the form of some external experience – and in such conditions we refer to the behaviour as being under the influence of extrinsic motivation. This is important in the challenge we face in changing behaviour. People need to see that there is value to be had in making the effort to change – highlighting the risk associated with the unsafe behaviour rarely does this.

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Key theories

There are a number of theories or approaches that provide a useful foundation. Each of these has something to offer us in considering how to influence safe behaviour.

- Social Learning Theory
- Reinforcement Theory
- Transactional Analysis
- Performance Feedback & Coaching
- Goal Theory
- Applied Behaviour Analysis

Social learning theory

This is a theory concerned with "observational learning". The basis of the theory is that people learn behaviours by observing others and then modelling those behaviours they perceive to be most effective. This is more than just copying, for the process of modelling is selective. In the context of behavioural safety, social learning has key significance in the displays of behaviour by leaders, managers and supervisors.

Reinforcement theory

Reinforcement theory seeks to explain how people behave in relation to the consequences they experience when they select that behaviour. Certain (positive) consequences reinforce behaviour and make it more likely to reoccur whereas negative consequences act as punishers and deter a person from behaving in that way again. In the context of behavioural safety, ensuring that safe behaviours are followed by positive consequences serves to reinforce the likelihood that they will be repeated. Similarly, seeing people consistently engaging in unsafe behaviour suggests that those behaviours are being reinforced in some way. This approach enables us to both understand

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why people choose to act unsafely and also to suggest how we can intervene to make a difference.

There are 4 key aspects of reinforcement theory that are central to understanding how it might be applied:

1. Behaviour is influenced by two variables: **antecedents** that precede the behaviour and act as behavioural prompts; and **consequences** that follow the behaviour and have meaning for the person who has behaved. Antecedents are relatively weak in influencing how we behave; consequences tend to exert most influence.

2. There are four different consequences: **positive reinforcement, negative reinforcement, punishment and extinction.** Positive reinforcement is the most effective in terms of generating voluntary (want to) behaviour and is the key to influencing safe behaviour.

3. The power of a consequence depends on 3 characteristics:

   - **value** to the individual (positive or negative)
   - **immediacy** in occurrence (immediately after the behaviour or some time in the future)
   - **probability** of occurrence following the behaviour (certain to follow the behaviour or uncertain).

4. Consequences occur in 3 different forms each of which have implications for a consequence management strategy:

   - **natural** consequences result from our interaction with the world around us (PPE can make us hot and uncomfortable in summer)

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- **social** consequences are the result of our interactions with others (praise, recognition, interest in us, challenge, criticism etc)
- **tangible** consequences tend to be manufactured outcomes (prizes, rewards, punishments, sanctions)

The application of Reinforcement Theory is often referred to as **Consequence Management**. It could be argued that patterns of behaviour in an organisation are the result of consequence management – what gets reinforced gets done. The theory is very useful in helping us understand how to influence people's choice of behaviour.

Transactional Analysis (TA)

As suggested in its title, this theory relates to interactions between people. It suggests that when we interact with another person we have a tendency to select one of three "ego types" or styles. The first of these is characteristic of parent type behaviour (paternalistic, advocacy, right and wrong). The second more like a rational adult (factual, reasonable, facilitating). The third more like a child (emotional, reactive, challenging). There is a lot to the theory but in the context here the most important assertion is that adopting a more adult type style is likely to be more effective when interacting with someone.

Performance Feedback & Coaching

This is a common term referring to a situation where information is given back to us in order that we might deduce something (learn) about our behaviour. Feedback is essential to our functioning and learning.

There are two types of feedback: **knowledge of results** (how well am I doing) and **corrective feedback** (what do I need to do to get better). Often, these different aspects of feedback are given at one and the same time. A more

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effective approach involves keeping the two separate. Knowledge of results is best immediately following a behaviour, with corrective feedback having most impact when given just before the behaviour is due to happen again (coaching).

The delivery of feedback is essential in giving people information about how they can improve their performance. However, the delivery of feedback needs to be treated sensitively – people do not always react well to being told that what they are doing is not good enough (either directly or by implication). A more effective approach is to facilitate the other persons thinking through the use of open questions. The advantage to this is that the target person generates the ideas for improvement and therefore is likely to be much more committed to putting them into action.

Goal Theory

Goal theory is familiar to many people in the context of objective setting and SMART targets. The principal behind the theory is that behaviour can be motivated through setting goals. The detail of the theory lies in what makes for an effective goal and hence SMART:

- Specific
- Measurable
- Achievable
- Realistic
- Timely

To this there are two further aspects that are worth listing:

- Challenging goals are more motivating than goals that are easy to achieve
- Goals that are set by those attempting to achieve them are similarly more effective

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Applied Behaviour Analysis (ABA)

Applied Behaviour Analysis is more of a methodology rather than a theory. ABA is concerned with changing behaviour through changing the conditions under which the behaviour occurs and measuring the effect on the behaviour. ABA involves running "behavioural experiments". As such, ABA can involve any of the above theories as part of the change strategy.

There are a number of distinct steps in an ABA approach:

- Identify the problem behaviour, describe it in measurable terms
- Carry out a baseline measure to establish current rate of the behaviour
- Analyse the problem, devise a change strategy and implement it
- Continue measuring to provide a post-baseline measure
- Assess the impact of the change strategy on the basis of the change in the rate of the behaviour
- Continue with or change strategy
- Continue measuring until desired rate of behaviour is achieved

In the context of behavioural safety, ABA is a tool that can be applied to tackle behaviours that are critical to safety but are seen as being resistant to other attempts to change them.

Effective Teamwork

We are increasingly of the view that **effective teamwork** is an important element in improving safety performance. Because of this we will include in this section a review of those factors that are associated with effective teamwork. A successful approach to behaviour change and improved safety performance is contingent upon the establishment of an effective team based approach to performance.

The following are a number of guidelines based on research conducted into effective teams (taken from Michael West's book Effective Teamwork):

1. Teams should have intrinsically interesting tasks to perform
2. Individuals should feel they are important to the fate of the team
3. Individuals should have intrinsically interesting tasks to perform
4. Individual contributions should be indispensable, unique, and evaluated against a standard
5. There should be clear team goals with built-in performance feedback

Why focus on teamwork? The research evidence for performance gains to be had from effective teamwork is compelling. Teams can produce far more compared with the product achieved by its individuals working alone. In the context of safety, with all of its interdependence, the case for an emphasis on teamwork is even more compelling. Given this and the above pointers, what are the key implications?

- **Size of team:** smaller sized teams create greater personal effort and avoid the problems of "social loafing" – team games perhaps provide some clues as to optimise size – ideally 5 – 10 persons with a maximum of 15.

- **Purpose / focus:** the team should have a clear purpose, which has direct interest for its members. The team should also have a reasonable degree of latitude in determining how they will set about achieving their purpose.

- **Goals and performance feedback:** there should exist a small number of SMART goals (3-5) and, importantly, performance feedback should be provided frequently.

- **Interaction and review:** team should have the ability to meet on a regular basis to review performance, to make any adjustments required

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to meet the goals set and to set new goals. In addition, teams should hold celebrations to mark milestone achievements.

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The Practice of Safety Leadership

Leadership in Health and Safety

Effective leadership is critical if a company is to achieve its aims and objectives. Because of this the subject of leadership has attracted much attention over the years. Some of this attention has focused on identifying the characteristics of a good leader (leader traits), whilst other approaches have been more concerned with identifying the functional aspects of the leader role. A popular theory is more concerned with a more dynamic proposition and suggests good leaders flex their approach depending on the nature of the task in hand and the people / team involved. This is "contingency theory".

In the context of behavioural safety, safety leadership has until recently been something that has been afforded too little attention. Historically, approaches to behavioural safety have stressed the importance of developing workforce led processes on the pretext of needing to gain a sense of ownership and involvement. Unfortunately, the danger is that this emphasis becomes overdone to the extent that management bring in behavioural safety but then hand it over to the workforce and stand back. In so doing, there is an implicit lack of recognition of the part that leaders and managers play in influencing how people behave.

The behaviour chain

How one person behaves typically depends on how others behave. In any situation where someone has displayed a certain problematic behaviour, analysis will usually reveal that others have played a part in making the display of this behaviour more likely to occur. Further analysis will reveal that this second person's behaviour will similarly have been influenced by the behaviour of yet another person. What we see in such situations is a chain of behaviours.

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These chains can often be seen as reflecting the management structure of an organisation. This should be no surprise to us as the very concept of people management is, or should be, concerned with exerting influence down the line. In the case of Health and Safety, if the analysis is focused on understanding why someone has got hurt or why an incident has occurred, more often than not one of the significant contributory factors will be the behaviour of that person or another. As with the above analysis, the behaviour of that person will have been influenced in some way with how others have behaved around him etc. This is evident in the investigation of major accidents where often the resulting conclusions have a heavy focus on "management failure". Clearly, in focusing on how people at the front line behave, we must also focus on the behaviour of those who occupy positions of influence, and given that influence starts at the top, that is where we should start.

Leadership and behaviour

A focus on leadership behaviour is important because people are not naturally compliant. Life in organisations would be straightforward if leadership were simply a matter of defining what it is that people need to do and communicating this to them. However, our experience tells us that this is far from the case – to behave in a certain way people need to be convinced of the value of so doing. In this respect the leadership challenge represents the need to exert influence over others such that they choose to act in a way that aligns with the needs of the business.

Whilst communicating to others what it is they should do and ensuring that they have both the ability and capability to do so are necessary, they are often insufficient to guarantee compliance. We know from experience that people do not always behave in line with expectations or rules. We also know that how leaders behave is an important variable in increasing, or decreasing, the probability that people will behave as required.

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This argument could lead us to the conclusion that leaders need to model the right behaviours in order to achieve influence and to engage others in conversations about how they should behave. Whilst these are important, this is neither the whole story nor the place to start. The first question to address is "what behaviours" and this is concerned with leaders creating **clarity** about what is important in the company.

Values, vision and principles

Behaviour in organisations ought to start with a clear articulation of the values that are held to be important. This is particularly important in the area of health and safety and the definition of the company culture. Associated with these values will be the company vision for the future. If the health and safety of the various stakeholders is deemed to be important then the vision should reflect some sense of the future state in terms of the management and performance associated with health and safety.

These are tasks for the leadership team and once agreed there is a need to ensure that they have relevance in the life of the company. This means a number of things. First of all there is a need to ensure that the values and vision are clearly **articulated** in a manner that is meaningful to everyone else associated with the company (the stakeholders). Secondly, there is a need to ensure that the values are consistently **reinforced** and are reflected in all communications and requirements. Thirdly, there is a need to provide **guidance** as to what the values should mean through the definition of a number of key principles that should serve to provide the basis for all decision-making and behaviour in the organisation – almost an organisational template.

This should be a dynamic process. Too often our experience is that whilst the values and vision have been agreed, and some attempt made at communicating these, this is where the action stops. The main requirement is for these vision and values to be consistently reinforced and the manner in

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which leaders behave represents one very important way in which this can be achieved.

The leadership task therefore begins with defining what it is that is important, what it is that has to be achieved, and the guiding principles and expectations that serve to provide the basis on which people make decisions and choose how to behave. In so doing, leaders serve to establish a sense of organisational clarity and so provide the basis for the development of a strong organisational culture – the "how we do things round here".

A key issue to address here is how to position the importance of safety relative to other business concerns. "Safety is the number 1 priority" is a statement we often encounter. But what is the reality and how will people react if their perception is that this not the case. This will need careful consideration. Managing organisational meaning involves understanding the symbolism conveyed by certain decisions and behaviours.

Leaders as "Company Icons"

Leader behaviour is symbolic. The more senior a position, the more a person's behaviour is scrutinised for meaning. Leaders send out messages in how they behave about what is important and valued. This may be intentional but can also be unintentional and in such cases it can result in mixed messages being received. When health and safety is said to be the number one priority, and people in the front line seem to behave otherwise, perhaps paying more attention to productivity, this is often because the signals being sent out reinforce this. What this all means is that leaders need to be highly aware of how their behaviour is interpreted and therefore manage it with extreme care and purpose. The task here therefore is to identify those critical behaviours that leaders ought to engage in and the means to establish that they in fact do so through some form of feedback / review system.

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Leaders make choices about how they behave

We all have preferences about how we spend our time and where it is possible these preferences tend to influence how we behave. What this means in company life is that we may not always engage in the behaviours that are most needed. A common response when asking workers about leadership's involvement can be "we never see them". Visibility is often a key aspect to achieving influence – being out there and being seen is particularly important. Indeed, other forms of contact are much less effective. But, when faced with a busy schedule a leader may favour other activities perceived to be of high importance and even postpone site visits. Given the choice between making a scheduled site visit on a cold and wet winter's day or staying in the office to work on a report that is nearing its deadline, the dilemma is often easy to solve – "I'll do the report".

The belief might be that this makes little difference. The reality could be very different indeed. In such situations the signal sent may be that I don't really care about what happens out on site and more generally "its not that important to do that which is important around here."

Do the simple things well

Leadership behaviour does not have to be complicated. Indeed what is often most lacking is an emphasis on doing the simple things well! Just think of the impact to be achieved if everyone in a position of responsibility always did a specific number of things. A focus on the right behaviours and the collective and consistent demonstration of these has the potential to exert considerable influence.

An important question is what behaviours do good safety leaders choose and then exhibit. One way of finding this out is to ask those who are the targets of safety leadership attempts to influence. If we can find out what these people are sensitive about, then we know what safety leaders should do.

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Culture shaping role

Through the consistent display of behaviours that are manifestations of the articulated values and vision, leaders play a significant role in shaping the culture of the organisation. This is likely to be most powerful when there is a perception from those outside that consensus exists within the leadership team, there are high degrees of consistency in terms of how its members behave, and there is coherence between the various policies they promote. This represents a significant agenda item for a leadership team in their efforts to achieve influence down through the organisation. How leaders behave (what they attend to, what they show interest in) has a significant part to play in shaping the culture of an organisation.

In broad terms, what leaders do can be represented in just three words:

- **Clarity** – leaders provide a sense of what is important, the vision and the goals, and the expectations about how people should behave that align with these
- **Consistency** – leaders consistently reflect through their own behaviour that which has meaning and is important. What leaders attend to, how they spend their time etc has both functional and symbolic significance.
- **Consequences** – leaders actively manage consequences so as to reinforce the behaviours that are consistent with the vision.

Time For Safety

Safety leaders are only effective when they consistently exhibit behaviours that are consistent with the espoused safety vision. Words generally don't influence people, what they see happening does. PsychaLogica has developed a simple process concerned with promoting consistent and regular displays of safety leadership behaviour. This is described in a separate document "Time For Safety".

Winning Hearts and Minds

A blame-free culture?

The idea that there should be a blame free approach to the management of health and safety has been driven by the objective of achieving an open-reporting culture. The need for intelligence is important in the drive for continuous improvement and achieving a situation in which people feel able to report anything, even a deliberate violation, without fear of retribution has led to the idea of *blame free*. The problem with such an approach is whether it can be delivered? What about someone who blatantly disregards a safety rule, which leads to someone else getting hurt? Clearly the idea of promoting a "blame free" approach needs some extremely careful consideration.

What seems a more appropriate proposition is the development of a *just culture*, in which people's expectations are carefully managed, where the emphasis is mainly on a positive approach, but where sanctions are applied when the situation is judged to demand it. Such an approach seems *justifiable* in that most people would consider it appropriate for people to be held accountable for their actions, particularly where deliberate unsafe acts have led to injury.

The use of discipline

This needs managing with extreme care. The clumsy and inappropriate use of discipline can lead to a lack of trust and a tendency to withhold information about problems for fear of being held responsible for them. The sole use of discipline should be to prevent the likelihood of reoccurrence of an unwanted behaviour – not to punish. Care should be taken to understand what has happened and why with an emphasis, like any other investigation, of identifying root causes as well as those that are immediately apparent. With this emphasis on root cause, the possibility of others being involved in the

causal chain becomes apparent. Should management be disciplined for not fulfilling their responsibilities? If we consider recent investigations of major accidents, this certainly has been the case.

Overall, the use of discipline should be seen to have functional relevance in that it is considered to be the most appropriate means to prevent re-occurrence. The danger is however is that discipline, both in terms of those who use it and those who receive it, has more of an emotional dimension to it. The use of discipline may not always achieve the desired aim of reducing the likelihood of reoccurrence and the promotion of a stronger safety culture.

Managing expectations

Managing people's expectations is critical. Problems often occur when the management of a company suddenly change their approach and start getting hard on people. This is often a knee-jerk response to problems that have been building up and rarely leads to an improvement. The outcome typically is one of conflict and dissatisfaction and the solution is often a poor match to the nature of the problem.

People generally like to know "where they stand" in relation to others and when this is achieved it often leads to a sense of having respect for those people. In this context effective influence is associated with three concepts: clarity of expectations, consistency in how these are managed, and the consequences that follow for the individual when their behaviour matches, or otherwise, these expectations. It is an emphasis on these three aspects that create the basis for effective influence through establishing for people what is expected of them, the knowledge that such expectations will be consistently attended to and reinforced, and the appreciation that meaningful consequences will follow when the expectation is met or not.

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A positive health and safety culture

The emphasis on clarity, consistency and consequences provides the foundation for the development of the company's safety culture. When the emphasis is mainly on encouraging and recognising effort and achievement the outcome is often a more positive culture characterised by people willingly putting in the extra effort required to drive up performance. In addition, with such an emphasis, those same people are likely to validate the use of discipline in situations where there has been a clear and deliberate breach of critical safety rules. In such situations, the problem behaviour will be seen as exceptional and in need of a response. If however, the behaviour is more regarded as being in the area of *custom and practice* then this validation will be much less likely.

Defining the non-negotiables

Achieving clarity will involve determining the "bottom line" or those behaviours that are never acceptable. As long as these behaviours can be justified as being unacceptable, then it is likely that the workforce will regard action against those who choose to act in such a way to be valid and fair. But some caution needs to be addressed here. In situations where highly combustible material is present the vast majority of people would regard smoking as a non-negotiable behaviour.

However, when this is extended to, for example, having matches or lighters on one's person the situation becomes more complex for doing so could be the result of a slip or lapse rather than a deliberate violation. Given that everyone can make a mistake, then action against such behaviour may be regarded as heavy handed and less than fair. Non-negotiable behaviours ought to relate to deliberate and conscious acts that do not fall within the area of "common practice" and have the potential to be safety critical. Many violations do not fall within this definition and the use of discipline is in many cases not appropriate.

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A learning culture

The real objective here is the development of a learning culture with an emphasis on open reporting, critical challenge and continuous improvement. The constant search is for the existence of any unnecessary risk and the means to remove this. An over-emphasis on rules, control and the use of discipline is most unlikely to achieve this. When faced with an unsafe act, the key question that needs to be answered is what is the most cost-effective way to prevent the likelihood of reoccurrence. With such an emphasis, the role of discipline becomes quite specific and transparent in that it will be clearly understood by all as to when it should apply which in turn should be in rare circumstances. If the opposite is true, then there will be something fundamentally wrong which will need addressing.

Continuous improvement

Building on the emphasis on learning, achieving safety excellence ought to be regarded as a never-ending journey rather than an end state. The very best performing organisations are those that place significant emphasis on continuous improvement in all that they do. The key driving logic within the organisation needs to be defined in terms of safety improvement rather than safety management.

Significant within this is employee involvement and ownership, and the development of value-adding but achievable plans. This can mean an emphasis on strategic plans with a wider focus and longer-term view, and set within this more local plans that have a much shorter focus.

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Supervision & Coaching

The manager's role

Managers and supervisors have a key responsibility to play in being **good role models** and in **monitoring and coaching** the behaviour of those who work with them. As part of their responsibility, they need to ensure that the members of their team practice the right behavioural habits such that health and safety are always keen concerns.

It is now well understood that simply telling people what to do is unlikely to be a totally successful strategy. People do not always do as they are told and typically resent this type of approach. The use of direction backed up by threat creates compliance but only *minimal compliance*. Because the behaviours are not part of the team's normal repertoire, when the manager or supervisor is not around the chances are that other unsafe behaviours will take their place. Compliance driven through the use of negative reinforcement will always require policing.

In view of this, and in the context of flatter organisational structures and wider spans of control, the role of the manager and supervisor has to take on a different approach and skill set. Managers and supervisors need to seek to exert influence not through control but through the behaviours they themselves exhibit and how they reinforce the behaviours of their team through coaching and recognition.

Modelling the critical behaviours

Managers and supervisors are local leaders. They have a responsibility to play in articulating and reinforcing the values and principles of the company through the behaviours that they consistently exhibit and through their talk. However, as with other human beings, managers and supervisors have preferred and non-preferred behaviours and are also busy people. In view of

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this it would be wrong to assume that they quite naturally will take on the behaviours that are critical to reinforcing the company's safety values. This is something that needs explicit attention.

- **Step 1** in this process involves the critical behaviours that the person in the specific role should consistently practice.

- **Step 2** focuses on the means to ensure that these behaviours do indeed get consistently practice through some system of accountability and reporting.

The emphasis here is on doing the simple things well. This is best achieved through emphasising just a few behaviours and ensuring that these are practiced. This should not be a complex process. The behaviours that typically have most impact are well known and easy to identify. The problem is more to do with an inconsistency in how they are practiced.

Observing and coaching

As we have noted earlier, many approaches to behavioural safety place significant emphasis on observation. Our position is that observing how people behave, and coaching for improvement, should be a standard expectation rather than needing to form part of a special process. As we have intimated above, this is precisely one of the key reasons as to why we have managers and supervisors. The issue therefore is not whether managers and supervisors should take on an observer role, this is a critical behaviour, but how they should go about practicing it. Our focus is therefore on the key skills required to achieve maximum influence.

Developing the coaching role

The development of the coaching role is likely to be one in which different people will be at different starting points. Development should therefore be seen as a process rather than a discrete set of skills to be learnt. Some people

are "naturals" whereas others have to work hard at this important aspect of management. There may even be some who just do not have the more general people-management skills to perform this complex role and it may be decided that they are just too high-risk to take on such responsibility.

Visibility and contact

The place to start is "being out there". Too often we hear from teams that they just do not see their managers. It is very difficult to achieve influence if you don't have personal contact. With flatter structures and greater spans of control this represents a challenge but the need for managers and supervisors to be seen increasingly is being recognised in many companies such that other responsibilities are being taken off them in order that they can have regular contact. However, this is not the full picture. Getting out of the office and onto the shop floor is not necessarily regarded as a preferred behaviour – the manager might see things he would rather avoid, he might fear losing control of his e-mails, he might have to answer difficult questions etc.

Building rapport and confidence

Of course, just being out there is the first step. The next concerns the ability to build rapport and confidence. This does not have to be a complex process and is often facilitated through a manager / supervisor taking genuine interest in the work and wider issues of his team members. In so doing the emphasis will be more on listening than talking prompted through the use of open questions. In so doing, the manager will identify issues, concerns and personal interests, to be stored in memory and used in future dialogue. This represents "taking an interest".

Observing and talking

Having developed a sense of rapport and confidence, the next step involves a focus on what is being done. Although observing work in hand is part of the manager's responsibility, this should not be taken for granted. If a particular worker is being observed, then it is only civil to ask their permission first to

do so. If time has been spent on developing the relationship, this should not be a problem. The focus of the observation should be on the person's behaviour and in the context of health and safety it should relate to risk and compliance. As well as this, the focus should be on what is being done well as well as on identifying problems.

Observation may involve talking to explore what it is that is being done and the person's perceptions about the task. The use of open questioning is required here: what, how, why, etc.

In our approach to coaching we place specific emphasis on a risk assessment model:

- Conversations begin with a discussion as to ***how the person might get hurt*** (identification of the hazards)
- The conversation then moves on to the ***personal impact this would have for the individual*** (focus on actual risks)
- Finally, the conversation concludes with ***what could be done to avoid or mitigate the risks*** (put in place controls).

The aim of the conversation is to bring about a change in behaviour and risk reduction. The final part of the conversation is therefore critical in that it should take the form of an agreement of who is going to do what differently. The onus might be on the target of the conversation to act differently in the future. However, it is also possible that issues will be identified that will entail the coach taking actions away to pursue elsewhere (for example a change to a procedure, modification to work conditions etc). This serves to emphasise that the coaching conversation is directed at understanding the problem behaviour in the wider context.

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Feedback

People who are being observed like to know how well the observer judges they are performing. Some form of feedback is therefore essential and the more specific the feedback, the stronger the effect. Typically, feedback will be about things observed that are positive or about things that require some correction. There can be a tendency to focus on both of these although there is an argument to keep the discussion either on recognising positive behaviour or on correcting unsafe behaviour.

Recognition or challenge?

Recognition should be delivered frequently, and in particular much more frequently than challenge and correction. In most situations, the vast majority of a person's behaviour will be compliant and risk free but the tendency is to focus on the one or two things observed that are wrong. We all like to be recognised for the things that we do well, and when this happens regularly we are much more inclined to take on board challenge and correction when this happens.

Of course, if unsafe behaviour has been observed and is assessed as being high risk, then this has to be the focus of the discussion, and might even involve stopping the job. This will be a judgement call and is difficult to legislate for.

There is a need for sensitivity when observing for in many situations it is likely that it will always be possible to identify something that is not quite right. There is a need for balance – and the balance should be in favour of recognising good practice in a ratio in the order of 4:1 at least.

Recognition

Recognition is the means through which positive reinforcement is delivered. The principal behind recognition is to encourage the repeated occurrence of the behaviours being reinforced. For recognition to be effective it should be:

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- Sincerely delivered
- Specific with respect to what has been observed
- Occur as soon after the behaviour has occurred as possible
- Personalised / sensitive to the needs of the individual(s)
- Short but sweet (fit the recognition to the event)

Recognising what people do well seems to be much less natural than identifying faults – and yet if asked we all like to be recognised! Increasing the amount of recognition delivered is something in which there is often considerable room for improvement and if delivered appropriately it can make a significant difference to both performance and climate. Over time, it also plays a key part in reinforcing a positive culture.

Correction and coaching

The use of coaching and correction works best when it is accompanied by an emphasis on recognition although it is probably best to keep these as separate conversations. When correcting a person's behaviour the most effective strategy is once more the use of open questions to facilitate a person's focus on the problem behaviour. The need is to develop their thinking, understanding and identification of alternatives and not to attribute blame or criticism. The coach can also ask what they can do to help make it easier for the person to engage in the safe behaviour. This recognises that there are often wider issues that need to be addressed that have some bearing on the "problem" and a joint approach to problem solving. The conversation should finish with a summary of who is going to do what so as to make a difference.

Challenge & difficult conversations

There are situations in which the appropriate response may be challenge rather than coaching and correction. Such a situation is likely to exist when the same person has been observed repeating an unsafe behaviour that has

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already been the subject of a coaching conversation(s). In such situations the need is for the manager to:

- Make the conversation a private one
- Challenge the behaviour rather than the person
- Focus on the standard expectations, risks involved in non-compliance and potential outcomes (accident and injury)
- Avoid getting into any "emotional behaviour" – be civil and in control
- Require an improvement and raise expectation of further monitoring
- Outline possible consequences for continued non-compliance in line with company disciplinary code

These situations should be exceptional and unusual. If the opposite is true then there are wider issues that will need attention.

Coaching the coaches

All of the above is relatively easy to describe but not necessarily easy to practice. If managers can get it right then they can make a big difference to performance and morale, and also can make their job an easier one to accomplish. However, these skills are rarely naturally occurring and the requirement is for training and follow-on coaching. The principles described above apply equally to the process of coaching the coaches as it does to reinforcing safe behaviour. Too often people are provided with an introduction to the skills involved and then left to get on with it. This can be a high-risk strategy.

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My brother's keeper

There is an argument that the best form of behavioural observation and coaching is that carried out peer on peer. The basis behind this is that it fosters a sense of teamwork, inter-dependency and of custodianship for each other. These are principles that are difficult to argue against and achieving a system in which peers observe, challenge and coach one another is something to aim for. However, in our experience this type of approach requires considerable skill and perhaps more importantly a sense of trust and confidence. Because of this, we would not suggest that such a development is not considered until it is felt that this level of maturity has been reached.

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