

TAMA ROBSON

Operational Safety Leadership

IN PRACTICE

Reflect. Reset. Prepare.

Recognising Risk Before It Escalates



Elevating Intelligence Across
People, Systems, & Strategy

Operational Safety Leadership in Practice - Reflect. Reset. Prepare.

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This book is intended for educational purposes. The examples and concepts presented reflect operational safety leadership principles and should be applied within the context of organisational policies, legislation, and professional judgement.

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Foreword

Across every high-risk industry, from the precision of engineering to the massive scale of mining and rail, we share one inescapable common denominator, risk. As technical and operational professionals, our primary mandate is to manage and control that risk through engineering, systems, and rigorous procedures. However, we have all seen environments where the paperwork is perfect, yet the outcomes remain tragic.

This book addresses the critical gap between technical intent and operational reality. It recognises that for those in leadership, those entrusted with the immense responsibility of managing high-value assets, complex work environments, and, most importantly, personnel, the challenge is never one-dimensional.

To lead effectively in these environments requires discipline. Leaders are expected to maintain operational momentum while working within the boundaries of safety legislation and regulatory requirements. This is not a trade-off to be negotiated; it is a discipline to be mastered.

Operational Safety Leadership in Practice – Reflect, Reset, Prepare provides the professional's "***lens***" for this mastery. By moving through the cycle of Reflect, Reset, and Prepare, this framework helps us recognise "Operational Drift" before it becomes a failure. It challenges us to look at our internal State, the Signals we often miss under pressure, and our Response when conditions inevitably change on the ground.

Leadership in these environments is not a passive title; it is the active, continuous management of decisions.

This book is a call to action for every supervisor, manager, and executive to move beyond the "***Compliance Trap***" and lead with the technical and emotional intelligence required to ensure our teams return home safely, after every shift, every day.

Michael Solomon

Founder - Director

TechSafe Industries

Author Note

Operational environments are complex places to lead. Conditions change, pressure builds, and leaders are required to balance safety, production, and performance in real time.

Throughout my career across high-risk industries in the Asia-Pacific region, I have worked alongside operational leaders managing these demands every day. I have also seen the consequences when risk is not recognised early enough. Like many in this field, I have witnessed serious injuries and fatalities that leave a lasting impression and reinforce an important lesson.

Serious incidents rarely occur because people do not care about safety. More often, they develop gradually through routine decisions, familiar work practices, and small adjustments made under pressure.

This book was written to support operational leaders in recognising those patterns earlier.

The ideas presented here are drawn from practical experience developing leadership capability across high-risk environments. They focus on how leaders observe work, communicate with their teams, make decisions as conditions change, and solve problems safely and effectively.

My aim is to help leaders strengthen these capabilities and improve the systems that protect the people working within them. Because in high-risk environments, leadership carries real responsibility. The decisions made each day shape the conditions of work and ultimately determine whether people return home safely.

Tama Robson

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Introduction

When Routine Work Goes Wrong

It was routine work. The kind of task that had been completed many times before without incident.

Nothing about the job suggested it would end differently.

One incident has stayed with me throughout my career.

A FIFO worker was nearing the end of a three-week swing. Final day. Final hours. He was lifting and positioning a large component using an overhead crane.

The load had been lifted but was not yet secured. It remained suspended.

As he moved past it carrying tools, he dropped a spanner. It landed beneath the load.

When he bent to retrieve it, the crane remote in his pocket was inadvertently activated.

The load lowered, with fatal consequences.

At no point did the situation appear unsafe in the way people typically expect. There was no single catastrophic mistake. The task was familiar. The worker was experienced.

The environment appeared controlled.

Yet a series of ordinary conditions aligned at the wrong moment.

This is how serious incidents occur.

Not during abnormal work. But during work that feels completely under control.

And it is far more common than most organisations realise.

Research conducted by Sentis across more than 70 operational sites spanning eight industries and nine countries, involving over 20,000 workers, found that approximately 86% of organisations operate within negative safety cultures heavily reliant on compliance, enforcement, and consequence.

On the surface, these environments appear controlled.

But in practice, engagement with risk is limited. Reporting reduces. Conversations narrow.

Critical signals are less likely to surface. This does not mean risk is absent. It means it is developing unnoticed.

Serious incidents rarely begin with something obviously wrong. More often, they develop through routine work repeated.

Over time, familiarity reduces vigilance. Assumptions replace verification. Small deviations begin to feel acceptable because nothing has gone wrong yet.

This is how complacency develops. This is how systems drift. Risk builds quietly in the background, often unnoticed.

Looking back, the warning signs were there. They were present but not acted on early enough.

In many incident investigations I have been involved in, a similar pattern appears. Organisations had systems in place. Hazards were understood. Procedures had been written, communicated and trained. Permit systems were in place. But the way work was being performed had slowly changed.

These systems are necessary. But they are not sufficient.

The gap is not in what is written. It is in how work is led in practice.

Small adjustments are made to deal with pressure, time constraints, and the realities of the job. Those adjustments appear to work, so they are repeated. Over time, they become normal practice.

Organisations can find themselves operating outside the safety boundaries they believe are still in place.

When an incident occurs, it becomes clear that the conditions leading to the event had existed for some time.

Operational work is dynamic. Conditions change. Pressure increases. Equipment behaves unpredictably. People must make decisions in real time.

In those moments, safety is influenced less by what is written in procedures and more by how leadership is applied in practice.

Leaders influence safety through how they communicate expectations, how they respond to emerging problems, and how they make and manage decisions as conditions change.

When these capabilities are strong, organisations recognise and manage risk more effectively. When they are weak or inconsistent, the early warning signs of failure are missed.

This book examines how leadership shapes safety outcomes in real operational environments.

It explores the patterns that appear repeatedly in serious incidents, the conditions that allow risk to develop unnoticed, and the leadership behaviours that help teams recognise and respond before something goes wrong.

Because in high-risk industries, the responsibility carried by leaders is real.

At the end of every shift, every person who came to work should be able to return home safely.

Operational leadership determines whether that outcome is achieved.

Operational Safety Leadership in Practice

Operational safety leadership is developed over time. It is shaped through experience, through incidents, and through the way leaders respond as the operating environment shifts. Performance may not remain constant. It moves. Conditions improve, then deteriorate. Pressure rises, then recedes.

To guide this journey, this book draws on three leadership practices inspired by the principles of **Matariki**, the *Māori* New Year in *Aotearoa* New Zealand.

Traditionally, **Matariki** marked a time of **Reflection**, **Renewal**, and **Preparation**. It was also used as a point of reference for navigation, guiding journeys through uncertain conditions.

Operational environments are no different.

Leaders operate in conditions where the path is not always clear. Information is incomplete. Pressure is real. Decisions must be made in real time, often without the luxury of stopping to fully reassess every situation. In these moments, leadership requires discipline.

Leaders must **Reflect** on how incidents occur and what their organisations are learning from them.

They must **Reset** their attention on the conditions that exist now, recognising that signals often appear before something goes wrong.

And they must **Prepare** their teams to operate safely in environments where pressure, uncertainty, and complexity are part of everyday work.

I have come to see these not as separate activities, but as a continuous leadership discipline:

Reflect. Reset. Prepare.

Together, these practices form a continuous cycle:

- Leaders **Reflect** on what has happened.
- They **Reset** their attention on what is happening now.
- And they **Prepare** their teams for what comes next.



This cycle provides a practical guide for navigating the realities of operational safety leadership and forms the foundation for the ideas explored throughout this book.

The lessons presented here are drawn from real operational environments and from the investigations that follow when things go wrong. They reflect the realities faced by those responsible for leading work where the consequences of mistakes can be severe.

Operational safety leadership determines whether that outcome is achieved ... or NOT.

The Operational Safety Leadership Model (OSLM)

In high-risk environments, safety does not fail because procedures are missing. It fails when execution breaks down under pressure. Across high-risk industries, the same pattern appears repeatedly: the systems are in place; the hazards are known; and the procedures exist.

Yet something still goes wrong. To understand why, we need to look beyond documentation and examine what shapes performance in real operational conditions.

This is where the **Operational Safety Leadership Model (OSLM)** provides clarity. It is grounded in how incidents develop in operational environments.

The Operational Safety Leadership Model (OSLM):



This model provides the structure for the concepts explored throughout this book.

How Performance Is Shaped Under Pressure

Safety performance in operational environments is not controlled by a single factor. It is shaped by the interaction of three critical elements:

1. **Human Performance** - How people think, perceive, and act in real time.
2. **The Leadership Cycle** - How leaders influence, reinforce, and improve performance
3. **The Operational System** - The conditions, structures, and environment in which work is performed

These three elements are always present, and under pressure, they determine how work is executed, not how it was intended.

Human Performance - How decisions are made in real time

In operational environments, people are constantly interpreting information, making decisions, and acting often under time pressure, fatigue, or uncertainty. Performance in these moments is shaped by a simple sequence:

- **State** – The physical and psychological condition under pressure
- **Signals** – What is noticed, missed, or misinterpreted
- **Response** – The decisions made and actions taken



When conditions are stable, this process often works effectively. But under pressure, attention narrows. Signals can be missed. Assumptions replace verification.

This is where risk begins to increase.

Not because people don't care, but because performance is being shaped in real time by conditions they may not fully recognise.

The Leadership Cycle - How performance is shaped and sustained

While human performance determines what happens in the moment, leadership determines how consistently people perform. Effective operational leadership follows a continuous cycle:

- **Reflect** - Understanding what happened and how risk developed.
- **Reset** - Re-evaluating current conditions, risks, and signals.
- **Prepare** - Strengthening capability, communication, and decision-making before work begins.

This cycle is not a one-off activity. It is a discipline. Organisations that apply it consistently build stronger awareness, better decision-making, and more reliable execution under pressure. Organisations do not often find themselves reacting after something has already gone wrong.

The Operational System - The conditions that shape behaviour

Work related tasks do not operate in isolation. Every action or decision is made within a system that influences how work is performed. This includes:

- Workload and time pressure.
- Competing priorities (safety vs production).
- Quality of planning and supervision.
- Communication standards.
- Clarity of roles and accountability.
- The way procedures are applied in practice.

These conditions do not just support work; they shape how work is performed.

In practice, an Operational System determines:

- What people pay attention to.
- What they prioritise.
- What is accepted as normal.

When these conditions are stable and well managed, they support consistent performance.

When they are misaligned or under pressure, they can gradually shift how work is performed, often without it being immediately recognised.

Why This Matters

Most organisations invest heavily in systems, procedures, and compliance. These are necessary, but they are not sufficient. Because safety is not determined by what is written down. It is determined by how people perform, how leaders influence that performance, and the conditions in which actions and decisions are made.

The **Operational Safety Leadership Model** brings these elements together. It provides a practical way to understand:

How risk develops:

- Why warning signs are often missed.
- How leadership influences outcomes in real time.
- What needs to change to improve performance under pressure.

A Practical Lens for Leadership

Throughout this book, you will see these elements repeatedly:

- How risk develops within operational systems.
- How signals are missed or misinterpreted.
- How decisions are shaped under pressure.
- How leadership influences what happens next.

The goal is not to introduce theory. The goal is to provide a practical lens that helps operational leaders:

- Recognise risk earlier.
- Make better decisions under pressure.
- Strengthen how work is executed in real environments.

Because in high-risk industries, safety is not controlled by systems alone. It is shaped in moments. And those moments are influenced by people, leadership, and the conditions in which they operate.

Section One – Reflect

This section focuses on how risk develops within operational systems, how work changes over time, and how early signals are often present long before an incident occurs.

The ***Operational Safety Leadership Model*** relates to how conditions within the operational systems evolve, and how signals that indicate increasing risk are often present but not always recognised in real time.

In high-risk industries incidents rarely occur as the result of a single mistake or sudden failure. More often they develop gradually through small changes in attention, behaviour, and everyday operational decision-making and problem solving.



Tasks become familiar. Assumptions begin to replace deliberate evaluation. Small adjustments to how work is performed accumulate. While each individual change may appear reasonable, together they can gradually move work closer to the limits of unsafe operations.

The **Operational Risk Progression Model** illustrates a common progression through which operational risk tends to develop.

These changes rarely attract attention while they are occurring. Over time, however, they can significantly reshape how work is performed.

For operational leaders, recognising these patterns early is critical. The chapters that follow explore the stages of this progression and explain how these changes can influence the way work is performed in real operational environments.

Leaders must first **Reflect** on how risk develops within operational systems. They must then **Reset** their awareness of the **Signals** that indicate conditions may be changing. Finally, they must **Prepare** their teams to **Respond** effectively when those signals appear.

This **Reflect → Reset → Prepare** sequence reflects the **Leadership Cycle** introduced earlier and forms the foundation for the chapters that follow.

Chapter 1: The Reality of Risk

One of the most important lessons I have learned in high-risk industries is that serious risk rarely appears in obvious ways. It is often hidden inside ordinary work, familiar tasks, and conditions that appear manageable on the surface.

In many operational environments incidents do not begin with dramatic failure. More often they develop gradually through small decisions, routine adjustments, and assumptions that seem reasonable at the time. Risk can exist long before anyone recognises it.

Throughout my career I have worked with organisations operating in environments where the consequences of mistakes can be severe. Mining, oil and gas, construction, rail, manufacturing, and other heavy industries all share a common characteristic: the work is complex; conditions change quickly; and the margin for error can be very small. In these environments leadership plays a decisive role in how effectively risk is recognised and managed.

Operational leaders do far more than simply ensure tasks are completed. They must interpret changing conditions, communicate clearly with their teams, and make decisions in real time, often with incomplete information and under considerable pressure.

These decisions are not made in isolation. They are shaped by the conditions of the operational system, including workload, time pressure, competing priorities, and how work is organised in practice.

When serious incidents are examined, it is often clear that many of the technical controls intended to manage risk were already present.

- Procedures existed.
- Training had been delivered.
- Systems described how work should be performed safely.

The problem was not always the absence of controls. More often it was the way everyday decisions, conversations, and adjustments gradually changed how the work was performed and how controls were applied.

Work environments rarely remain perfectly predictable. Equipment behaves differently than expected. Environmental conditions shift. Unexpected obstacles appear. Teams adapt to keep work moving. Many of these adaptations are practical and necessary.

However, if these adjustments are not recognised and examined, they can also introduce new risk. Across many organisations I have seen the same pattern emerge. Change rarely appears as one dramatic breakdown.

Instead, it develops gradually through small decisions and adjustments that seem reasonable at the time. A step may be shortened. A condition may be accepted. A deviation may go unchallenged.

Individually these moments attract little attention. Collectively, they can begin to reshape how work is performed.

Recognising this reality is the starting point for operational safety leadership. Safety in high-risk environments is shaped not only by procedures and controls, but by the everyday interactions and decisions that influence how work is carried out.

To understand how these patterns develop, leaders must also recognise another common feature of operational environments, the gradual loss of vigilance that can occur when work becomes familiar and routine. That is where **Complacency** begins.

Chapter 2: Complacency — The Invisible Risk



One of the most dangerous characteristics of high-risk environments is that much of the work eventually becomes routine. Tasks are repeated day after day.

Equipment becomes familiar. Workers develop confidence in their ability to manage the hazards associated with the job.

Experience is essential in operational settings. Skilled workers understand their tools, recognise warning signs, and know how to respond when conditions change. Organisations rely heavily on this experience to operate effectively.

However, familiarity introduces a subtle and often overlooked risk. When work becomes routine, the level of attention applied to it can begin to change. Tasks that once required deliberate thought, gradually become automatic through repetition. Over time people rely more on memory and experience than on actively evaluating the conditions in front of them.

This shift rarely occurs suddenly. It develops gradually as individuals and teams perform the same tasks successfully over long periods of time. When work is completed without incident day after day it is natural to assume the task is under control. Procedures that once required careful attention may begin to feel unnecessary. Hazards that once demanded focus can start to appear predictable. This is how **Complacency** begins.

These patterns do not develop in isolation. They are shaped by the conditions of the operational system, particularly how work is structured, supervised, and repeated.

Complacency is rarely the result of people deliberately ignoring safety requirements. In many cases the individuals involved are experienced workers who have completed the task successfully many times before. Their confidence is built on past success.

The difficulty is that past success can quietly reduce vigilance. Checks that once felt important may be shortened or skipped because the outcome appears predictable. Pre-start discussions may become brief because the team believes they already understand the job. Risk assessments may be completed quickly because nothing unusual is expected.

Individually these changes appear minor. Together they can gradually reduce the level of attention applied to the work.

Experience plays a central role in how this shift occurs. As workers gain skill and familiarity with their tasks, the effort required to perform those tasks decreases. Activities that once demanded concentration eventually become second nature.

In many ways, this is exactly what organisations want. Competence allows work to be completed efficiently and reliably. However, the same familiarity that improves competence can also reduce conscious attention.

When work becomes automatic, people may stop actively thinking through each step of the process. Hazards that once stood out begin to fade into the background because nothing has gone wrong during previous attempts. The task feels predictable. The risks appear well understood. At this point competence can begin to move in one of two directions.

One, in environments where leaders encourage questioning, reflection, and discussion about risk, competence strengthens operational awareness. Workers continue to examine the task carefully, challenge assumptions, and learn from experience. Familiarity becomes a source of insight rather than overconfidence. In these environments competence contributes to stable operations and reliable performance.

Two, in other environments the opposite can occur. When work becomes routine and assumptions are rarely questioned, familiarity can begin to replace active attention. Workers rely on past success rather than evaluating current conditions. Small shortcuts may appear because the job is believed to be well understood. These shortcuts can begin to feel normal.

This dynamic is illustrated in ***The Competence Pathways Model***.

The model shows that competence does not automatically lead to complacency. Instead, leadership behaviour plays a critical role in determining the direction experienced teams take. When leaders encourage reflection and discussion about risk, competence strengthens operational vigilance and supports safe and stable operations.

When leadership attention weakens and work becomes routine, familiarity can lead to assumptions, shortcuts, and eventually the normalisation of deviation.

For operational leaders this distinction is important. Competence itself is not the problem. Competence is essential for safe and reliable performance. The challenge arises when competence becomes routine and the level of attention applied to the work begins to decline.

Maintaining curiosity about routine work is therefore essential. The more familiar a task becomes, the more important it is to remain attentive to how it is being performed.

Simple questions can help restore awareness.

- What are we assuming here?
- What has changed since the last time this job was done?
- What are we no longer checking because the job feels familiar?
- What has become normal in this team that would have concerned us six months ago?

These questions bring attention back to work itself.

They remind teams that routine tasks still require deliberate awareness. Because when attention fades, small changes can begin to appear in the way work is performed:

Individually these adjustments may appear harmless. However, when these changes are repeated they can gradually reshape how the task is performed.

The Competence Pathways

How Leadership Turns Competence Into Vigilance or Drift



What begins as routine behaviour can slowly evolve into accepted practice. This gradual shift in the way work is performed is rarely recognised while it is occurring.

These small adjustments accumulate, and the gap between how work was originally designed to be performed and how it is now performed begins to widen.

This is the beginning of **Operational Drift**. The next chapter explores how these small adjustments accumulate and how safe systems can slowly migrate away from their intended boundaries.

**Routine work is often where
serious risk hides**

Chapter 3: Operational Drift - How Safe Systems Slowly Fail

While working in operational environments and later during incident investigations, I began to recognise a recurring pattern. Systems rarely fail suddenly. In many cases the failure had been developing quietly for some time.

After serious events it is common to hear statements such as:

- ***“We have been doing it this way for years.”***
- ***“That is how the job is normally done.”***

These comments reveal something important about how work evolves over time.

Every safety system is designed with an expectation of how work should be performed. Procedures, risk assessments, and safe work methods describe the organisation’s intended approach to managing risk. They represent the organisation’s best understanding of how hazards should be controlled.

This is commonly referred to as **“work as designed”**. However, operational environments rarely unfold exactly as planned. Equipment behaves differently than expected. Environmental conditions change. Production pressures increase. Unexpected obstacles appear. In response, people adapt.

Teams who adjust keep work moving. Equipment may be used slightly differently to solve a practical problem. A step may be shortened to save time. Informal methods may develop that allow tasks to be completed more efficiently.

In many cases these adaptations are sensible and necessary. Operational work requires flexibility, and experienced teams are often very capable of adjusting to changing conditions.

This reality is often described as “**work as performed**”. The challenge is that “**work as performed**” does not always remain aligned with “**work as designed**”.

When adjustments are repeated without being examined, they can slowly reshape how the task is performed. An adaptation that initially solved a problem may be repeated during future tasks because it appears to work.

Eventually the adjustment becomes part of the normal way the job is done. New workers entering the environment may never realise the task was originally designed to be performed differently.

Operational Drift: Drifting Into Failure

How Work Gradually Migrates Towards The Boundary Of Unsafe Operations



This gradual shift is known as **Operational Drift**. Safety researcher *Sidney Dekker* describes this process as organisations slowly “**drifting into failure**” as small adaptations accumulate and move work toward the boundaries of safe/unsafe operation.

Each adjustment may appear reasonable when viewed in isolation. Workers are solving problems, responding to pressure, and trying to keep operations functioning. However, these small changes accumulate, and the system gradually migrates closer to the limits of unsafe operation.

In most organisations a clear boundary exists between the intended system and the reality of operational work. The upper boundary of the above diagram represents the organisation’s designed safety system. Procedures, risk assessments, and controls which describe how the work is expected to be performed.

Below this sits the reality of operational work. This represents the way tasks are carried out under real conditions. Between these two boundaries small changes begin to appear.

- Shortcuts may emerge.
- Workarounds may develop.
- Production pressure may influence decisions.
- Routine familiarity may reduce attention.

Each adjustment may appear minor. However, when these changes occur repeatedly, they gradually move the way work is performed further away from the system that was originally designed to manage risk.

One of the reasons operational drift is difficult to recognise, is that the work often continues to be completed successfully for long periods of time. Because no incident occurs, the adjustments appear safe.

This reinforces the belief that the modified way of working is acceptable. Over time the deviation becomes normal, and the new method replaces the original system. By the time an incident occurs the conditions that contributed to it may have been present for months or even years.

Recognising operational drift requires leaders to remain curious about how work is being performed. It requires observing tasks directly and encouraging open discussion about how teams adapt to operational pressures.

The operational leadership challenge is ensuring these changes are recognised, discussed, and properly evaluated so the organisation understands their impact on safety.

When this awareness is absent the gap between the intended system and the operational reality continues to widen.

One factor that often accelerates this gap is the way organisations approach safety systems themselves. This leads to another common pattern in safety management, the ***Compliance Trap***.

Safe systems rarely fail all at once

Chapter 4: The Compliance Trap



In most high-risk organisations, safety is supported by many systems. Procedures describe how tasks should be performed. Risk assessments identify hazards, risk, and controls. Permits are used to control high-risk activities. Meetings, audits, and inspections are intended to confirm that these systems are working.

These systems serve an important purpose. They create structure, establish expectations, and help organisations demonstrate that risks are being managed responsibly.

However, a common problem begins to appear when organisations start to treat these systems as evidence that safety itself is under control.

When documentation becomes the primary measure of safety performance, attention can slowly shift away from the work where risk exists. This is what I refer to as the “**Compliance Trap**”.

The **Compliance Trap** occurs when organisations rely heavily on documentation as evidence that safety is under control while the operational behaviours that manage risk receive far less attention.

Documentation has an important purpose. Procedures create consistency. Risk assessments help teams consider hazards, risks, and controls. Permits establish some control over high-risk activities. These systems provide structure and help organisations demonstrate regulatory compliance.

However, the difficulty arises when documentation becomes the primary measure of safety performance. To see how this occurs in practice, consider a routine maintenance job inside a processing facility.

A team is scheduled to replace a valve on a section of pipework. Before the task begins, a risk assessment is completed and a permit to work is issued.

The documentation describes the isolation points, the tools required, and the steps and controls needed to complete the task safely.

On paper, the system appears fully compliant.

When the job begins the crew encounters a practical problem.

One of the planned isolation points cannot be accessed easily due to surrounding equipment.

Rather than stop the job completely, the team adjusts the method so the work can continue.

The change appears reasonable and the task is completed without incident. However, the paperwork still reflects the original plan.

The permit, the risk assessment, and the documentation all describe a method that was not ultimately used.

From a compliance perspective the job appears correct.

From an operational safety leadership perspective, the conditions controlling the risk have quietly changed without review and evaluation, or documentation being recorded and/or updated.

Situations like this occur regularly in operational environments. Work rarely unfolds exactly as planned, and experienced teams often adapt to keep tasks moving. The difficulty arises when these adaptations occur without discussion or evaluation. When safety systems become primarily administrative processes, the focus of safety conversations can begin to shift away from the work itself.

Leaders may ask whether the paperwork has been completed rather than whether the hazards are fully understood. Risk assessments may be signed quickly because they are required rather than limiting the risk with appropriate controls in place. Safety meetings may repeat familiar messages without encouraging meaningful discussion about emerging risks and how to control them.

From a compliance perspective the organisation may appear to be performing well. From an operational safety leadership perspective, the understanding of risk may be weakening.

This pattern is not isolated. It is reflected consistently across industry.

Research conducted by Sentis, examining safety culture across 73 organisational sites spanning eight industries and nine countries, included over 20,000 participants in safety climate surveys, supported by more than 5,000 face-to-face interviews and 562 focus groups.



The findings were consistent. 86% of organisations were operating within what the researchers describe as a “**negative**” safety culture, one heavily reliant on compliance, enforcement, and consequence.

In these environments, safety behaviours tend to be surface level. Work is performed in line with expectations when observed, but engagement with risk is limited. Reporting reduces, conversations narrow, and critical signals are less likely to surface.

This does not mean risk is absent. It means it is less visible.

In practical terms, this means many organisations are operating in conditions where signals exist, but are less likely to be raised, recognised, or acted on.

Avoiding the **Compliance Trap** requires leaders to remain closely connected to the workplace. Leaders must observe how tasks are performed. They must listen carefully to the people doing the work and encourage open discussion about how conditions are changing.

Safety systems should support these conversations. They should provide structure for thinking about risk, not replace the thinking itself. When leaders use safety systems as tools for discussion and learning, those systems can strengthen communication, decision-making, and problem solving, if utilised well. When systems become primarily administrative processes, they can unintentionally create a false sense of security.

Because in the end, safety is not created by documentation alone. It is created by the problem solving, decision making & management, meaningful communications through relevant conversations, and actions that shape how work is performed. Understanding this difference is an important step in developing effective operational safety leadership.

The next section of this book explores how leaders recognise the signals that indicate risk may be increasing and how they respond before incidents occur.

Identify Operational Exposure Before It Escalates

The Operational Safety Leadership Index (OSLI) helps operational leaders identify:

- leadership variability
- operational drift
- weakened reassessment
- operational exposure under pressure

Receive:

- ✓ Operational exposure scoring
- ✓ Leadership consistency insights
- ✓ Structured diagnostic feedback
- ✓ Practical recommendations

[Explore The OSLI — \\$97 AUD](#)

Section Two – Reset

In the first section of this book, we explored how risk develops in operational environments. We examined how complacency, operational drift, and over-reliance on compliance systems can gradually move work away from the safety boundaries organisations believe are in place.

Recognising how this occurs is critical. However, understanding risk development alone does not prevent incidents.

Operational leaders must also recognise when conditions within the operational system are changing in real time and respond before those conditions deteriorate.

The Operational Safety Leadership Model is where human performance becomes critical. In operational environments, decisions are shaped through a consistent sequence: ***State → Signals → Response***.

In operational environments these signals are rarely dramatic. They usually appear as small changes in behaviour, communication, or workplace conditions.

A worker may hesitate before starting a task. Equipment may behave differently than expected. A deviation from the plan may appear during the job. Under pressure these signals can easily be overlooked.

The purpose of this section is to explore how leaders recognise these signals and how their own communication, decisions, and behaviour influence how teams respond when conditions begin to change.

Because effective operational safety leadership is not only about understanding risk. It is about recognising when the system needs to reset.

Chapter 5: Leadership Under Pressure

Operational environments do not fail under calm conditions. They fail under pressure.

Work accelerates. Conditions shift. Priorities compete. Decisions are made faster, with less information and greater consequence.

In these moments, performance is not determined by what is written in procedures. It is determined by how leaders think, communicate, and act.

Pressure is not the problem. Unmanaged pressure is.

Experienced operational leaders are often capable in demanding environments. They can prioritise, coordinate, and maintain momentum when challenges arise. But pressure changes how information is processed. Attention narrows. Communication compresses. Decisions rely more heavily on experience.

When attention narrows, leaders focus on what is directly in front of them. Subtle changes in conditions become harder to recognise. Signals that would normally prompt questions are overlooked because they do not align with expectations.

This is a consistent pattern in operational environments. The warning signs are often present before an incident occurs. Conditions have changed.

Something does not quite align. Someone has noticed. Yet the signal is not recognised or acted on in time.

This is not a failure of competence. It is a shift in attention.

**Pressure does not only
affect pace**

The Impact of Pressure on Communication

Communication is often the first area affected. As pressure increases, conversations become shorter and more directive. The focus shifts to maintaining pace. Instructions replace dialogue. Questions become less frequent.

In this environment, workers may hesitate to speak up. Not because they do not recognise risk, but because the conditions suggest that raising concerns will disrupt progress. This is where risk begins to hide.

The people closest to the task often see the earliest signs of change. If communication does not allow those signals to surface, the system loses access to critical information.

Effective leaders recognise this shift. They deliberately slow communication when pressure increases. They ask more questions. They invite more input. They make it clear that speaking up is expected, not optional.

Because when communication narrows, awareness reduces.

The Safety vs Production Myth

Pressure often exposes a long-standing belief within operational environments that safety and production compete.

It shows up in familiar language like:

- ***“We need to get the job done.”***
- ***“We can’t slow the operation down.”***
- ***“Just this once.”***



This creates a false choice. Be productive or be safe. This is not a trade-off, it is a design failure.

When work is not designed to be executed safely under normal operating conditions, the gap is transferred to the worker.

In real time, that gap is managed through small adjustments. Steps are shortened, controls are treated as flexible, and deviations become acceptable as long as the task progresses.

Individually, these decisions appear practical. Collectively, they reshape how work is performed.

High-performing organisations approach this differently. They do not ask workers to choose between safety and productivity. They design work so both can be achieved together.

The question is not: ***Which matters more?***

The question is: ***How should this work be performed so it remains safe under real conditions?***

This shift changes how leaders respond under pressure. Instead of bypassing controls, they adjust the system. Instead of compressing the process, they seek clarity.

Over time, this creates stability. Teams communicate more openly. Risks are recognised earlier. Decisions are made with a clearer understanding of their consequences.

Planning as a Leadership Function

Planning is often treated as something completed before work begins. In operational environments, this is a mistake. Planning is not separate from execution. It shapes it.

Effective planning is not about predicting every outcome. Conditions will change. Equipment will behave differently. Constraints will emerge.

The purpose of planning is preparation. It establishes what matters, what must not fail, and how the team will respond when conditions begin to shift. It creates alignment between what is expected and how decisions will be made when the situation changes.

Poor planning creates the illusion of control. It looks complete but fails under real conditions.

Effective planning prepares leaders and teams to recognise change and respond deliberately. Because in operational environments, leaders rarely have the time to stop and fully reassess every situation. They rely on the clarity established beforehand to guide their actions.

Plans do not control outcomes. They shape how people respond when conditions change.

“Plans are useless, but planning is everything.” — Dwight D. Eisenhower

Leadership is the Management of Decisions

Leadership thinker *John C. Maxwell* describes leadership as the management of decisions. In operational environments, this idea is practical.

Decisions in operational environments are not isolated. They evolve as conditions change and must be actively managed.

Each decision influences what follows. It shapes how work is understood, what is accepted, and how the system responds under pressure. These decisions establish patterns that define how work is performed.

The situation evolves. Information changes. What was once the right decision may no longer align with the reality of the work. Effective leaders recognise this. They do not treat decisions as fixed. They monitor, reassess, and adjust as required.

A Practical Example

A team is carrying out work outdoors.

The task has been planned, approved, and is underway. Conditions were stable when the job began, and the team is progressing as expected.

As the work continues, weather conditions begin to change. Dark clouds move in. Lightning is observed in the distance. It is not directly overhead, but it is moving closer.

The team notices. The leader is informed.

At this point, nothing has failed. No alarm has sounded. The task is still progressing.

But the conditions are no longer the same.

The decision that allowed the work to begin was based on what was true at the time. The question now is whether that decision still holds.

Continuing maintains progress. Pausing introduces disruption.

This is where leadership is tested.

If the work continues without reassessment, the original decision remains in place despite changing conditions.

If the work is paused, the decision is actively managed. The situation is reviewed. The course is adjusted based on new information.

This is how leadership operates in practice. Decisions are made. Conditions evolve. Leaders either adapt, or they continue based on what was previously true.

Bringing It Together

Serious incidents rarely result from a single dramatic decision. More often, they develop through a series of decisions that were not revisited as conditions changed.

New information became available. But the decision remained.

Over time, this is how risk increases. Not through a single failure, but through a pattern of decisions that no longer align with the reality of the work. This is why operational safety leadership is closely connected to decision making and management.

Leaders influence safety through how work proceeds, how concerns are addressed, and how teams respond when something does not appear right.

When leaders slow down, ask questions, and respond to changing conditions, they strengthen the system's ability to manage risk.

When decisions remain fixed despite new information, the system begins to shift. And when the system shifts without recognition, outcomes begin to move in the same direction.

The challenge for operational leaders is not simply making and managing decisions. It is recognising when the situation has changed, and responding appropriately before the outcome does.

Chapter 6: State → Signals → Response

In operational environments, decisions are only as good as the information they are based on. The challenge is not making decisions. It is recognising when the situation has changed.

This raises a more fundamental question; ***How do leaders recognise that those conditions are changing in the first place?***

Because before a decision can be adjusted, something must signal that it needs to be adjusted.

The Leadership Sequence

Operational leaders are constantly interpreting information. They observe the workplace, listen to their teams, and assess how conditions evolve as work progresses. Based on this, they decide how work should continue.

In practice, this process follows a consistent sequence that shapes how leaders recognise and respond to risk: **State → Signals → Response**



This is not a theory. It is how leadership operates in real time. Leaders do not always respond to reality directly. They respond to what they recognise. And what they recognise is shaped by their state.

State

A leader's state is their internal condition in each moment. It includes:

- focus
- fatigue
- emotional state
- level of pressure

In operational environments, leaders are rarely operating under ideal conditions. They are managing competing priorities, resolving issues, and maintaining progress.

When leaders are calm and attentive, they observe more effectively. They notice changes in conditions, pick up on subtle cues in conversations, and remain open to information that may challenge their expectations.

When leaders are under pressure, distracted, or fatigued, their attention narrows. The focus shifts toward completing tasks rather than evaluating conditions. This matters. Because a leader's state determines what they can identify and recognise.

Signals

Signals are the indicators that something in the system may be changing. They are rarely obvious. In most cases, they appear as small inconsistencies:

- hesitation before a task begins
- a piece of equipment behaving differently
- uncertainty in a conversation
- a deviation that “seems manageable”

Individually, these signals are easy to dismiss. That is the risk.

Signals are rarely missed because they are absent. They are missed because they are subtle. They do not align with expectations or experience.

When work feels familiar or under control, people are less likely to question it. When pressure is present, there is less appetite to slow down and explore uncertainty. This is how signals are ignored.

Communication plays a critical role.

Workers closest to the task often see the earliest signs of change. If they feel able to speak, those signals become visible. If they do not, those signals remain hidden.

In this way, signals are not just observed. They are shared.

Response

Once a signal is recognised, a decision should follow.

The response may be to continue, slow down, reassess, or stop. What matters is not the action itself, but whether it reflects an accurate understanding of the situation. Effective responses are rarely made in isolation.

They involve:

- gathering input.
- clarifying uncertainty.
- testing assumptions.
- aligning the team.

When signals are recognised early, responses can be deliberate. When signals are missed, responses may become reactive.

The Critical Link

The relationship is simple, but often overlooked:

- Response is shaped by what the leader recognises.
- What the leader recognises is shaped by their state.

This is where leadership either strengthens or weakens the system in real time.

- If a leader's state limits what they notice, signals are missed.
- If signals are missed, decisions are not adjusted.
- If decisions are not adjusted, the system begins to drift.

This is the connection to **Decision Management**. Leaders do not fail because they made a poor decision in isolation. They fail because they did not recognise that the decision needed to change.

What This Means in Practice

Effective operational leaders do three things consistently:

- They remain aware of their own state.
- They create conditions where signals can be shared.
- They respond early when something does not align.

These are not complex behaviours. But they require discipline. Because in high-risk environments, the earliest indicators of failure are often the easiest to ignore.

The sequence **State → Signals → Response** becomes a practical way to understand how leadership influences safety. It shifts the focus from procedures alone to attention, communication, and awareness.

But recognising signals is only part of the equation. For signals to be useful, workers must be willing to speak up.

Understanding how leaders create that environment is the next step in effective operational safety leadership.

Chapter 7: Self-Awareness in Practice

Operational leaders are trained to look outward: at the work; at the task; at the hazards; at the team. This is necessary. But it is not sufficient.

Because before a leader can recognise what is happening around them, they must recognise what is happening within them. This is where self-awareness becomes critical.

Self-awareness is the ability to recognise your own state in real time and understand how it is influencing your thinking, your communication, and your decisions.

They may not realise when fatigue, pressure, or frustration is shaping how they respond. They may not recognise when their attention has narrowed, when they are becoming reactive, or when they are no longer open to new information.

In high-risk environments, this matters.

Because a leader who is under pressure but does not recognise it becomes a risk within the system. Not intentionally, but structurally.

What Self-Awareness Looks Like in Practice

Self-awareness is not reflective theory. It is a practical discipline applied in real time. Effective leaders check their state at key moments:

Before the shift

- What am I bringing into today?
- Am I focused, or distracted?
- Am I prepared to listen, or just to direct?

During the work

- Am I asking questions, or pushing for progress?
- Am I open to input, or dismissing it?
- Has my attention narrowed?



When pressure builds

- Am I reacting, or thinking?
- Am I still taking in information?
- Would I recognise a concern if it was raised right now?

These are not abstract questions. They directly influence how leaders recognise signals and how they respond.

The Link to the Model

Self-awareness is what allows the model to function. If a leader cannot recognise their own state:

- they will miss signals,
- they will not adjust decisions,
- they will continue based on outdated information.

This is how competence becomes routine. This is how routine becomes complacency. This is how drift begins.

The self-aware leader notices this. They recognise when they are on autopilot. They pause. They reset.

And in doing so, they prevent small shifts from becoming larger problems.

Recognising your own state is one part of the system. But for leaders to act effectively, they also rely on something else.

They rely on people being willing to speak up.

Chapter 8: The Circle of Safety

Previously, we examined how leaders recognise signals and adjust decisions as situations evolve. Leaders respond based on what they recognise. For that to happen, they must have access to accurate and timely information. In operational environments, much of that information comes from the people doing the work.

Leaders are not present at every point in the operation. They rely on others to communicate what is changing, what is uncertain, and what does not align with the plan.

If that information is not communicated, it is not available to the leader. The signal exists, but it does not influence the decision.

Psychosocial risk refers to the likelihood that the way work is designed, organised, and led will negatively affect how people think, communicate, and respond in the workplace.

In practice, this shows up in how pressure is applied, how work is organised, and how people respond when conditions change.

It is present when people feel unable to speak, when concerns are dismissed, or when raising an issue carries a cost.

In this context, psychosocial risk is not separate from physical risk. It directly affects how information flows, how signals are shared, and how decisions are made. When these conditions are not managed, critical information remains unspoken, and emerging risk is not recognised early.

This is where the **Circle of Safety** becomes relevant. Leadership author *Simon Sinek* describes the **Circle of Safety** as the environment leaders create where people feel protected from internal threats.

In operational terms, this is not about comfort. It shapes how people behave, what they communicate, and how information moves through the system.

The earliest indicators of change are usually seen by those closest to the task. They notice when conditions do not match the plan, when equipment behaves differently, or when a task begins to feel uncertain.

These signals are often incomplete, but the value comes from them being shared early. Information does not move unless the environment allows it. Under safe and stable conditions, people are more likely to raise concerns. There is time to question, clarify, and explore uncertainty. Under pressure, this can change.

As pace increases and priorities compete, communication can become shorter and more directive. The focus shifts to maintaining progress. In this environment, raising a concern can interrupt momentum, delay the job, or require decisions to be revisited.

If experience suggests that raising concerns will not change the outcome, people become less likely to raise them. The signal is still observed, but it is not passed on.

Leaders are then working with an incomplete picture. Conditions may appear stable when they are not. Decisions continue based on the original plan, even though the environment has changed.

This creates a gap between what is happening and what is understood. That gap is where risk develops.

This does not happen through a single failure. It develops in routine work.

The following example illustrates how this occurs in practice.

A team is preparing to start a routine maintenance task that has been completed many times before.

During the pre-start, one of the workers hesitates. Something about the setup does not feel quite right. The equipment configuration looks slightly different, but the issue is not immediately clear.

*The supervisor runs through the plan quickly. The job is behind schedule, and there is pressure to return the equipment to service. **"Everyone Clear?"** the supervisor asks. No one responds.*

The worker considers raising the concern but pauses. Similar questions in the past have been dismissed or have delayed the job without changing the outcome.

The concern is not raised. Work begins.

As the task progresses, the condition becomes more significant. What initially felt uncertain develops into a failure that stops the job and creates a safety risk.

When the situation is reviewed, the early indication had been present before the task began. It had been noticed but not raised. At the time, the decision to stay silent appeared reasonable.

The concern was not fully understood. The job needed to proceed. The likely response was already known. But the signal never entered the conversation.

This is the point.

The signal was seen.

It was not shared.

The decision did not change.

The issue was not that the signal was missed.

The issue was not the individual.

It was the conditions that shaped their response.

This is how the **Circle of Safety** operates in practice. It determines whether information enters the system early enough for decisions to be adjusted.

The outcome was not determined by the condition alone. It was determined by whether the information entered the system in time.

The **Circle of Safety** is not defined by what leaders say. It is defined by how they respond when information challenges progress.

If a concern is raised and dismissed, the information is lost. The decision remains unchanged, and people become less likely to raise similar concerns.

If a concern is raised and considered, the information is examined, decisions can be adjusted, and future concerns are more likely to be shared.

This is how leadership behaviour shapes the flow of information.

When concerns are not raised or not acted on, the operation continues, but with reduced visibility. Work appears normal, but the system is operating with less information than it needs.

This is where the connection to ***Operational Drift*** becomes clear.

When changing conditions are not recognised and decisions are not revisited, small deviations begin to accumulate. Work continues, but the way it is performed gradually shifts away from what was intended.

Leaders influence safety through the decisions they make in the course of their work experience. The quality of those decisions depends on the quality of information available.

When information flows, decisions can be adjusted. When information is restricted, decisions remain fixed. The difference is not procedural. It is informational.

The ***Circle of Safety*** determines whether leaders have access to the information required to recognise change and respond effectively.

Creating that condition is not passive. It is shaped by how leaders act, how they respond under pressure, and how they handle information when it challenges progress. Understanding how leaders establish this in practice is the next step.

**If people do not feel safe to speak.
Leaders cannot see the signals that matter**

Section Three – Prepare

In the previous sections, we explored how operational leaders recognise risk as it develops within operational environments. Pressure, communication, and the internal state of the leader all influence whether signals of emerging risk are noticed or overlooked.

When leaders remain attentive to these signals and maintain open communication within their teams, organisations are better positioned to respond before problems escalate.

However, recognising risk is only part of the leadership responsibility.

Within the ***Operational Safety Leadership Model***, this section reflects the ***Leadership Cycle*** of ***Reflect → Reset → Prepare***, where awareness is translated into consistent leadership action.

Operational environments require leaders who can translate awareness into consistent action. The way leaders communicate expectations, make decisions, and respond to problems directly shapes how work is performed and how risk is managed in everyday operations. This influence is most visible at the frontline.

It is through daily interactions with teams that leaders establish how work is carried out, how concerns are addressed, and how competing priorities are balanced. These interactions define the standards that guide behaviour in the workplace. The chapters in this section focus on how leaders apply this influence consistently in real operational environments.

Chapter 9: The Operational Leader Effect

When organisations talk about safety and leadership, the focus often lands on senior management. Executives set direction, allocate resources, and establish the policies that shape how the organisation operates. Their role matters, particularly when it comes to defining expectations and creating the structures that support safe work.

But in high-risk environments, the greatest day-to-day influence on safety is rarely exercised in boardrooms or leadership meetings. It is exercised much closer to where the work is performed. Time and again, the people leading work at the frontline have the greatest immediate influence over how safety is experienced within a team.

Whether they are team leaders, supervisors, frontline managers, or owners directly involved in operations, their daily interactions shape how hazards are understood, how standards are applied, and how decisions are made when conditions begin to change.

This is where culture becomes real. Workers pay close attention to how their immediate leaders behave. They notice what is challenged and what is ignored. They notice whether concerns are welcomed or brushed aside. They notice whether production pressure overrides caution, or whether the leader is prepared to slow the job down and reassess when something does not feel right. These observations shape how teams interpret what truly matters.

Communication

Communication



Communication is one of the clearest ways this influence is expressed. The tone set during pre-start meetings, task conversations, and everyday interactions sends a constant message about how seriously risk should be taken. When leaders ask questions, listen carefully, and encourage open discussion about hazards and uncertainty, they create the conditions for risk to be recognised early.

When communication becomes rushed, purely directive, or dismissive, those opportunities begin to disappear. Workers may choose to keep concerns to themselves rather than interrupt the pace of the job or create tension within the team.

In that environment, important information about changing conditions remains hidden until the situation has already deteriorated.

Decision Making & Management

Decision Making



Decision making and management is another area where frontline leadership becomes highly visible. Throughout a shift, leaders are required to make and manage decisions about how work proceeds.

Some decisions involve obvious risk. Others appear minor at the time, such as whether to continue with a task, adjust the sequence of work, pause to clarify uncertainty, or accept a deviation because the job appears to be under control. These decisions do not remain fixed.

Conditions change, information evolves, and what was once an appropriate decision may no longer align with the situation. Effective leaders recognise this and actively manage decisions as conditions develop. They reassess whether the original decision still holds, seek additional input when required, and adjust the course when the situation changes.

These decisions do more than shape the immediate task. They signal what is acceptable.

When leaders pause, seek input, and reassess decisions as conditions change, they reinforce that safety is part of how the work is carried out. When decisions remain unchanged despite emerging information, a different standard is established.

Over time, teams come to understand whether decisions are actively managed or simply followed through, regardless of how conditions evolve.

Problem Solving

Problem Solving



Problem solving plays a similar role. Operational work rarely unfolds exactly as planned. Teams are constantly required to adapt to changing conditions. How leaders guide these adaptations is a strong indicator of leadership maturity.

Some leaders treat problems as interruptions to resolve as quickly as possible. Others use them as opportunities to understand the system more clearly. When teams are involved in working through problems, challenging assumptions, and discussing safer ways to proceed, they become more capable of managing risk together.

When solutions are imposed without discussion, teams may comply in the moment but fail to develop the awareness needed to recognise similar risks in the future. The role of the leader is not simply to keep work moving. It is to shape how work is understood, discussed, and executed under real conditions.

The Accumulation of Small Moments

Most of this influence is not exercised through dramatic interventions. It happens in ordinary moments.

- A leader choosing to listen instead of dismissing a concern.
- A leader asking one more question before work begins.
- A leader noticing hesitation and taking the time to understand it.
- A leader deciding to slow the job down when pressure is building.

These moments may appear minor, but they accumulate quickly. Over time, they establish the behavioural standards that define how work is performed. Improving safety performance in high-risk environments requires more than systems and procedures.

It requires capable leaders at the frontline who can communicate clearly, make sound decisions under pressure, and involve their teams in solving problems before those problems escalate.

This is where safety leadership is applied. Not in policy, but in practice. However, applying these behaviours consistently is not automatic. Operational environments are dynamic. Conditions change, pressure builds, and attention shifts. Without a deliberate approach, even capable leaders can drift back toward routine, assumption, and fixed decision-making.

This is why operational safety leadership must be treated as a discipline. A discipline of attention, communication, and decision management. Understanding what that discipline looks like in practice is the next step.

Chapter 10: The Discipline of Operational Safety Leadership

Throughout this book, we have explored patterns that repeatedly appear in high-risk operational environments. Complacency develops when work becomes familiar. Operational drift occurs when small adjustments gradually reshape how tasks are performed. Compliance systems can create a false sense of control when documentation replaces genuine leadership engagement with the work. These patterns rarely develop suddenly.

They emerge through everyday decisions, conversations, and problem solving. Tasks that have been completed successfully many times begin to feel predictable. Assumptions replace verification. Small deviations become normal. The system begins to operate differently from how it was originally designed.

When incidents occur, investigations often reveal that the conditions leading to the event had existed for some time. The warning signs were present, but they were not recognised or acted on early enough.

Safety in high-risk environments is not determined by procedures, policies, or compliance systems alone. These are necessary, but they do not operate independently. Their effectiveness depends on how leaders interpret and respond to the conditions surrounding the work.

Operational leaders influence safety every day through how they communicate, how they manage decisions under pressure, and how they guide problem solving as the situation evolves. In practice, this is a discipline of attention.

Leaders must remain attentive to signals that indicate change. They must notice when routine work begins to feel too familiar, recognise when pressure begins to influence judgement, and be willing to question conditions that do not align.

When this attention is present, organisations are better positioned to recognise risk early and respond before problems escalate. When it is absent, early warning signs can go unnoticed. Effective leaders tend to follow a consistent rhythm in how they manage this responsibility.

This rhythm closely resembles the spirit of **Matariki**. In *Aotearoa* New Zealand, *Matariki* marks the beginning of the *Māori* New Year and traditionally signals a time for **Reflection**, **Renewal**, and **Preparation**. Communities take time to reflect on the past year, consider what has been learned, and prepare for the season ahead.

- Operational leadership in high-risk environments requires a similar discipline.
- Leaders must **Reflect** on how risk develops within their operations.
 - They must **Reset** their awareness of emerging conditions.
 - They must **Prepare** their teams to respond effectively when those conditions change.



Together, these practices form the **Operational Safety Leadership Model**. The model describes a practical leadership approach.

Leaders begin by **Reflecting** on how incidents and failures develop. This includes recognising patterns such as complacency, operational drift, and the gradual normalisation of unsafe practices.

They then **Reset** their awareness of the conditions surrounding the work. This involves recognising signals, understanding how pressure influences behaviour, and maintaining communication that allows concerns to be raised.

Finally, they **Prepare** their teams by strengthening the behaviours that support safe operations. Clear communication, effective decision management, and collaborative problem solving enable teams to respond when conditions change.

At the centre of this model is the Leadership Sequence process: **State → Signals → Responses**

A leader's internal state influences the signals they recognise. These signals inform the decisions they make, and those decisions shape how the system responds. Those responses determine whether operations remain within safe boundaries or drift beyond them.

Operational safety leadership is not defined by a single decision or policy. It is defined by the consistent discipline of leaders who **Reflect**, **Reset**, and **Prepare** in response to changing conditions.

This model provides a structured way to understand how operational safety leadership functions in practice. But models do not lead. Leaders do.

And in high-risk environments, how leaders apply this in real conditions carries real consequence. Understanding that responsibility is the final step.

The **Operational Safety Leadership Model** brings together three elements that are always present in high-risk work.

The Operational System shapes the conditions in which work is performed. These conditions influence what people pay attention to, how work is organised, and what is accepted as normal.

Human Performance determines how those conditions are interpreted in real time. A leader's state influences the signals they recognise, and those signals shape the decisions and actions that follow.

The Leadership Cycle provides the mechanism for influencing both. Through the cycle of **Reflect, Reset, and Prepare**, leaders maintain awareness, recognise change, and guide how work responds as conditions evolve.

These elements do not operate independently. They interact continuously:

- The system shapes behaviour.
- Behaviour shapes decisions.
- Decisions shape outcomes.

Operational Safety Leadership is the discipline of managing this interaction in real time.

Leading with Responsibility

Operational environments are demanding places to lead. Conditions change, pressure builds, and decisions must be made with incomplete information. In these environments, safety is not determined by intention. It is determined by how work is performed.

Throughout this book, a consistent pattern has been explored. Work does not fail all at once. It shifts.

Conditions within the operational system change. Pressure influences attention. Decisions are made based on what is recognised at the time.

These small shifts influence how work is performed, often without being fully recognised while they are occurring.

At the same time, people are constantly interpreting and responding to the conditions in front of them. What is recognised, what is questioned, and what is acted on is shaped in real time. Under pressure, this becomes more difficult. Attention narrows. Signals become easier to miss. Decisions are made based on an incomplete picture.

This is not a failure of intent. It is how performance operates in real environments. Within this dynamic, leadership plays a critical role.

Leaders influence how work is understood through their communication. They influence how risk is managed through the decisions they make and how those decisions are revisited as conditions change. They influence how teams respond through the way problems are explored, discussed, and resolved in real time. They also shape how competing priorities are handled.

When safety is treated as something to be balanced against production, trade-offs begin to appear. When safety is integrated into how work is designed and led, those trade-offs reduce, and decisions become clearer under pressure.

Leaders influence whether safety systems remain practical tools for managing risk or become administrative processes that create a false sense of control. In this way, leadership determines whether the system remains aligned with the reality of the work.

The discipline of operational safety leadership is maintaining awareness within this environment and responding when it matters.

The practices of **Reflect, Reset, and Prepare** provide a practical way to do this:

- Reflecting builds understanding of how risk develops.
- Resetting maintains awareness of the conditions that exist in the present.
- Preparing strengthens how teams respond when uncertainty appears.

Applied consistently, this cycle helps leaders stay connected to the reality of the work, recognise change earlier, and guide more effective decisions under pressure.

Because in high-risk environments, safety is not created by systems alone, and it is not sustained by individual effort in isolation. It is shaped through the interaction between:

- The conditions in which work is performed.
- How those conditions are interpreted in real time, and
- How leaders guide communication, decisions, and problem solving as situations evolve

This is the responsibility leaders carry in high-risk operational environments.

It is not defined by policy or position. It is defined by attention, judgement, and action in everyday moments.

It shows up in:

- the questions they ask
- the signals they explore
- the decisions they revisit
- how they respond when something does not align

Because in the end, leadership in these environments is not just influence. It is responsibility. And how that responsibility is applied determines whether people go home safely.

He aha te mea nui o te ao?
He tangata, he tangata, he tangata

What is the most important thing of this world?
It is people, it is people, it is people

Chapter 11: The True Cost of Safety

The cost of safety is rarely understood in the way it needs to be.

In many organisations, safety is still framed as a moral obligation. Something that should be done because it is the right thing to do. And it is.

But in operational environments, that is not enough.

Every function within a business is required to justify its value. Finance, operations, and commercial teams all speak in terms of performance, return, and impact. Safety is no different.

Organisations do not struggle to invest in safety because they do not care. They struggle because the true cost of harm is not clearly understood or articulated.

And when the cost is not understood, the urgency to act is reduced.

Because in the end, operational performance depends on people. No people on the job means no operation.

The Visible Cost

Most organisations can quantify the direct impact of incidents: lost time injuries; medical treatment; insurance claims; legal costs; and downtime.

These figures appear in reports. They are reviewed by governance and leadership. They form part of the organisation's performance metrics. But even these numbers are often underestimated.

Because the true financial cost of harm extends beyond the incident itself: lost productivity, replacement labour, overtime, disruption to operations, and delayed schedules.

Most organisations underestimate how much of their operational performance is directly tied to the availability of their people. Yet this is only part of the story.

The Invisible Cost

The most significant costs are rarely captured in a report. They are experienced.

After a serious incident, something changes within a team. Trust shifts. People begin to question the safety of their environment. Conversations change. Confidence in leadership can be affected. Some individuals withdraw. Others become more cautious. Some leave entirely.

These impacts do not appear on a balance sheet. But they influence how work is performed long after the event itself.

They also change how people engage with their work. Discretionary effort reduces. Attention shifts. The willingness to speak up declines.

Over time, this affects how work is performed and how risk is managed. These are not abstract impacts. They are real and operational.

There is also a personal cost. Leaders involved in serious incidents often carry the weight of the decisions that led up to that moment. Decisions that may have seemed reasonable at the time, but in hindsight, are viewed differently. This is not something that can be measured. But it is something that is real. And it is often lasting.

When these impacts are viewed in isolation, they appear manageable. When viewed collectively, they represent a direct loss to operational performance, productivity, and financial outcomes.

This is where safety begins to align with business reality.

The Leadership Cost

When a serious incident occurs, it rarely starts in the moment of failure. It is the result of conditions that developed over time; signals were present; decisions were made; and work continued. The system shifted gradually.

The real cost of safety failure is not just the outcome. It is what the outcome exposes. It exposes the gap between what leadership believed was happening, and what was happening.

It shows that the system was already under pressure. The system shifted gradually as work continued under changing conditions. Not because people intended harm. But because the conditions allowed it.

This is the cost that matters most. Because it shows that the failure was not sudden. It was developing.

The Cost of Inaction

In many organisations, safety improvements are often delayed. Not because the risk is unknown, but because the impact is not fully understood.

There is a tendency to believe: ***“It won’t happen here.”*** Or ***“We have managed this before.”***

This is where risk is allowed to grow. Because when the cost of failure is underestimated, action is delayed. And when action is delayed, conditions continue to shift without correction.

What This Means

The cost of failure is not created in the moment of the event. It is created in the decisions that came before it.

It is created when signals are present but not acted on. When conditions change but are not recognised. When work continues based on what was previously true, not what is true now.

By the time the outcome becomes visible, the system has already moved beyond the point where intervention was possible.

This is not a failure of intent. It is a failure of recognition. And that is where leadership matters most.

Final Reflection

By the time the cost of failure becomes visible, the opportunity to prevent it has already passed. That is the reality of operational environments.

Incidents do not begin in the moment of failure. They develop through conditions that were present, signals that were available, and decisions that were made but not revisited.

This is not a failure of intent. It is a failure of recognition.

And that is where leadership matters most.

Because in high-risk environments, the difference is rarely what is known. It is what is noticed.

It is what is questioned.

It is what is acted on before the outcome is decided.

Leadership does not remove risk. It determines whether risk is recognised in time.

And in the end, that responsibility sits with the people leading the work.

Every shift. Every decision. Every moment that appears routine.

Operational Safety Leadership 90-Day Program

Structured implementation support for leaders seeking stronger operational leadership execution under pressure.

Strengthen:

- operational rhythm
- leadership consistency
- execution discipline
- accountability under pressure

Designed for operational leaders seeking practical implementation support across real operational environments.

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Putting It Into Practice

The Operational Safety Leadership Model (OSLM) is built on three connected disciplines: ***Reflect***, ***Reset***, and ***Prepare***.

These are not steps to be followed in sequence. They operate together in real time, shaping how leaders understand work, respond to change, and guide their teams under pressure.

- ***Reflect*** focuses on understanding how work is performed.
- ***Reset*** focuses on recognising when conditions shift and responding accordingly.
- ***Prepare*** focuses on establishing the conditions required for work to be performed safely under pressure.

Understanding the model is only useful if it changes how leaders act. In practice, this means asking better questions.

Reflect

- Where is this task most likely to drift from plan?
- What assumptions are being made about conditions, equipment, or capability?
- Where has this work required adjustment in the past?
- What does “work as performed” look like in this environment?

Reset

- What is different from what was expected?
- Is anyone hesitating, uncertain, or working around a problem?
- Are we still operating within the conditions the work was planned for?
- Has anything changed that requires us to pause or reassess?
- Am I responding to current conditions, or relying on past experience?

Prepare

- What are the conditions under which this work must not proceed?
- What would cause us to stop and reassess?
- Have we created an environment where concerns can be raised without hesitation?
- Have we made it clear what matters if conditions begin to shift?

These prompts are simple by design. Their value is not in complexity, but in consistent use.

About the Author



Tama Robson has spent his career working in and alongside high-risk operational environments where leadership decisions carry real consequences. Across industries including mining, oil and gas, construction, rail, manufacturing, and defence, he has supported organisations to better understand how leadership behaviour influences safety outcomes.

Through operational experience, incident investigations, and leadership development work, he has seen consistent patterns in how serious incidents develop. Many are not the result of a single catastrophic failure, but the accumulation of small decisions, communication breakdowns, and missed signals that gradually increase exposure to risk.

His work focuses on strengthening the leadership capability required to recognise and manage risk in real conditions. This includes communication, decision-making and management, and problem solving in dynamic operational environments.

The ideas in this book are drawn from those environments and the leadership challenges faced by those responsible for guiding work under pressure.

At the heart of this approach is a clear belief: leadership plays a direct role in whether risk is recognised, understood, and managed before harm occurs

This means taking responsibility for how work is led, how decisions are made, and how risk is managed before people are exposed to harm.

Tama Robson is the founder of Elev8iQ Solutions, specialising in operational safety leadership, risk management, and leadership development across high-risk industries.

His work focuses on bridging the gap between safety systems and operational reality, supporting organisations to better recognise and manage risk under real conditions.

For more information, visit: <https://www.elev8iq.com.au/safety-leadership-resources>

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HIGH-RISK ENVIRONMENTS DO NOT FAIL BECAUSE PEOPLE IGNORE SAFETY. THEY FAIL UNDER PRESSURE.

Work accelerates. Conditions change. Decisions are made with incomplete information. In these moments, risk is not always obvious. It develops through small changes in how work is performed, how decisions are made, and how signals are recognised.

Operational Safety Leadership challenges the traditional view of safety as a system of compliance and control.

Instead, it focuses on how leaders influence the way work is actually carried out.

Drawing on real operational experience across mining, construction, rail, oil and gas, and manufacturing, this book explores how incidents develop over time, often through routine decisions that appear reasonable in the moment.

It introduces a practical model built on three elements: Reflect, Reset, and Prepare. A framework designed to help leaders recognise change early, respond effectively under pressure, and maintain safe operating conditions in real work environments.

THIS IS NOT A BOOK ABOUT PROCEDURES. IT IS ABOUT HOW LEADERSHIP DECISIONS SHAPE OUTCOMES.

For leaders responsible for guiding work in high-risk environments, the question is not whether risk exists.

IT IS WHETHER IT IS RECOGNISED IN TIME.



TAMA ROBSON is the founder of Elev8iq Solutions and a specialist in operational safety leadership across high-risk industries.

With over 15 years of experience in mining, construction, rail, oil and gas, and manufacturing, his work focuses on improving how leaders recognise and manage risk under real conditions.

He works with organisations to bridge the gap between safety systems and operational reality, strengthening leadership capability where it matters most.

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