PART 2

Talking about "What Happened"

Post-event risk communication

Don't hide your misdeeds. Go public with your investigation.

By PETER M. SANDMAN

Many organizations make serious errors talking about the past — in the aftermath of an accident, say, or a near-miss, or an OSHA decision to impose a fine. Last month, I offered five recommendations for a post-event communication protocol, grounded in the lessons of risk communication. Here is Part 2, with five additional recommendations. Comments and suggested additions are welcome at peter@psandman.com.

Show what you're doing to make it right.

The process of forgiveness begins with acknowledgment and apology (and letting others berate you). Then you have to make it right.

"Making it right" after an accident means at least two things. First, it means doing as much as you reasonably can for those who were harmed. If there are people in the hospital, for example, offer to pay medical bills without requiring any sort of legal release as a precondition. If some cars in the parking lot got scorched by the fire, give the owners enough cash for a new paintjob.

The second half of making it right is to learn your lesson visibly. Of course harvesting accidents and near-misses for "lessons learned" is standard operating procedure for industrial safety professionals. What may not be standard is aggressively communicating your determination to do so — and later, just as aggressively communicating what you learned (that is, what was wrong that you are now making right). My clients are typically much more willing to learn from their mistakes than they are to say what those mistakes were. But candor about what you have learned gives the accident meaning in the minds of those who suffered the consequences. It is a prerequisite to forgiveness.

Conduct a public investigation.

One way to dramatize that you are serious about "lessons learned" is to conduct a public investigation. Like many other suggestions in this two-part article, this one may run afoul of legal problems; certainly you can't do your own public investigation without regard to what regulators and plaintiffs' attorneys might be doing. But if you have the will and the courage, you can invite everyone with relevant information to come tell you what they know, and everyone with a stake in the findings to come listen and deliberate with you.

This sort of transparent investigation not only gets closer to the truth of complex events; it also makes clear your determination to let the truth come out. Your company can't easily hide its misdeeds in this sort of environment — but your company's critics can't easily nail it for misdeeds it didn't commit. Critics and conspiracy theorists thus face a tough choice: Either they join you in collaborative fact-finding, or they marginalize themselves by refusing to participate.

Discuss rumors, even false ones.

Decades of experience with rumor control efforts all boil down to three principles. (1) Don't even bother trying to keep people from telling each other (and an inquiring reporter) what they've heard. It can't be done. (2) The only effective way to diminish the impact of rumors is to compete with them, not to try to squelch them. Put out your own information, lots of it. (3) Ignoring false claims in rumors because you don't want to give them added currency and credibility is usually a mistake. If people are saying X when the truth is Y, don't just say Y. Say you heard that X rumor too; you tracked it down, and here's what you learned....

Publicize near-misses and other kinds of warnings.

"No harm, no foul" is terrible safety policy, and it is just as terrible risk communication. Near-misses deserve a full court press in both arenas. When awful things almost happen, in other words, the right thing to say is: "We got lucky. But that was too close for comfort. We need to figure out how to correct the

continued on page 38

10 recommendations

1 - Tell everyone who should know.
This includes federal, state, and local regulators that you are legally obligated to notify. It also includes people in your own chain of command, and very likely your attorneys and insurers.

2 - Tell everyone who knows already or is likely to hear.
Give the people who were involved (and their families) a full accounting.

3 - Don't ever minimize what happened.
If someone gets hurt, apologize and hope for a full recovery instead of downplaying injuries.

4 - Include damaging or embarrassing information.
Post-event communication isn't about telling your side of the story. It's about telling the whole story.

5 - Say you're sorry.
Blame works like a seesaw. The more you blame yourself, the less we blame you.

continued on page 38

Talking about "What Happened"

continued from page 36

mistakes that almost caused a catastrophe." Near-misses are wonderful opportunities for sharing ideas and concerns in a much less blameful atmosphere than after an actual accident. And since near-misses usually hit the rumor mill quickly, you need to address them quickly too.

Other kinds of warnings also deserve to be communicated. When a regulator fines your company for allowing dangerous conditions to exist, for example, it is tempting to say nothing, or to dismiss the fine as unimportant because nobody got hurt. But it is wiser to publicize the fine as a warning shot across your bow — and then to publicize the steps you have taken to correct the underlying problems. This is better for your safety culture, better for your credibility, and better for your relationship with the regulator. (After an actual accident, prior safety violations are inevitably big news. Raise them yourself and frankly discuss what relevance they might have to what just happened. Don't wait for Eyewitness News to do it for you.)

In the health arena, what I have sometimes called "yellow flags" also deserve public acknowledgment. Suppose you have a study that suggests, very tentatively, that a chemical used at your facility might be carcinogenic. The evidence is still weak and preliminary; the regulators know about the study and haven't required any changes; the chemical is still in use, and rightly so. But you're a little warier now, alert to see if other studies trend in the same direction. Don't wait for more data before telling management and employees about the study.

Be the last, not the first, to "forget."

This is another risk communication seesaw. How long we dwell on an accident before it is time to "put it behind us" is up to us, not you. We dwell on it longer if you prematurely urge us to move on. During the anthrax attacks of 2001, U.S. health agencies didn't realize that "weaponized" anthrax spores could escape from sealed envelopes. By the time they discovered they were wrong, two postal facilities were contaminated and two postal workers were dying. At first the authorities wanted to hurry past the error and focus on what to do next — and postal workers, understandably preoccupied with the error, remained mistrustful and incompliant. Only when the authorities backed up and apologized more fully for the past did the postal workers feel ready to concentrate on the future.

For similar reasons, Union Carbide used to publish an ad on the op-ed page of The New York Times every year on the anniversary of the Bhopal disaster. Others may have forgotten, the ads suggested, but the company must never forget. There is much to criticize in Carbide's handling of its responsibility for Bhopal, but these ads were a bright spot. | ISHN

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10 recommendations

continued from page 36

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7 - **Conduct a public investigation.**
A transparent investigation makes clear your determination to let the truth come out.

8 - **Discuss rumors, even false ones.**
The only effective way to diminish the impact of rumors is to compete with them, not to try to squelch them.

9 - **Publicize near-misses and other kinds of warnings.**
"No harm, no foul" is terrible safety policy.

10 - **Be the last, not the first, to "forget."**
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