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AFFAIRS OF GOVERNMENT 2016:

Some Thoughts on Real Risk Management

Thanks so much for again inviting me to Utah to speak to you regarding your chosen profession. It is an honor to be here with you today, and I hope that my comments over the next three hours or so allow you to go back to your department and further improve your operations.

I know that you are a mixed group of public safety personnel and some managers and Executives present here today. With that in mind I guarantee you that not every word I am going to say today will apply to you. But hopefully by the end of our time together you will pick up some information that you can take back to your respective organization and make work for you with the ultimate goal of improving the quality of your operations.

If you have been to any of my programs over the last 36 years you know that I spend a lot of my life studying tragedies. These tragedies are sometimes caused by intentional misconduct, but many involve errors or mistakes made by our own personnel.
As I study tragedy (in any occupation or profession) I am looking for the *cause* of the tragedy. All too often, when people search for *cause*, they default to the event that immediately preceded the tragedy – and somehow that event is given the title of *cause*.

Here is a primer on risk management. The event that instantly preceded the tragedy can be identified the *proximate cause*. Real risk managers like to go back in time and search for *Root Cause,* or conditions or cultures within the organization – issues that really caused the tragedy.

When you do this analysis conscientiously, oftentimes you will find *problems lying in wait* that people knew about or should have known about and no one did anything about it. And to conclude this thought, when you identify root cause you can then put appropriate control measures in place to help prevent a similar tragedy from occurring again.

To be fair, not all tragedies can be prevented. If some idiot is bent on shooting a cop today here in Utah, he is going to pull it off. It is very difficult to prevent intentional misconduct.

But almost all of your tragedies (injuries to personnel, death of personnel, lawsuits and organizational embarrassments) are caused by error and thus can be addressed proactively – and you have a key role here in going back to your respective organizations here in Utah and establishing appropriate control measures to address the real risks you face. How can this be done in your high-risk and complex profession?

What can be done to address the voluminous risks and increasing complexity of our jobs? Years ago we witnessed all of the problems that Japan faced with their nuclear power plant that failed after the earthquake and subsequent tsunami.

That ongoing event has caused me to recall a name from graduate school – a man who was attempting a very complex and risky assignment and who faced tremendous obstacles. His name was Admiral Hyman Rickover, known to many of you as the father of the U.S. nuclear navy.

I was fortunate enough to be introduced to his work when I was a young kid in grad school in the mid '70s – and as I was impressed with what this immigrant to the U.S. in 1906 was able to do for our nation in the '50s, '60s, and '70s.

The end of the story is that he directed the building of a nuclear fleet that has not only protected my country and the rest of the free world, but that simultaneously has achieved an outstanding safety record. This impressive safety and reliability record is the result of a lot of hard work by Admiral Rickover and his staff.

He developed some rules to achieve success (read – safe operations and deployment ready) known colloquially as the Seven Rules of Rickover. One of the goals of the graduate program I was in was to learn how his rules could be made applicable to other branches of the U.S. military. As I sat there 40 years ago, I was wondering if these rules applied to my complex, high-risk job in CHP operations.

As you read these, ask how many of them apply to the complex world of your operations here in Utah. Let's take a look at each of these rules and explore the possibilities.

Rule 1. You must have a rising standard of quality over time, and well beyond what is required by any minimum standard.

We have to get better and better at what we do. Minimum standards are just that – minimum standards. Your profession deserves better than minimum standards. The communities you serve deserve better than minimum standards. Your personnel deserve better than minimum standards. The people you have in-custody deserve better than minimum standards.

We must be constantly looking for a better way to do things. Status quo – we have always done it this way – is no longer acceptable. And sadly I see a lot of status quo around this great nation.

Continuous improvement has got to be part of the way we do business. Anything you can quantify and anything we can measure has to be identified and we must be constantly searching for the next best way. And when we find the next best way must commence the search for the *next* next best way. And I am not talking about change for change's sake – but a bona fide effort to continually improve the way we do business.

Strategic Hints for Your Consideration:

- What is the lost time injury rate in each unit of your organization, and what control measures can you put in place to reduce this injury rate?
- What are the fleet maintenance costs in your organization and what can be done to reduce these expenditures?
- What is your fleet mileage and what can be done to increase that number?
- When was the last time your people were trained and tested on their *core critical tasks*? More on this throughout our time together, but in every job there are a limited number of events that end up in tragedy.

Rule 2. People running complex systems should be highly capable.

Successful operations require people who know how to think. Fifty years ago, you did not need to be all that sharp to be a cop or a firefighter. Back then you had to be competent and a hard worker.

While the above attributes are still important, we must recognize that things have changed. Technology, equipment, strategies, and tactics involved in providing services to our community and protecting our citizenry have all changed. This is an extremely complex job, and if you hire people who can't think things through, you are en route to disaster.

If you allow the hiring of idiots or thugs, they will not disappoint you – they will always be idiots or thugs. In view of the consequences that can occur when things do not go right in your complex, high-risk job, this may end up being the cause of a future tragedy. We have learned this lesson time and time again, but somehow seem to forget it all too often.

And please don't tell me that you have nothing to do with the hiring process. Each of you has a role in recruitment and each of you has a role in the probationary process of each

employee. More on this throughout our time together, but you have got to take your role in these processes seriously.

I could tell you stories about organizations – including organizations just like yours – from around America who failed to weed out a loser and paid the price. Every nickel you spend in weeding out losers up front has the potential to save you a million dollars. If you get bored tonight, just Google "Annie Dookhan" and see how much grief one bad employee can do.

Strategic Hints for Your Consideration:

- Does your workforce reflect the community you protect and serve?
- After date of hire, when is the next time you do a background investigation on your personnel?
- Do you have a process to assure that the probationary period is being taken seriously?
- If I were to audit two years' worth of performance evaluations, what would I find?

Rule 3. Supervisors have to face bad news when it comes, and take problems to a level high enough to fix those problems.

When you take an honest look at tragedies in any aspect of your operations, from the lawsuits to the injuries, deaths, embarrassments, internal investigations, and even the rare criminal filing against our own personnel, so many of them get down to supervisors not behaving like supervisors. The primary mission of a supervisor is systems implementation.

If you promote people who either can't or won't enforce policy, you are en route to tragedy. To be sure, the transition from line employee to supervisor is a difficult one, but the people chosen to be supervisors have to understand the importance of their job.

Sadly, we have too many people who call themselves supervisors who have never made a successful transition from buddy to boss. Not to beat this point to death, but you show me a tragedy in any operation – including some in the news today right here in Utah – and I will show you the fingerprints of a supervisor not behaving like a supervisor – or a supervisor who tried to do his/her job and was not supported by management. There will be more on this throughout our time together.

Strategic Hints for Your Consideration:

- What is the process you have in place to promote people? Is there a better way?
- Do you have a formal training program prior to their being promoted?
- Do you have a formal mentoring program to assist them in this transition?
- Do you analyze events after occurrence to assure that supervisors were doing their job?
- Have you considered bringing back the best of the best to help train and mentor your new supervisors? I really like this idea and I know it can work for you.

Rule 4. You must have a healthy respect for the dangers and risks of your particular job.

All of your jobs are high risk in nature, and the consequences for not doing things (tasks, incidents, events) right can be dramatic. Remember the basic rules of risk management: **RPM** - Recognize, Prioritize, Mobilize. Later in the program we will discuss the importance of the risk assessment process – and you have a key role in recognizing the real risks you and your personnel face.

You must recognize the risks you face. You must then prioritize them in terms of frequency, severity, potential of occurrence, and time to think. Then you must mobilize - act - to prevent the identified problem from occurring.

Also you must fully understand that the job you have chosen is filled with risk and that there is always a potential for the unthinkable (take a look at a great book by Amanda Ripley – *Unthinkable*) event to occur in our workplace.

Strategic Hints for Your Consideration:

- Have you done a risk assessment on each job description in your organization? In your job description, how do personnel get killed, hurt, sued, fired, embarrassed, or indicted? You must know this information for each specific job description.
- Do not limit your assessment to the past history in your organization. There are thousands of departments around the state and throughout America, and many of them are just like yours.
- Have you developed a protocol for prioritizing these high-risk tasks?
- Do you have a process in place to identify emerging *core critical tasks*?

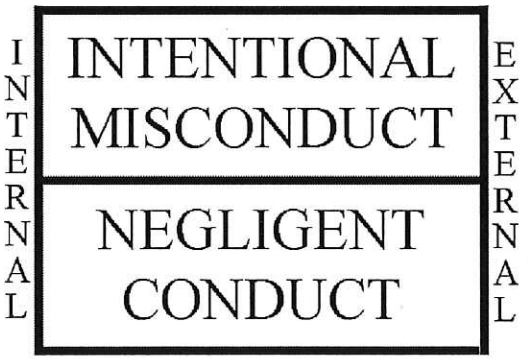
Rule 5. Training must be constant and rigorous.

Every day must be a training day! We must focus the training on the tasks in every job description that has the highest probability of causing us grief. These are the High Risk, Low Frequency, Non-Discretionary time events: chemical spills, medical aid, shoot, don't shoot; jail fires; or workplace violence events – these are considered *core critical tasks*.

Every job description in your operations has these *core critical tasks*. These have to be addressed seriously. We must assure that all personnel are fully and adequately trained to address the tasks that give them no time to think, and that they understand the value of thinking things through when time allows.

The vast majority of things that your people do, they are doing right. But when things don't go right, there is a reason why. Where do you need to focus your efforts when you get back to work? Here are some thoughts for you.

If you study enough tragedies and look for the cause, you will learn that there are two things that cause us grief. Someone did something bad on purpose – or someone made a mistake. Here is a chart for your consideration.



Let's start with the top right of this box. External Intentional Misconduct is very difficult to prevent. If someone is bent on killing a cop or firefighter today in Utah or California, this is a relatively easy thing to do. If someone is bent on lighting an arson fire, they could pull that off with great ease.

It only gets worse when you start to think of our great national concern, terrorism. Terrorism is a form of External Intentional Misconduct. Do not be so naïve as to think that September 11 was a one shot deal.

As I prepare these handouts in January, we are witnessing terrorist attacks around the world. Please recognize that this will occur with greater frequency over time, and stand-by for what happens when the US fully pulls out of Afghanistan, Syria and Iraq. We will have thousands of Jihad thugs with no one left to fight against – so let's get on a plane and go to Canada and then come into the U.S. I have heard that this migration has already started.

And if you study the history of terrorism, terrorists love going after government personnel and their buildings. Look at who is getting attacked in Iraq, Georgia, Northern Ireland, Somalia and all the other places that have experienced terrorism. What can you do?

While it is difficult to prevent such external intentional behavior, we can thwart it by bringing back the vigilance we had on September 12, 2001 (almost 15 years ago), and through understanding the principles of random irregularity. Here are some brief thoughts for you regarding this issue - and please do not think that bad people are not studying the systems of your specific operations.

Another issue that concerns me is External Negligence. This is where otherwise good people outside of our profession make mistakes and we suffer a harm or loss as a result of their errors. While there are many ways this can happen, the most common way that good people harm government personnel is through vehicle operations.

You can help mitigate this exposure by driving defensively, staying off the cell phone, being well rested, wearing your seatbelt, and when outside of your vehicle on or near a roadway, please be thinking. Check out www.respondersafety.com for some interesting thoughts in this regard. Please talk to all of your street personnel about this issue.

The other way we get in trouble is from intentional misconduct perpetrated by our own personnel. A percentage of our nasty consequences come from intentional misconduct perpetrated by our own people. This includes cops and firefighters (and other government personnel) who lie, cheat, steal, perjure, beat, assault, rape, or otherwise do bad things on purpose. Each of these behaviors has occurred on the CHP, and each of these behaviors has occurred in Utah public safety (and other government) operations.

I am absolutely convinced that we could eliminate this type of misconduct if we did a better job of screening out losers up front. Government is not an evil cauldron that hires good people and turns them into bad people.

Too many government agencies, for a lot of poorly thought our reasons (many times the advice of lawyers for whom the future is Friday) occasionally hires bad people and puts them in a position of trust in which they continue to perpetrate their nefarious behaviors.

Once we eliminate the internal intentional misconduct, all we have to worry about is the negligence, or the errors. James Reason (one of the great writers on risk management

today) describes different types of errors: Kb, Rb, Sb (knowledge based, rule based, skill based). He goes on to talk about how errors, lapses, omissions, and mistakes happen in any given workplace. We can learn something from him and the other smart people talking about this stuff.

If you don't want to read a British author, check out any book by Tony Kern, Todd Conklin, Dietrich Dorner, Gary Klein, Amanda Ripley, Laurence Gonzales, or any of the others on my recommended reading list. I would love to send you a copy of this, so just drop me an e-mail right now and you will get it by the end of our time together.

Where do errors occur? Where will your specific errors occur? Let me show you something that you may not yet be familiar with. Trust me, by EOW today you will know this inside out. This requires your referencing the chart on the next page of the handouts.

Most of the things you and your people do in your job in your organization are High Frequency, and your past experience will show you how to do it right the first time. This brings up the topic of **RPDM**, or Recognition Primed Decision-Making.

The principals of **RPDM** are as follows. Consider your mind as a hard drive, or for those of you over 50, a slide tray. Your daily experiences help load this drive. This process started when you were born; some argue it commenced before you were born.

Everything you do and experience is loaded into your hard drive. When you get involved in any task or incident, your magnificent brain quickly scans your hard drive and looks for a close match. Give me a good woman or man and put them in a high-frequency event, and there is a darn high probability that they will do the task right this time.

There are exceptions to this rule. Occasionally you will find that errors occur on high-frequency events. When this occurs and you look for what really caused the tragedy, there are five issues that keep on popping up. They are:

Complacency Hubris Fatigue

Risk Homeostasis Distractions

Let me explore these with you for just a moment.

Complacency: I don't care how many times you have done any given high-risk task. The next time you do it, it is as risky as the first time. The level of risk does not change – but our acclimation to the risk does change. And when high-risk tasks become routine bad things will happen.

Hubris: I want your personnel to be confident – but don't let this grow into cockiness. Getting cocky in this line of work is a ticket for nothing but problems.

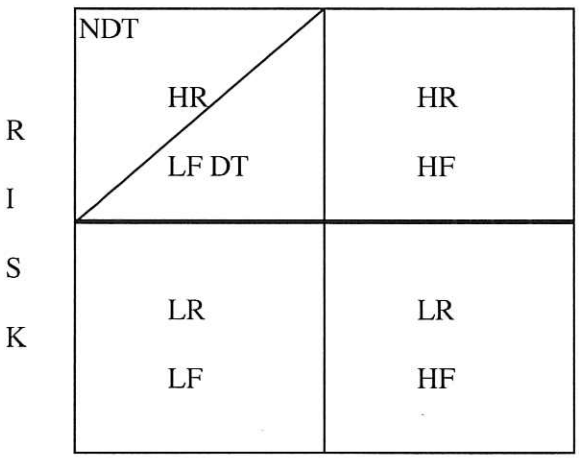
Fatigue: If you are not getting seven hours of uninterrupted sleep every night, you are suffering from fatigue. And fatigue impacts decision-making, judgment, critical thinking skills, and disposition. Please make sure that you are well rested. I really wonder, how many of your tragedies have fatigue as a causational factor? I would love to send you a document prepared by a long time friend of mine – Dr. Bryan Vila. I first met him in the '70s when he was with LASO but now he is the PhD guru on sleep issues in public safety. Drop me a quick email and I will get a recent article he wrote on this critical topic to you before you leave this program.

Distractions: The job is complex enough without adding in all the distractions like cell phones, GPS devices, in-car computers, and other things that divide our attention. Get some strong policies in place regarding use of these tools while a vehicle is in motion and please enforce the rules.

Risk Homeostasis: Sometimes we do things to make people more safe – and in fact we make them less safe. Always remember the concept of unintended consequences.

Bottom line: If you allow anyone of these to be present while doing any event, you have a *problem lying in wait*. But even when you factor these in, rarely do mistakes occur on the high-frequency events. However, if you put a good person in a low-frequency event – particularly one that is high risk in nature, and I hear trains coming.

Here is another chart for your consideration.



This is the classic risk/frequency analysis developed decades ago by people focusing on risk management. By EOW, I want to convince you to have this chart indelibly imprinted

over your left eye, and have you go through life, both your personal and professional life, looking at things through these four boxes. Indeed, every thing that gets done in any of the scores of job descriptions you have within your operations can be put into one of these four boxes.

Some things you do are high risk (meaning if they go bad, the consequences are big), and some are low risk (meaning if they go bad, the consequences are relatively low). Some things you do a lot, and some things you do rarely. So, how can this information help you? Here are some further thoughts on the actuarial risk assessment process.

When you are in the high-frequency area, no problems. When you are in the low-risk area, no problems. However, when you or your people get involved in a low-frequency event (particularly one high risk in nature) I get very worried. When you get back to work next week, I want you to start the practice of **RPM** – Recognition, Prioritization, Mobilization.

First, you must recognize the tasks that fall into the top left box in the job description(s) that you manage. This requires the actuarial risk assessment I spoke of earlier. Now you must prioritize these risks. Here are some thoughts on this process.

Please recognize that this top left box has been divided into two areas. Some tasks need to be done immediately (NDT – non-discretionary time), and some give us time to think (DT – discretionary time). The top left portion of the top left box scares me a lot, as these tasks truly give you no time to think.

Included here are: shoot, don't shoot; pursue, don't pursue; fighting; CPR; jail fires; tail rotor failure; workplace violence; chemical spills; bomb threat calls and the like. These are the tasks that have higher priority in my way of thinking, as they have a higher probability of getting you in trouble. These are the *core critical tasks* that I mentioned earlier on in the program.

These are the events (tasks) that need the regular and ongoing training. This is the mobilization component of RPM. Every day must be a training day and it should focus on one of these HR/LF/NDT events. Here are some ways to make this work for you.

The good news here is that in an average career of 30 years, <u>less than one shift</u> is really spent on this type of task. The bad news is that in an average career of 30 years, <u>less than one shift</u> is really spent on this type of task.

But, because of the high level of risk involved in the task, these need to be trained on regularly to make sure people know what to do if they ever get involved in the HR/LF/NDT family of tasks. More on this later, I promise.

The great news is that most of the tasks in the top left box are not NDT, but rather DT meaning that you have time to think before you act. That may include asking someone who does the task at a higher frequency (and that may mean only once more than you) how to do it so it gets done right. Government operations can be very complex.

However, **most** of the incidents we get involved in are ones that we have done a lot (HF) or ones that give us **total discretionary time**. These tasks include employment law, report writing, domestic violence incidents, SIDS and other child-related matters, or traffic stops where we have information up front that there may be a larger problem than traffic are fully discretionary time in nature.

> Your role is making sure that you and all of your people in each and every job description are adequately trained for the NDT events (the *core critical tasks*), and that you (and they) understand the value of thinking things through when they are involved in a Discretionary Time task.

Strategic Hints for Your Consideration:

- Do you have a daily training program that focuses on *core critical tasks*?
- Do you have a process to assure that the training is being taken seriously?

Rule 6. Audits and inspections of all aspects of your operations are essential.

Audits and inspections are an important part of your job in government operations. We cannot assume that all is going well. We must have control measures in place to assure things are being done right. This is not micro-management – it is called doing your job. We need a feedback loop in every organization.

And while I am ignorant regarding the internal workings of your specific operations – I've looked at too many public organizations in detail – audits are either non-existent or a joke. I call these the "lip service" audits where we are very concerned about having a piece of paper in place saying we are all squared away, when in reality that is not true.

If you do not have the audits (formal and informal) in place, you will not know about problems until they become consequences, and then you are in the domain of lawyers. Then it is too late for action, as all you can do at that point is address the consequences.

And if you take the time to study the life of Admiral Rickover, you will quickly learn that he was widely despised in the navy because of his insistence on using the audit process as a tool to hold people accountable.

And with the recent scams going on regarding COMPSTAT and NCLB – (if we have time I will get into this) – we need to take a close look at these issues.

Strategic Hints for Your Consideration:

1. Do you have a serious audit process in place to assure what you say you are doing is in fact being done?

2. Do you have audits of the audits to make sure this is being taken seriously?

Rule 7. The organization and members thereof must have the ability and willingness to learn from mistakes of the past.

Analysis of past data is the foundation for almost all risk management. All of you in government are making the same mistakes over and over again.

As I read the lawsuits, injuries and deaths, organizational embarrassments, internal investigations and even the rare criminal filing against your personnel I know that we can learn so much by studying the mistakes we have made in the past. It all gets down to risk management.

Government operations entail a tremendous amount of risk. Risk can be eliminated, avoided, shared, controlled, or transferred. For those of you who are the executives in this program (today or in the future) you must be asking these questions.

Each of these is a form of risk management. Every identifiable risk is a manageable risk. Unfortunately, many government operations have no clue as to what ***real*** risk management is all about. Allow me to explain this briefly.

What are we doing that we should not be doing? What high-risk tasks can we transfer to someone else? How can we better control the risk involved in this operation? Do we need SWAT? Do we need an explorer program? Do we really need a motorcycle squad? Does this person really need to be taken into custody? It all gets down to managing risk!

Let's start off with what risk management is not! Real risk management is not another assigned duty of the Finance Director. Real risk management is not a quick mention of the topic during supervisor training. Real risk management is an ongoing process that permeates everything we do.

Real risk management starts with an understanding that bad things do not have to happen in government operations and once this is understood then you practice **RPM**. Risks must

first be **recognized**. Then you must **prioritize** these identified risks in terms of frequency, severity, and available time to think. Finally, you must **mobilize** – meaning you have to act on the identified risks. Risk management must be part of everything we do!

Everything we do involves a level of risk. Since we do tens of thousands of things – there are tens of thousands of risks. I have spent quite a bit of time taking all of these risks – and putting them into different families to make understanding them a bit easier.

1. External Environment – Risks arising from outside the organization that impact your government operations. And we know there are a number of these and they are increasing in frequency and severity.

   Included here are natural disasters and conduct by members the public that impacts our operations. We have to do something about the American attitude on complacency. The current thinking of many citizens is that the disaster will not happen, and if it does it will not impact me, and if it does impact me it will not be severe and if it is severe, I could not have done anything up front to prevent it.

   When I take over (more on this later) risk management will be taught in grade school but here are some worries I have right now about the future of our great nation:

Birthrate	Fundamentalist Religions
Immigration	Demand for Transparency
Water and Food Supply	Communist China
Climate Change	NBC/WMD
Population Change	The Rebuilding of Russia
Terrorism	Homegrown terrorists
Natural, Intentional and Accidental Disasters	Economic issues

2. Legal and Regulatory – Risks arising from the complexity of or non-compliance with of the legal framework imposed on government operations here in Utah. If there is a law or ordinance in state or federal statutes that requires action or prohibits action – this rule must be known and followed.

And I am jumping way ahead in the program, but the easiest way to lose a lawsuit is to have a law or policy in place and have that rule not followed by your personnel.

I am always amazed at how many organizations (including big ones with huge budgets and staffing) are not in compliance with state and/or federal requirements. One of the greatest violators of the California PRA was the California Department of Justice. Perhaps we suffer from the same attitude that many citizens have regarding complacency.

3. Strategic – Risks arising from the lack of priority setting and business planning leading to a reactive organization that is not prepared or flexible enough to deal with unforeseen events. This goes on a lot, particularly in smaller agencies that do not have sufficient personnel or time to plan for the future. Where will your City/County be in 30 years? I can give you a hint: Your future is regionalization, outsourcing, consolidation and technology – and those that understand this will prevail in the future. Those that don't – won't.

4. Organizational – Risks arising from not clearly defining roles and responsibilities, not demonstrating the values of the your agency or not having monitoring processes in place. This is not my focus today but you have a key role in getting and keeping good PEOPLE, developing and maintaining good POLICY, building a TRAINING program that works, assuring that there is appropriate SUPERVISION of personnel, and having a DISCIPLINE system in place to address the people that think that rules were meant to be broken.

5. Operational – Risks arising from concerns that processes in place do not ensure appropriate investigation, enforcement or transaction reporting. This is not my focus today, but all of our personnel must be fully and adequately trained to do their core critical tasks – and understand the value of thinking things through when time allows.

6. Information – Risks arising from untimely, inaccurate or unreliable information that supports the discharge of roles and responsibilities. Be aware of the dangers of ignorance, complacency and cognitive bias. Also, we must have a free flow of information up and down the chain of command within your operations.

7. Human Resources – Risks arising from work environments that do not receive adequate resource allocations, lack internal mutual trust, acceptable performance levels, or suffer from a lack of transparency or good management.

This is probably the greatest financial risk you face today in 2016. It is also the easiest risk to address. If you don't get anything else out of our time

together – please recognize that all employment law is discretionary time in nature – so please take the time to think prior to making any employment law issue. Get your thoughts to the good people at HR or Personnel or competent counsel prior to making the decision.

8. Technology – Risk arising from outdated or unreliable information systems where user requirements are not met. I have major concerns about this issue including external and internal security measures, hacking, malware, social media, compatibility of systems, lack of qualified CTOs, and many others.

9. Financial and Reputational – Risks arising from improper budgeting, forecasting and expenditure controls, including contracting, asset management, internal audits, improper salaries, misuse of overtime and poor revenue oversight. I am always amazed at who is managing (or not managing) the money. Anything that reduces public trust is very problematic.

10. Political – All Utah government personnel should stay out of the fray of politics. Your mission should not be impacted by which political party is in control of the state. This is a tough one, particularly at the local level.

Bottom line: You need to make sure that real risk management is a major part of your operations. I would love to see risk management on the highest levels of your organizational chart.

Time out for some definitions: *Webster* takes a stab at defining "risk" as the "possibility of meeting danger or suffering a harm or loss," or "exposure to harm or loss." As a follow then:

Risk management is any activity that involves the evaluation of, or comparison of, risks and the development, selection and implementation of control measures that change outcomes.

Here are three statements that have guided me through most of my RM life. First is a quotation, albeit paraphrased, from the great risk management guru of the '40s, Archand Zeller:

> "The human does not change. During the period of recorded history, there is little evidence to indicate that man has changed in any major respect. Because the man does not change, the kinds of errors he commits remain constant. The errors that he will make can be predicted from the errors he has made."

What does this mean? We have not figured out any new ways to screw things up. We are making the same mistakes over and over again. Mines have figured out no new ways to

collapse. Ships have figured out no new ways to sink. Refineries have not figured out any new ways to blow up. Restaurants have not figured out any new ways to kill people. Planes have not figured out any new ways to crash.

Fire departments and firefighters have not figured out any new ways to get in trouble. Law enforcement officers (federal, state, county, city) have not figured out any new ways to get in trouble. Please do not give me that nonsense that "bad things just happen and there is nothing you can do about it."

I am sick of hearing that faulty "poor me" refrain. I can show you organizations in every high-risk profession that are underrepresented in problems because they understand the principles of risk management starting with the reality that there are no new ways to get in trouble. To be sure, there are variations on a theme, but in reality it is the same stuff over and over again. Let me jump ahead in the lecture.

IDENTIFIABLE RISKS ARE MANAGEABLE RISKS

The second statement important in my life thus far came from my mentor, professor and friend Chaytor Mason. He was a risk management guru in the '60s. Here is a capsulized version of his response when I accused him of being the smartest person who ever lived:

> "The smartest person in the world is the woman or man who finds the fifteenth way to hold two pieces of paper together."

My instant response when I first heard this was confusion, but then I figured it out. While there are no new ways to screw things up (Zeller) there are always new ways to fine tune and revisit our existing systems to prevent bad things from happening and simultaneously making us more efficient

We, too, must be looking for new and improved ways of doing this most complex job, and you are the ones who can do that. There are better ways to hire personnel, and there are better ways to train them. There are better ways of doing performance evaluations, and there are better ways to track personnel to identify future problems.

Status quo (we have always done it that way – we have never done it that way) does not work. There is a better way of doing business, the 15th way, and we must constantly be looking for it. My third belief in life is a summary of the above two thoughts.

Predictable is Preventable

It was an honor to address you today. I came here with several goals. First, I wanted to introduce you to the big difference between *proximate cause* and the real *problems lying in wait* that will ultimately lead to a tragedy.

We then spoke about The Seven Rules of Rickover and give you some thoughts on how to use them in your specific government organization so that you can become a HRO. His ideas worked very well for the nuclear navy and I am sure they can be of benefit to you.

I moved on to a brief discussion on the ten families of risk that we face in government operations. I am hoping that you can take this back to work and take a look at each family of risk and identify the three (or higher if you are ambitious) greatest risks you face in each of these families and assure that you have viable control measures in place to address these risks.

All of you as leaders in Utah government have a key role in each of the above pillars of success. Please address each of these issues proactively.

I do look forward to seeing you again soon. In the interim, if you need anything, please do not hesitate to contact me anytime.

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