HOW STRONG COMPANIES BECOME VULNERABLE

By Justin Molocznik

"We've been doing it this way for years." An experienced safety professional has likely heard this phrase several times and knows that this justification has probably led to taking on some unrealized risk.

The author has heard this phrase just as often in relation to struggling projects as with award winning, high-performing organizations. In fact, some of the safest, most successful organizations and leaders the author has worked with have used this phrase with a great deal of pride. And this is exactly why it deserves attention.

Organizations that experience serious events are not always the ones with poor safety programs, inadequate resources or disengaged leadership. Often, it is organizations that have been successful for a very long time that experience serious events—and understandably so, as these organizations have utilized statistics and lagging indicators as measures of future performance, collectively justifying the sentiment, "what has worked in the past will work in the future."

Think about significant incidents, whether they have occurred within your own organization or through lessons learned that others have shared. A common theme often exists across these significant incidents. For example, rarely is there a sudden breakdown in safety systems. Instead, a series of small decisions, adaptations and assumptions have accumulated over time. From these findings, a safety professional can start to differentiate between what is being tracked and what information could actually lead to identification of a potential significant event (NSC, 2024).

In most cases within an organization, nobody intends to create additional risk. Employees do not wake up one morning and decide to take shortcuts and get injured. Certainly, there is no safety-minded leadership group that decided that their organization should allow risk and potential loss to creep into their operations. Yet, somehow these entities gradually drifted away from the practices that originally made them successful. Safety researcher Sidney Dekker (2011) describes this phenomenon as "drift into failure," conceptualized as a "gradual, incremental decline into disaster driven by environmental pressure, unruly technology, and social processes that normalize growing risk." This concept resonates because it acknowledges an important truth: organizations do not generally fail because they stop caring; they become vulnerable because the change occurs so gradually that it often goes unnoticed.

The moment work (or overall operation) feels routine is often the moment professionals stop looking at it with fresh eyes. Every organization changes over time. New employees join the workforce, experienced supervisors retire, customer expectations evolve, technology changes, production pressures fluctuate. Even training programs are revised and repeated year after year. None of these changes are problematic by themselves; many are signs of growth. The challenge is their cumulative effect. In organizations that have operated successfully for 20, 30 or 50 years, experience is an area of great strength. Yet, experience can become a blind spot. When a process has worked for years, it is easy to assume it will continue working indefinitely.

Diane Vaughan's (1996) research on the *Challenger* disaster introduced the concept of the normalization of deviance, describing how organizations gradually come to accept departures from established standards when those departures do not immediately result in negative consequences. Over time, what once felt unusual begins to feel normal. And it is very easy for this to go unrecognized. For instance, a temporary workaround becomes permanent, a pretask discussion becomes shorter because everyone already knows the job, or a field or floor visit is postponed because production demands seem more urgent. Individually, none of these decisions appears significant. Collectively, they can slowly reshape organizational risk.

The same challenge exists when analyzing performance metrics. Safety professionals spend much time talking about numbers. They monitor total recordable incident rates, workers' compensation claims, OSHA citations, audit scores and observations. These metrics absolutely have value and are certainly a part of evaluating risk and safety performance; however, lagging indicators rarely tell the entire story. Some of the strongest safety statistics the author has seen have existed in organizations that were simultaneously struggling with declining employee engagement, high turnover, fewer hazard reports and observations, reduced field presence by leadership, or increasing reliance on workarounds.

Those trends may not appear on a dashboard, but they matter. Karl Weick and Kathleen Sutcliffe (2015) found that highly reliable organizations maintain a constant sensitivity to operations and emerging risks, even during periods of

IDENTIFYING HIDDEN RISKS

- **Challenge "the way we've always done it."** Regularly revisit long-standing processes and assumptions rather than treating past success as proof that current practices remain safe.
- **Watch for gradual risk drift.** Look for small adaptations, shortcuts, postponed activities and temporary workarounds that have quietly become normal operating practice.
- **Look beyond lagging indicators.** Pair injury rates, claims, citations and audit scores with signs such as turnover, employee engagement, hazard reporting, observations and leadership field presence.
- **Ask workers how work actually gets done.** Use site walks, jobsite conversations and pretask discussions to uncover emerging risks and system vulnerabilities that dashboards may not reveal.
- **Treat routine work with fresh eyes.** Periodically reassess familiar tasks as staffing, technology, customer expectations, production pressures and other operating conditions change.
- **Lead with "What might we be missing?"** Make this question part of safety meetings, project reviews and leadership discussions to challenge assumptions and identify risks before they become serious events.

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strong performance. In other words, they do not allow success to reduce their curiosity, which aligns closely with what the author appreciates most about human and organizational performance; it reminds safety professionals that workers are often the first to recognize vulnerabilities developing within a system. The most productive safety conversations will occur not in conference rooms but in jobsite trailers, during site walks or simply as part of a brief conversation with someone who was willing to explain how work was actually getting done. Those conversations often reveal risks that metrics never capture.

Todd Conklin (2019) writes that learning should be valued as much as outcomes. This principle becomes increasingly important as organizations mature. The longer safety professionals operate successfully, the more important it becomes to remain curious. Strong companies do not become vulnerable because they stop caring. They become vulnerable when success causes them to stop questioning.

Safety professionals should ask of their own organizations: What assumptions have not been challenged recently? What practices exist today simply because they have always existed? What risks have become so familiar that they are no longer discussed? At the next safety committee meeting, project review or leadership discussion, resist the temptation to begin with injury rates and performance metrics and instead start with a different question: "What might we be missing?"

This question has the potential to uncover more about an organization's future risk than any lagging indicator ever will because the organizations most likely to sustain excellence are not the ones that believe they have all the answers. They are the ones that remain humble enough to stay curious and keep asking questions. **PSJ**

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Cite this article

Molocznik, J. (2026, Sept.). How strong companies become vulnerable. *Professional Safety, 71*(9), 38-39.

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