



Weekly Safety Briefings

Week 41 – Monday (October 7) - Friday (October 10, 2025)

Using HOP After an Accident/Injury

Introduction

Several years ago, I was hired by a large company with the explicit direction to change company culture by driving Human and Organizational Performance (HOP) philosophy throughout the organization. I was very excited, but there was only one problem. I didn't know what HOP was or how to do it. Over the next several years, I tried many different things, and I had some successes and a lot of failures. I would like to share with you one of the important lessons I learned which resulted in significant success. I hope this story will challenge you to go out in the workplace and learn from those closest to the work. Learn where real hazards lurk. Equipped with the knowledge of where hazards are lurking, you may be able to save someone's life.

Monday- The Accident

In my story, I had been with the company a few short months when a forklift incident occurred. Two forklifts had collided, and a team member suffered neck and back pain, resulting in a recordable injury. The leadership was very concerned about this incident and wanted to know what needs to change to prevent this from happening again. There was **a lot of pressure** to get the right answers quickly. So, an "investigation" was launched and a few HSE team members went to the site to get answers.

Here is what they reported based on their investigation:

1. It was near the end of day shift when the incident happened. One forklift driver was stationary and was counting inventory. The driver was inside the cab of the forklift at the time of the collision. This individual's forklift was backed into by another forklift. The individual counting inventory was the person injured.
2. The injury was a strain/sprain to neck/back where muscle relaxers and pain medication were prescribed by a physician and the team member was placed on light duty.
3. The second forklift driver was picking up tipper bins of trash and emptying them in the large dumpster outside.
4. The forklifts were brand new. The new fleet had been delivered two weeks prior. The forklifts were outfitted with blue spotlights to alert pedestrians and other operators of approaching forklifts, back up alarms, an advanced warning system with key fobs to audibly and thru vibration alert pedestrians of an approaching forklift, amber strobes when operational
5. Both drivers had up to date training. Neither driver was under the influence of any controlled substance. Both drivers had been forklift drivers with over 5 years of experience.
6. Conclusion: The operator that struck the stationary forklift was at fault for failing to look behind him before moving his lift. Recommendation: retrain.

In my experience in various organizations, this is a standard type of "investigation" report. Someone made a mistake, an incident happened, and to fix the issue we need to retrain.



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Think & Discuss

1. Does this type of “investigation” report sound like the reports in your workplace? Why or why not?
2. What questions do you think the investigators asked?
3. Do you feel the investigators came to the correct conclusion? Why or why not?

Tuesday – Asking a Different Question

The results of the investigation did not feel right to me. I had recently been trained in the HOP philosophy, but I had never really tried using any of the tools before. I was nervous because Leadership wanted answers, and I didn't have any that I felt were correct.

I asked the investigation team what questions they asked the forklift drivers. They listed several pretty standard questions:

1. What were you doing just before the incident occurred
2. Were you following the safety rules, i.e. did you sound your horn before you backed up, was your back up alarm working, were you wearing your seat belt
3. Were you distracted
4. When was your last forklift certification, who trained you
5. Did you hear the horn or backup alarm before you were struck
6. How long have you been operating a forklift

I decided I would try and use some of the HOP tools I had been trained on. I decided I would do some operational learning and just ask a group of forklift operators about their work. I can tell you I was nervous. Very nervous. I wanted to ask the traditional questions I had always asked post incident – very similar questions to what the investigation team had asked. I pushed through my discomfort, gathered the operators and asked the very first question:

1. What is it like to be a forklift driver here?

This question made me so nervous because I didn't feel like it was going to lead me to answers about the incident. After all, I wasn't even asking about the incident.

A flurry of information came quickly, and I found myself engaging in a very fruitful conversation. I listened to what the operators said and asked a lot of follow up, clarifying questions. Here is what I learned:

1. We are like ballet dancers. It is very tight working conditions. All day long we cross paths and have the potential to have a collision because we are moving so quickly, and the space is so tight.
2. The new forklifts do not have a handle to hold when backing up. After a long day of driving in reverse, your neck and back get tired. A handle would really help that fatigue. Sometimes I don't turn around to look because my shoulders and neck and back are sore.
3. When a driver calls out sick, or if a forklift is out of commission, the team really struggles. We must fill in for the gap. This creates a lot of rushing around.



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4. Many of the loads that come in from certain customers are extremely dangerous to unload. The load has shifted during transit and it's like one big jenga puzzle inside the trailer. Lots of opportunities to get injured there.

I asked the operators to take me out on the floor and show me where it was easy to make a mistake. The information I gained that day was transformational. I could see very clearly all the error traps that these operators dealt with daily. Every day they worked in an environment where it was easy to make a mistake and have a collision or injury. There were so many opportunities to make improvements and prevent the incident I could hardly believe it. Retraining as the corrective action seemed ludicrous after this.

Think and Discuss

1. The first investigation team was asking questions that tested their theory of what happened. What is different between the question I was nervous to ask and the one they asked?
2. Why do you think the question I asked was so fruitful?
3. Now that you know more about the incident, do you think retraining would have helped prevent this type of incident? Why or why not?

Wednesday – One More Question

Have you ever seen the old television series called Columbo? It was a popular television series from the 1970's. Columbo was a homicide investigator. He was a good one. He could ferret out the criminal like no one else. He always had one more question...and that question usually put the criminal on notice that he/she was caught.

As I wrapped up my analysis with the operators of their working conditions, I asked my own "one more question". I asked:

- Is there anything else I should know about?

Most of the operators shook their heads no, but one operator said – well, sometimes when I pick up a certain waste bin, my back tires get squishy. That was interesting. I had never heard of squishy tires before, so I asked him to explain it.

The operator told me that his back tires come off the ground sometimes when he empties a certain bin. I asked him to show me the bin. What I learned was that the recently purchased forklifts were undersized for some of the activities they were involved in. The forklift analysis prior to purchasing did not evaluate all the daily lifts the forklifts were involved in. This posed a serious risk to the operators. A risk that could have resulted in a fatal or very serious incident.

This "one more question" revealed a significant risk that I would have never found had I approached this incident in the traditional fashion. I now had a significant risk identified, that had nothing to do with the collision, but it was one that needed to be fixed quickly.



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Think and Discuss

1. If you were paying close attention, you will have noticed I changed my language a little bit today. I no longer referred to the post incident learning as “an investigation”. I shifted my language and used the term “analysis”. What do you think feels better, an investigation or an analysis? Does anyone like to be investigated?
2. Do you think it matters what words we use – for example: investigation vs analysis? Why or why not?

Thursday – The Fix

I felt like I really understood the day in the life of a forklift driver at that facility. I had lots of things to fix. The fixes were meaningful but most of them were difficult to implement. It took a lot of time, a lot more consulting time with the operators, and some investment on the side of the business.

After the learning was complete, we implemented the following changes:

1. We installed handles on the back of each forklift to make it easier to turn around when backing up. The handles were equipped with horns that could be operated with the thumb.
2. We relocated many of the waste bins to give operators more room to navigate
3. We changed the route of the forklift drivers so that they no longer had to do this delicate ballet dance to avoid collisions. Each driver now had an area they worked in and didn't have to cross into other areas throughout the day.
4. We did a full analysis of all the daily lifts to determine the correct lifting capacity needed. In some cases, we upgraded the lifts to a higher lifting capacity and in other areas we downsized the waste bins. Reducing the size of the bin reduced the weight of the bin and put it within the lifting capacity of the lifts.
5. We of course retrained, but we took the opportunity to review the training and made sure we had a stronger program than what we had started with.

The outcome of this event was the business became more efficient and safer. The forklift drivers were proud of the improvements we were able to implement because they were the main drivers of change (pun intended). Leadership was also happy. We were able to present Leadership with a list of important improvements that they could see would be very valuable to the safety of their team members as well as significant efficiency improvements.

Think and Discuss

1. What do you feel about this statement: workers are the solution not the problem. Do the team members in your area of influence feel valued and empowered? If not, what are some things that you could do to influence the team? If so, what are some of things that you are doing that makes the team feel valued?
2. Do you believe there are risks in your business/area of influence that you could learn about by asking open ended questions with the intent of just learning?



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Friday – Seeking to Understand

I had such an “aha” moment when I asked a different type of question. This event changed the way I looked at risks, how to find them, and how and what to fix. I can remember looking through a multitude of “accident investigations” and thinking – woah, I have a lot of work to do if I am going to change the culture here using HOP – and one of the biggest changes I needed to make was with me.

I needed to change myself first and do something that seems easy, but it’s hard – I had to learn how to learn. I had to become significantly more interested in how work was really being done. I had to shed the idea that I knew how work was being done. I had to go out and learn from those closest to the work.

The HOP journey has been extremely satisfying, and I’m still learning. And I think the biggest take away is keep learning, or rather, keep seeking to understand. Seeking to understand is a fundamental principle in communication, relationships, and improving safety (although clearly not limited to just safety). Seeking to understand is about listening actively, asking better questions, empathizing with others, and fostering genuine connections. Seeking to understand can help build trust, create an environment where open and honest communication can thrive, and ultimately improves our relationships and decision-making. This is the foundation of an improved workplace culture where safety culture begins to transform from a blame and shame culture to one of learning.

Want to learn more about HOP and how you can improve your workplace?