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# If a worker has to stop the job, a leader's decision has already failed

*Leaders are proud of stop-work authority. Six official investigations suggest it is a last resort, used when earlier decisions about authority, staffing and money have already gone wrong.*

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Many safety policies carry the same sentence near the front: every employee has the authority to stop unsafe work. Leaders say it with pride.

It deserves less pride than it gets. Stop-work authority asks the person with the least power on site to make the hardest call, in the least time, against the schedule their own supervisor is trying to meet. It is an administrative control that depends on courage. It should exist. It is also the last thing standing between a crew and harm when everything a leader could have arranged earlier has not been arranged.

## Five parties, and nobody closed the road

On 15 March 2018 a partly built pedestrian bridge at Florida International University collapsed onto an open road. Six people died and ten were injured. The US National Transportation Safety Board found the probable cause in calculation errors in the design.

It also found that cracking had been documented, that the firms involved met on the day to discuss it, and that the failure of five parties to stop work and close the road added to the severity.

The easy reading of this case is that authority was missing. The facts say otherwise. Authority was everywhere. Five organisations each had a claim to act. The lesson is harder: authority shared by everyone is held by no one. Each party could reasonably look at the other four.

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EXHIBIT

| CASE | WHAT WAS AVAILABLE | THE DECISION THAT WAS MISSING | CONDITION ABSENT |
|---|---|---|---|
| **Flagger, 2000** | A working back-up alarm. | Keep people on foot out of the reversing path inside the closure. | 1. Authority |
| **Florida bridge, 2018** | Documented cracking, discussed by the parties on the day. | Stop work and close the road. Five parties could have. None did. | 1. Authority<br>6. Verification |
| **La Porte, 2014** | A distress call. Known process problems, with improvements postponed. | Fund the fix earlier. Hold responders back from the building. | 3. No penalty<br>5. Resources |
| **DeRidder, 2017** | A gas test, taken outside the tank. | Decide who was in charge of the tank and its contents. Staff were confused about that. | 1. Authority<br>6. Verification |
| **Texas City, 2005** | One working alarm. Audits since 2002 that reached executives. | Keep a second operator for start-ups. Act on the audits. | 2. Cover<br>4. Bad news<br>5. Resources |
| **Macondo, 2010** | A pressure test that showed the well was not sealed. | Call for a second opinion on a confusing reading. | 2. Cover<br>4. Bad news |

## The same pattern in six inquiries

For our report *Time to act* we read six official investigations together. In five, an alarm sounded, damage was visible or a test was carried out before people were harmed.

- **California, 2000.** A flagger was killed by a reversing truck whose back-up alarm was working.
- **Florida, 2018.** Cracks documented, a meeting held, the road left open.
- **DeRidder, 2017.** A gas test was taken outside a tank whose flammable atmosphere was inside. The Chemical Safety Board found confusion among mill staff about who was in charge of that tank.
- **Texas City, 2005.** One alarm worked. Audits from 2002 had reported serious problems to executives and at least one board member.
- **Macondo, 2010.** The pressure test showed the well was not sealed. The National Commission found no internal procedure or formal training for the test at either company, and nothing requiring a second opinion on confusing data.

Six cases chosen by us are not a sample, and they are read with hindsight. We do not see the days when the same conditions held and nothing happened. What they show is how the conditions fail, and it is rarely for want of information.

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## The leader as the source of the hazard

Texas City is the case leaders should read slowly. The Chemical Safety Board found that fixed spending was cut by 25% from 1999 and that a further 25% was sought in 2004. The unit's board operators went from two to one. A 2003 review recommended a second operator for start-ups and was not acted on. On the day, operators had worked 12–hour shifts for at least 29 days in a row.

No one on that shift chose any of this. By the time a tired operator, alone at the board, might have stopped the start-up, the decisions that mattered had been made years earlier, in budget meetings, by people who never saw the unit.

That is the sense in which a stop is a failure upstream. The worker who halts a job is doing the right thing. The question for the leader is which earlier decision made it necessary.

## Six conditions that come before the stop

From the six inquiries and three studies we propose six conditions. Each rests on at least two official findings. The grouping is ours.

1. **Authority held by one named person.** For each fatal risk, one person and one deputy can stop the work and restrict the area at any hour, across every contractor. *Test:* who can stop this at 02:00 on a Sunday? Get a name, then phone them.
2. **Competent cover on the hardest shift.** *Test:* before any staffing or budget change, which duty goes uncovered, and when?
3. **No penalty for stopping or reporting.** At La Porte in 2014 the Chemical Safety Board found the bonus structure may have discouraged reporting. *Test:* trace the last stop through the invoices and payslips. Who paid?
4. **Bad news travels, and gets an answer.** *Test:* what did the executive committee last hear about a failed critical control? If the answer is an injury rate, the channel is not working.
5. **Money and authority to restore.** At Texas City the maintenance system let work orders close without the repair. *Test:* who can spend today, and up to how much?
6. **Verification independent of the job.** *Test:* have verifications repeated by someone outside the production line, and count the false passes.

## What the research supports, and what it does not

Two randomised studies bear on this. In a heavy manufacturing plant of 364 workers, supervisors given feedback on how they combined safety and production in daily talk with their crews saw safety behaviour and independently measured audit scores improve. In hospitals, a senior-manager walk-round programme lowered staff ratings of improvement, with better results where managers took responsibility for fixing what was raised. The second is a hospital study, so applying it to industry is our inference.

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Neither measured deaths. No study we found shows that a leadership practice reduces fatalities. What they support is narrower: a leader's response changes what people do, and a leader's presence without a response can do harm.

## The strongest case against this article

**"Stop-work authority saves lives. You are undermining it."** The opposite. It is a legal right in much of the world. The ILO Occupational Safety and Health Convention protects a worker who leaves a situation they reasonably believe presents imminent and serious danger. The EU framework directive requires employers to let workers stop and move to safety, and to act themselves when the supervisor cannot be reached. Keep it, protect it, and reward its use.

The argument here is about what leaders do with it. Those laws give a right to remove oneself. The decisions that failed in the six cases were over other people's work: close a road, hold a permit, keep a second operator, call the shore. No statute names who makes those on your site.

**"Leaders cannot foresee everything."** Agreed. Some stops are prompted by conditions nobody could have planned for, and those are the system working. The test is what happens next. If the same stop is needed again next month, it has become a decision someone is avoiding.

**"This just moves blame from workers to managers."** It moves the question. Blame looks backward at a person. The six tests look forward at an arrangement that can be changed this quarter.

## What leaders do themselves

- Count every stop as a finding about an earlier decision, and trace it.
- Put one name and one deputy against each stop decision. Rehearse it by removing the primary decision-maker and timing the result.
- Write into contracts that a stop made in good faith is not charged to whoever made it.
- Ask which critical duty goes uncovered before every cut.
- Leave every site visit owning at least one problem, and report back to the person who raised it.

## What would change our view

A controlled study in heavy industry linking any of these practices to verified control performance or serious-injury outcomes. We would then rank them by evidence. Today three rest on research into behaviour, two on what inquiries found missing, and one on judgement.

A stop-work card in every pocket is a good thing. A site where it is rarely needed is a better one, and only leaders can build that.

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**Read the full report.** *Time to act: what technology can and cannot add to critical controls* is published by Riskopilot Research on Riskolabs.

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