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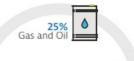
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About Alabama Power

About Us



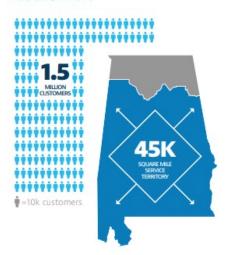


Generation Mix





Serving Our Customers



Total Nameplate Capacity 11,678 megawatts

Total Customers

Total		1,520,751
Residential	86.09%	1,309,284
Commercial	13.46%	204,617
Other (incl. industrial)	0.45%	6,850

Automated Power Outage Reporting 1-800-888-APCO (2726)

Customer Service (statewide)

1-800-245-2244

Electrical Safety Information and to Schedule Presentations 1-800-806-SAFE (7233)

Reservoir Information

apcshorelines.com

Outage Map outagemap.alabamapower.com **Outage Alerts**

Purchase Appliances

Good News From Home









alabamapower.com/alerts

smartneighbor.com

alabamanewscenter.com







AlabamaPower.com | @AlabamaPower

Power Delivery

Transmission

Towers: 10,307 Poles: 112,240

Distribution

Towers: 4

Poles: 1,459,836

Total Poles and Towers 1,582,387

85,679 miles





DISTRIBUTION 74,957 mi.

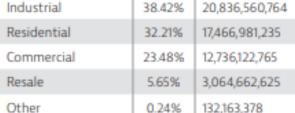
Our power lines would circle the world over three times.

The circumference of the

Commercial

Total kWh sales

Kilowatt-hour Sales



100%

54,236,490,767

APC Safety Pillars

Critical Risk Management Life EmPOWERing Rules



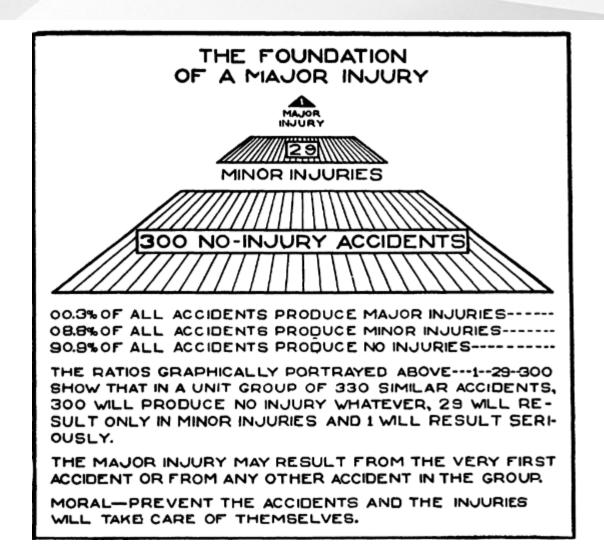
Learning Organization



Continuous Improvement



Pre 2016



88% of workplace accidents are caused by "unsafe acts"

SAFEmap International 2016 Safety Culture Survey

Safety Culture Model

Organization Scale

- 1. Commitment
- 2. Policy
- 3. Goals
- 4. Priority
- 5. Value
- 6. Job Security

Leadership Scale

- 7. Manager Credibility
- 8. Management Balance
- 9. Supervisor Credibility
- 10. Supervisor Balance
- 11. Decisions-making

Processes Scale

- 12. Consultation
- 13. Discipline (Rules)
- 14.Discipline (Incidents)
- 15. Follow-up
- 16. Systems
- 17. Training
- 18. Recognition

Risk Influences Scale

- 19. Risk Incentives
- 20. Work Pressure
- 21. Risk Attention
- 22. Peer Pressure
- 23. Risk Pressure
- 24. Risk Avoidance
- 25. Compliance

Attitudes Scale

- 26. Fatalism
- 27. Locus Of Control
- 28. Job Stress
- 29. Risk Experience
- 30. Risk Protection
- 31. Risk Action
- 32. Risk Reporting
- 33. Risk Candor
- 34. Accident Reporting

Rules Scale

- 35. Rule Validity
- 36. Rule Knowledge
- 37. Rule Complexity
- 38. Rule Acceptance
- 39. Rule Involvement

Task Scale

- 40. Task Urgency
- 41. Task Difficulty
- 42. Team Support
- 43. Work Ethic

Reactive

In denial
Messengers shot
Whistleblower sacked
Protection of power
Information hoarded
No responsibility
Faiture punished
New ideas crushed

Distrusted

Reluctant

Deal "by the book"
Conform to rules
Reactive
Repair not reform
Information rejected
Safety in silo
New ideas= problems

Accepted

Rational

Inspections
Develop risk systems
Target zero
Improve Measures
Improve information
Develop action plans
Monitor progress
Set objectives
Reporting culture

Approved

Righteous

Audit systems
Risk Management
Systems thinking
Advanced metrics
Improve consultation
Safety planning
Participation systems
Refine objectives
Target zero intense
Risk management
Just culture

Regarded

Reliable

Strategic focus
Rans widely known
Active leadership
Leading indicators
Accountability shared
Empowerment
Lean systems
Regular benchmarks
Values in safety
Competence
Seek active dissent
Critical risk program
Rexible culture

Respected

Informed culture

Resilient

Resilient systems
"What if?" scenarios
Reform not repair
Responsibility shared
Seek new ideas
Manage change
Messengers rewarded
Fallores prompt review
Rexibility of operation
Integrated
Consistent mindset
"Future risk"
Invisible safety
Critical risk systemic

Trusted

Learning culture

Insights

Improve Transparency

- Courage to recognize all events and injuries are not the same (Target Zero)
- OSHA recordable injuries are descriptive and not predictive (normal variation between years and random)
- How do safety personnel spend time?
- Transparency helps eliminate blind spots

Readiness to Respond to Risks Vs. Reacting to Events

- Safety systems, identify critical risks, and critical controls
- Understanding Human Performance
- Risk Registers

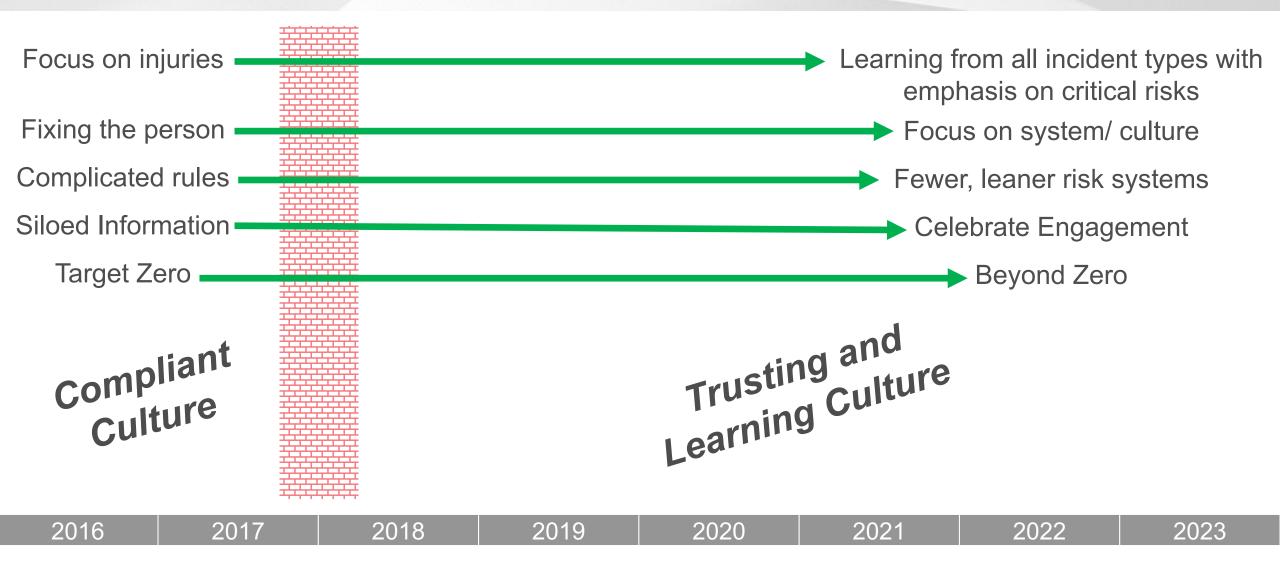
Proactive Recognition-of-effort systems

- Front-Line employee learning teams (focus on fixing systems vs. individuals)
- Reporting of Close Calls/Near Misses
- Safety Communications

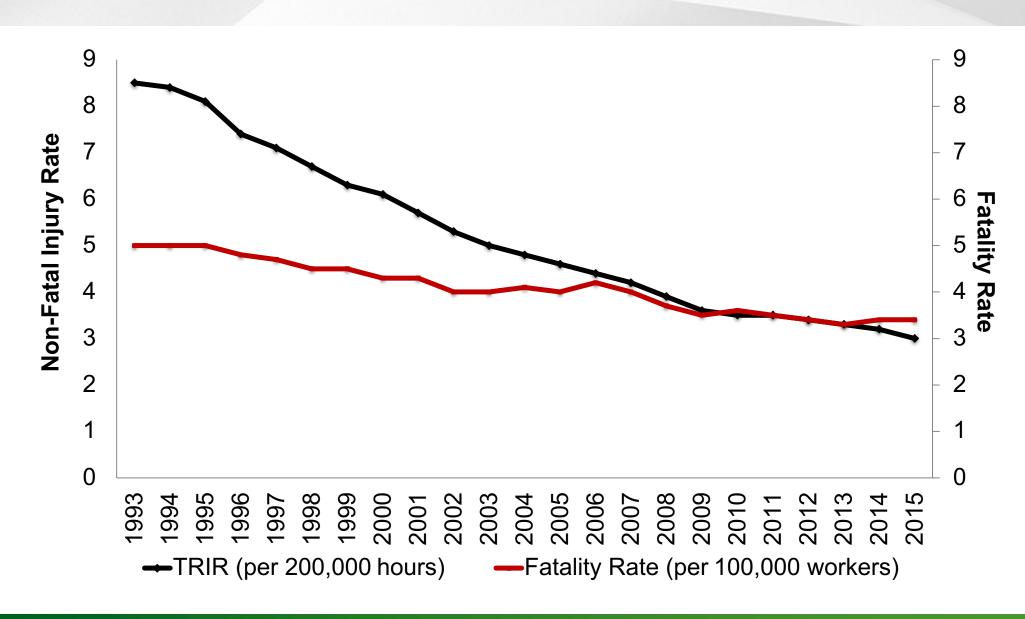
Be Mindful of Overconfidence

- Quality field coaching observations and focus on Critical Risks
- Do not normalize good performance in high-risk industry

The Journey



Serious Injury and Fatality Prevention



Critical Risk Management | Life EmPOWERing Rules



Goal: Ensure employees understand their critical risks and associated Life EmPOWERing Rules



High Energy Hazards



Great safety performance is not the absence of error but rather the presence of controls that keep us safe when a failure occurs.

What is in Place That is Controlling the High Energy



Critical Risk Management Life EmPOWERing Rules



Understand your critical risks and the controls that reduce risk

Learning Organization



Learn from events and share with others

Continuous Improvement



Proactively develop systems that improve the safety of our employees

Goals and Key Actions

- Risk Register Development
- Development of Life EmPOWERing Rules for high-risk organizations
- Identification of Critical Controls
- Ensuring employees understand concept of layers of protection
- · In-field observations and coaching
- Classifying events in terms of PSIF (Potential for Serious Injury or Fatality)

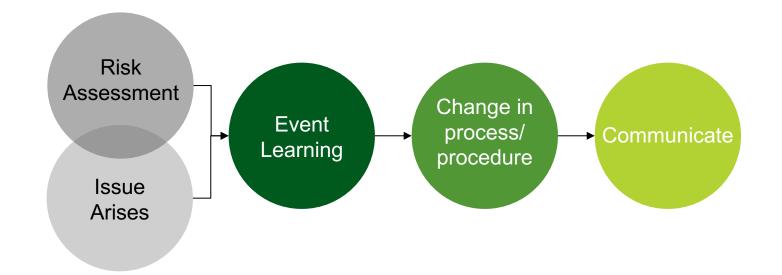
- Use Event Learning process based on Human and Organizational Performance (HOP) principles
- Identify error traps, work imagined vs. work in practice (blue line black line)
- Encourage and act on Close Call+ submissions
- Improvement projects identified using critical risk model
- Show transparency

- Challenge ourselves to improve systems
- Failure is not linear and there is seldom one root cause
- Ongoing communications that highlighting critical risks
- Proactive safety events
- Implementation of lone work app
- Began Functional Movement program

Learning Organization



Goal: Prioritize learning from events. Foster a culture of learning in which information sharing is second nature



Create meaningful change: Learn, share, grow, and prevent repeat events

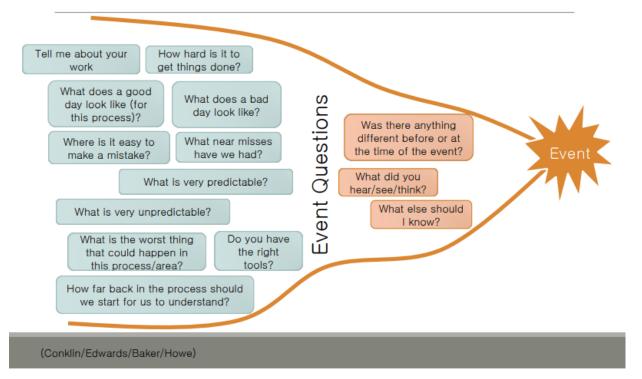
Learning Organization

Which is better – playing 20 questions so we can "figure it out" or asking people to describe it for us so we can learn.



Goal: Prioritize learning from events. Foster a culture of learning in which information sharing is second nature

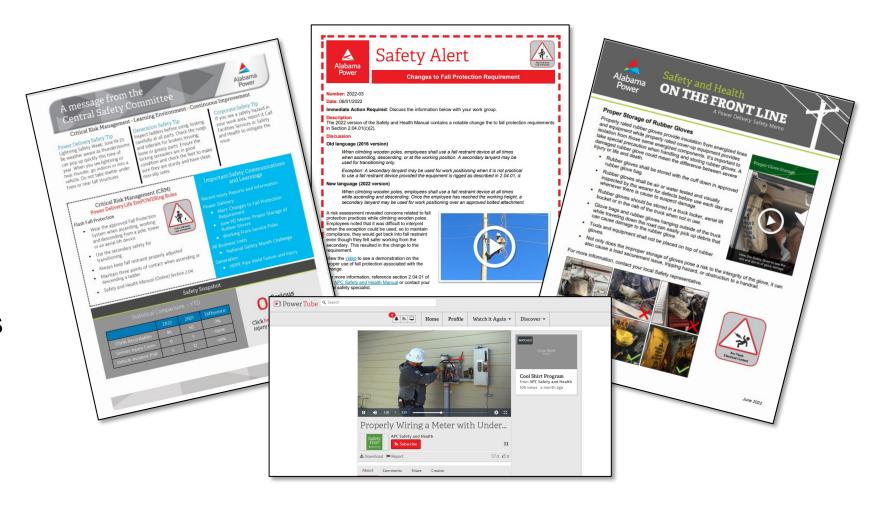
Operational Learning Questions



Continuous Improvement



- Biweekly newsletter
- Quick one-page topics
- Videos



Results Still Matter & Learnings So Far

- Continue to track recordables but less emphasis
- More emphasis placed on:
 - Serious Injuries
 - Close Calls or injuries that meet PSIF classification
- Robust and growing field observation and coaching program
- Greater transparency has shown us that ergonomics is more significant than we previously thought (increased reporting)
- Improved relationships and transparency
- Less anxiety amongst leaders and safety personnel due to chasing zero
- Safety staff spending more time on more meaningful tasks
 - Risk registers
 - Learning teams
 - Improvement projects
 - Evaluating improving and/or adding additional controls



• Examining the foundation: Were Heinrich's theories valid? Do they still matter? | Safety+Health (safetyandhealthmagazine.com)

• The Statistical Invalidity of TRIR Updated 12.22.2020 (colorado.edu)

- Quality of Safety Leading Indicators Scorecard Tool | Construction
 Safety Research Alliance (colorado.edu)
- Human Performance Sidney Decker, Todd Conklin, Edgar Schein

