



Edison Electric  
INSTITUTE

Thomas F. Farrell, II  
Safety Leadership and Innovation Award  
2022 Recipients

*Power by Association™*

**CATEGORY: EEI MEMBER COMPANY EXECUTIVE**

---

**Kimberly S. Greene, Southern Company Gas**

Kim has been a dynamic leader at a critical time in our industry, driving higher levels of engagement that will transform the way we assess safety programs with a focus on scientific and evidence-based improvements.

**Executive Summary**

Kim Greene is the Chairman, President, and CEO of Southern Company Gas, ensuring safe and reliable natural gas for more than 4.3 million utility customers.

Greene is a well-rounded leader with a passion for employee, customer, and public safety. She makes strides both within Southern Company Gas and in the outside world across all operational priorities – ranging from safety enhancements and cutting-edge innovation through employee engagement, sustainability and diversity, equity, and inclusion.

Through her work on the EEI CEO Task Force on Safety, Kim is leading industry efforts on transforming the approach to serious injury and fatality (SIF) prevention.

**CATEGORY: ACADEMIC/THOUGH LEADER**

---

**Dr. Matthew Hallowell, University of Colorado at Boulder**

**Nominating Company:** Xcel Energy

Developing an incident classification system through which EEI members can consistently track incidents with the potential to cause serious injuries and fatalities - the EEI Safety Classification and Learning Model.

**Executive Summary**

Dr. Matthew Hallowell served as technical advisor to an EEI work group of safety and health professionals tasked with developing a method for consistently classifying safety incidents and observations to enable shared learning for the prevention of serious injuries and fatalities. The resulting tool is the EEI Safety Classification and Learning (SCL) Model which leverages the latest scientific knowledge and the best features of existing methods. The model was tested and refined by the team reviewing 40 actual incidents. Using this model, consistency in incident classification among the workgroup increased from a baseline of 65 percent to 95 percent. This SCL model enables a common understanding of safety learning opportunities underpinned by a set of definitions for each of the seven incident and observation types in the model. This common language serves as the foundation for shared learning. Tracking and learning from incidents is an important step toward the elimination of SIFs. In the future, the SCL model and the associated definitions could be used to form new, more impactful safety metrics that complement traditional indicators like total recordable injury rates (TRIR). This would allow organizations to monitor progress toward the most important goal: saving lives.

## CATEGORY: PARTNER ORGANIZATION – CONTRACTOR

---

### Quanta Services' Capacity Model

**Nominating Company:** Xcel Energy

Quanta takes an innovative approach to solving our industry safety challenge of moving from a focus on minor injuries to actively addressing SIF injuries through controls and employee engagement.

#### Executive Summary

The Capacity Model is not a program or initiative but a different approach to how we plan, execute, and learn from work. This includes consistent identification of hazards and effectively controlling exposure to those hazards to protect our employees, the environment, and the people in the communities in which we work. The model has three pillars:

- Prevention: Continue to work at preventing accidents.
- Learning: Accept that mistakes are inevitable in life and business; learn from them to improve prevention and build capacity.
- Capacity for Failure: Apply enough safeguards and controls to absorb the consequences of an incident safely (without seriously injuring or killing anyone) when a mistake occurs.

The Capacity Model uses elements including the Energy Wheel and STKY or “Stuff that Kills You” to help our workforce identify and describe the hazards that can seriously injure or kill you.

- **Videos:**
  - [The Capacity Model](#)
  - [STKY Success: Dead End Platform Incident](#)

## CATEGORY: EEI MEMBER COMPANY EMPLOYEE LEADER

---

### Thomas B. Dyson, Ameren Corp

Multiple contributions to address longstanding safety issues and challenges.

#### Executive Summary:

Tom Dyson is being recommended for the Thomas F. Farrell, II Safety Leadership and Innovation Award for numerous leadership roles he has played fostering innovative solutions to advance safety and close gaps that have been persistent hurdles around contractor safety benchmarking and SIF identification and prevention. Tom has served on the:

1. Recordkeeping Committee
2. Serious Injury Fatality committee
3. Contractor Safety Statistics Team
4. Safety Classification and Learning Model
5. SIF Precursor Identification Team
6. NFPA 70E Consensus Standard Team on behalf of all EEI companies
7. Vice Chair of the EEI Safety and Health Committee

Looking at the award criteria Tom embodies what the award is meant to recognize.

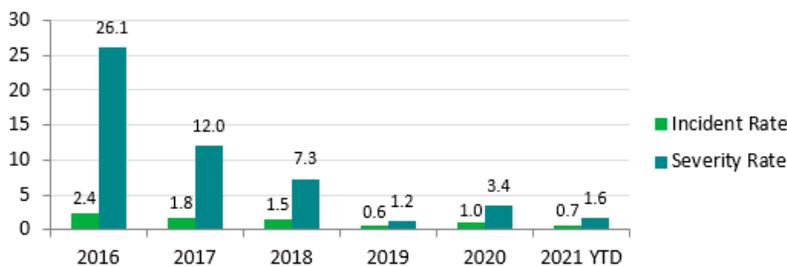
### Idaho Power Company - Practical Application of Psychological Behavioral Safety with Human Performance Principles

Nontraditional approach of combining psychological safety and behavioral safety with practical application of human performance principles, which resulted in increased employee engagement and the ability to work more safely on and off the job.

#### Executive Summary

Idaho Power’s safety culture of trust, openness, learning and accountability has created an environment of engagement and participation at every level throughout our organization. In recent years, we took an innovative, non-traditional approach of combining psychological and behavioral safety with human

Figure 1. Idaho Power incident and severity rates, 2016–2021



performance principles. We believe this approach has helped us achieve two of our safest years in company history — 2019 and 2020 — and we are on track to add 2021 as the safest third year (see Figure 1).

We are applying for the safety leadership and innovation award

as a method of sharing our approach with other interested utilities. As you will find in the description of achievement, we used three basic steps to combine behavioral and psychological safety with human performance principles. The result has been keeping our employees safer both on and off the job.

#### Description of Achievement

Idaho Power started its Safety department in 1927, over four decades before OSHA existed. The electric utility industry is among the most hazardous industries and consistently ranks high for both catastrophic injuries and fatalities. Regardless of how well we are performing in safety, we continuously strive to improve and better prepare our employees to be safe, both on and off the job. Our three company core values are safety, integrity, and respect.

Over the last five years, we took a nontraditional approach to combine psychological and behavioral safety with practical human performance principles to achieve exceptional employee engagement in safety. This has resulted in improving our employees’ ability to be safer both on and off the job. We are in our third safest year in the company’s history in terms of both incident and severity rates. There are three key parts to our approach:

1. We elevated our behavioral safety program to more general behaviors rather than focusing on teaching and applying every safe behavior required to keep employees safe, as is done with traditional behavioral safety. We assembled a team of highly respected employees and leaders from across the organization to analyze three years of incident reviews using the influencer model based on *Influencer: The Power to Change Anything* by Kerry Patterson, Joseph Grenny, David Maxfield, Ron McMillan, and Al Switzler. We looked for both employee and leader vital safety behaviors that could have prevented the incidents.

The team identified four vital safety behaviors for everyone: focus, assess, make the safe choice, and speak up. For the leaders, the team came up with additional vital safety behaviors of demonstrate your passion for safety, set clear expectations and hold yourself and others accountable. Recently, we added a fourth leader vital safety behavior of support a culture of speaking up. (See Attachment 1 for both sets of vital safety behaviors.) For our initial rollout of the vital behaviors to employees, we developed discussion guides for leaders and their teams.

2. We taught our employees how the brain works regarding safety. The principles are based on Daniel Kahneman's book *Thinking Fast and Slow* and Steve Casner's book *Careful: A User's Guide to Our Injury-Prone Minds*, along with human performance principles. Key concepts from the books and principles include the following:
  - Humans make errors (a basic human performance principle). Humans make five to seven errors per hour under normal circumstances, and more than double that amount in certain mental states such as hurrying, rushing, multitasking, and if we are feeling any kind of strong emotion (anger, frustration, happiness, sadness) or fatigue.
  - Essentially, our brains work in one of two ways regarding safety:
    - In System 1, or auto-pilot (where our brains spend most of the time), we operate largely out of habit. We function with little brain use. If you've ever pulled into your driveway after work, and you don't remember much about the drive home, System 1 thinking got you home. System 1 thinking is fast, habitual, intuitive, subconscious, and easy, but errors and injuries are much more likely to occur in System 1 thinking.
    - In System 2 thinking, we are actively focused on the task at hand, assessing, and making safe choices. System 2 requires effort. It is slow, deliberate, analytical, conscious thought. It can solve hard problems, but our brains prefer System 1 over System 2. System 2 is our safety thinking — it's our careful brain. System 2's critical thinking allows us to analyze a situation, recognize potential hazards and speak up.

We developed videos, posters, safety meeting templates, and other supporting materials to keep the vital behaviors and information on how our brains work active in the workplace. (See Attachment 2 for our system thinking poster.) We conducted a 60-minute, in-person brain training course with all employees.

Recently, we developed an interactive incident template that is used in safety meetings to walk teams of employees through an event that happened, almost happened, or could have happened. The template is generating significant discussion and engagement from our employees. Each step of the event is discussed while getting input from the teams about which system of thinking and which vital behaviors were used. This practical application has helped reinforce the principles while allowing our employees to actively apply what they have learned on and off the job. Now, when our employees enter safety observations, many of them are self-diagnosing the incidents using our vital behaviors and system thinking.

3. We clearly defined our safety culture based on feedback and integrated it into an accountability framework. We held safety culture check-in meetings with employees from across the company to see what was working for them, what was not and what they would change. The input was clear — employees wanted a culture of trust, openness, learning and accountability. To have openness — including reporting of incidents, near misses, good catches, safety hazards, concerns, and suggestions — we must have trust. We must have openness and sharing to learn as a company rather than every individual or team learning on their own. We must also have accountability, so we

don't repeat the same things we've already learned.

In our approach, we defined accountability not as discipline or punishment, but rather as owning our actions and taking responsibility to improve or change. With this definition of accountability, we created an accountability framework (Attachment 2) based on human performance. Our accountability framework defines each type of risk/action taken along with what the employee can expect from the company and what the company expects from the employee. Through its openness, this model has generated trust among our employees, as is demonstrated by the over 1,000 near misses and good catches our employees submit each year to help co-workers and the company learn and improve.

Within the framework, we deviated from traditional human performance principles when needed to stay true to our safety culture. First, we added a category for uncontrollable risk — defined as a situation in which an employee did nothing to contribute to the incident, nor was there anything they could have, or should have, done differently. Even though we approach safety with the mindset that all incidents are preventable, we wanted to acknowledge that sometimes things happen beyond our employees' control (e.g., an employee stops at a red light but another vehicle with a distracted driver plows into our employee). Our employees have more trust knowing we are willing to classify incidents as uncontrollable if employees are doing everything the company would expect.

Another deviation within our accountability framework we made from traditional human performance principles is combining the categories of human error and at-risk behavior (and repetitive human error with repetitive at-risk behavior). Human error is something that has been done that was not intended by the person who did it. It's not a conscious decision to depart from expected behavior. At-risk behavior is when an individual saw the risk and made the choice to do it anyway because they reasonably believed the risk was insignificant or justified and assumed probable success. We found our actions in response to these two categories were so similar it did not make sense to separate them.

Our process for reckless behavior (a behavioral choice to consciously disregard a rule or established policy or procedure, creating a substantial and unjustifiable risk) is consistent with traditional human performance models, with the exception that we have zero tolerance for repetitive recklessness. Our industry is too hazardous to allow for repetitive reckless behavior, and our employees are aligned that people who are repetitively reckless cannot work for our company.

Idaho Power's focus on developing meaningful vital behaviors, teaching employees how the brain works, and incorporating employee feedback into an accountability framework that encourages trust and learning have propelled our employees into being consistently safer. We would be honored to share our approach with other utilities as we continue our path toward safety excellence, with a culture where safety is a value.

- **Video – [Practical Application of Psychological Behavioral Safety with Human Performance Principles Video](#)**

## Attachment 1. Vital Behaviors

# VITAL BEHAVIORS



Idaho Power has a safety culture of trust, openness, learning and accountability. Safety starts with each of us, and employees are expected to be personally accountable. Employees are also expected to practice the vital behaviors of focus, assess, make the safe choice and speak up to keep themselves and others safe.

Focus	Assess & Make the Safe Choice	Speak Up
<ul style="list-style-type: none"> <li>• Pause anytime your mind is not in the moment during work activities.</li> <li>• Use spotters to help monitor your surroundings for safety concerns.</li> <li>• Remove potential distractions before you start a task.</li> <li>• Use the power of “self-talk” to keep yourself tuned into the task.</li> <li>• Prevent driving distractions (e.g., phone, text, email, eating).</li> <li>• Never drive drowsy. Pull over, take a nap, take a brief walk or do MoveSafe™ to increase alertness.</li> <li>• When performing detailed or repetitive work, periodically shift your focus to the larger surroundings and take breaks.</li> <li>• Check in with a coworker to determine mental fitness, fatigue, etc.</li> <li>• Continually scan for hazards.</li> </ul>	<ul style="list-style-type: none"> <li>• Ask yourself and others engaged in the work, “What are the worst things that could happen?” Then have a plan to prevent them (tailboard, Blue Book, etc.).</li> <li>• Refer to the <i>Safety Standards Manual</i> and the Safety Policy frequently so you know the safe choice.</li> <li>• Consult your leader or safety professional when the safe choice is unclear.</li> <li>• Reassess the job when:                         <ul style="list-style-type: none"> <li>• Time becomes an issue or you feel hurried</li> <li>• Something goes wrong</li> <li>• Conditions change</li> </ul> </li> <li>• Ask yourself:                         <ul style="list-style-type: none"> <li>• “Am I properly trained for this task?”</li> <li>• “Am I accepting a level of risk that would be unacceptable to the people who care about me?”</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• When you or others are:                         <ul style="list-style-type: none"> <li>• Distracted or off your game</li> <li>• Pressed for time/hurried</li> <li>• Nervous or inexperienced</li> <li>• Need help (lift, spot, etc.)</li> <li>• Not using proper personal protective equipment (PPE)</li> <li>• Going to use the wrong tool</li> </ul> </li> <li>• When your inner voice suggests something is not right</li> <li>• When you think, “Is there a safer way to do this?”</li> <li>• When conditions change and you need to reassess the hazards</li> <li>• When others are silencing safety concerns</li> <li>• When you need the advice of a safety professional, supervisor or other employee</li> <li>• When someone demonstrates safe work practices, or in support of individuals expressing safety concerns</li> </ul>

FOCUS • ASSESS • MAKE THE SAFE CHOICE • SPEAK UP

# LEADER VITAL BEHAVIORS



All employees are expected to practice the vital behaviors of focus, assess, make the safe choice and speak up. But leaders are also expected to practice vital behaviors that help them and their employees exemplify our core value of safety. These leader vital behaviors and the actions associated with them are outlined here.

Demonstrate Your Passion for Safety	Set Clear Expectations	Support a Culture of Speaking Up	Hold Yourself and Others Accountable
<ul style="list-style-type: none"> <li>• Make safety your first priority, immediately addressing issues that arise.</li> <li>• Regularly participate in monthly safety meetings, MoveSafe™ and other safety programs.</li> <li>• Wear appropriate personal protection equipment (PPE) and perform tailboards when needed.</li> <li>• Share meaningful safety moments you experience — be authentic and show your vulnerabilities.</li> <li>• Encourage and build safety leadership within your team, and acknowledge those who demonstrate the vital behaviors.</li> </ul>	<ul style="list-style-type: none"> <li>• Expect your team to know and exemplify safe work practices, including use of proper PPE/tools and performing tailboards.</li> <li>• Encourage the use of the vital behaviors and proper system 1 or 2 thinking.</li> <li>• Require your team to speak up/take action when they see a hazard or notice a change in work or personal conditions.</li> <li>• Expect team members to ask for and give help (team lift, spotter, etc.)</li> <li>• Have employees set safety goals, and review their progress regularly.</li> </ul>	<ul style="list-style-type: none"> <li>• Share your safety observations and safety solutions.</li> <li>• Lead meaningful safety conversations.</li> <li>• Speak up/take action when you see a hazard or notice a change in work or personal conditions.</li> <li>• Create a safe space for employees to speak up.</li> <li>• Express your appreciation for employees speaking up, or listening to others speak up.</li> <li>• Offer to help. Remind your team of the commitments you've made to keep each other safe.</li> </ul>	<p>Self:</p> <ul style="list-style-type: none"> <li>• Be mindful of the time pressure you create for your team.</li> <li>• Invite others to observe and coach you about your work practices.</li> <li>• Listen respectfully to all safety concerns and share actions taken to resolve them.</li> </ul> <p>Others:</p> <ul style="list-style-type: none"> <li>• Continually observe work practices.</li> <li>• Consider safety in employee reviews.</li> <li>• Address performance issues immediately.</li> <li>• Use the Safety Accountability Framework when needed.</li> </ul>

FOCUS • ASSESS • MAKE THE SAFE CHOICE • SPEAK UP

## Attachment 2. System Thinking Poster and Accountability Framework

The poster features a central illustration of a human brain split vertically. The left hemisphere is colored red and labeled 'SYSTEM 1 AUTO PILOT'. The right hemisphere is colored green and labeled 'SYSTEM 2 ACTIVE THINKING'. Below the brain, text describes the characteristics of each system. At the bottom, a 'BEWARE:' section lists conditions that increase the risk of injury, followed by a list of four key actions: FOCUS, ASSESS, CHOOSE, and SPEAK UP.

**IDAHO POWER** **Safety4Life**

# Injuries Occur in **SYSTEM 1** Thinking

---

**SYSTEM 1**  
AUTO PILOT

Routine Tasks  
Error Prone  
Not Really Thinking

**SYSTEM 2**  
ACTIVE THINKING

Focused  
Assessing  
Making Safe Choices

---

**BEWARE:**  
If you find yourself...

<b>Hurrying</b> <b>Rushing</b>	<b>Multi-tasking</b> <b>Complacent</b>	<b>Tired</b> <b>Frustrated</b>
-----------------------------------	---	-----------------------------------

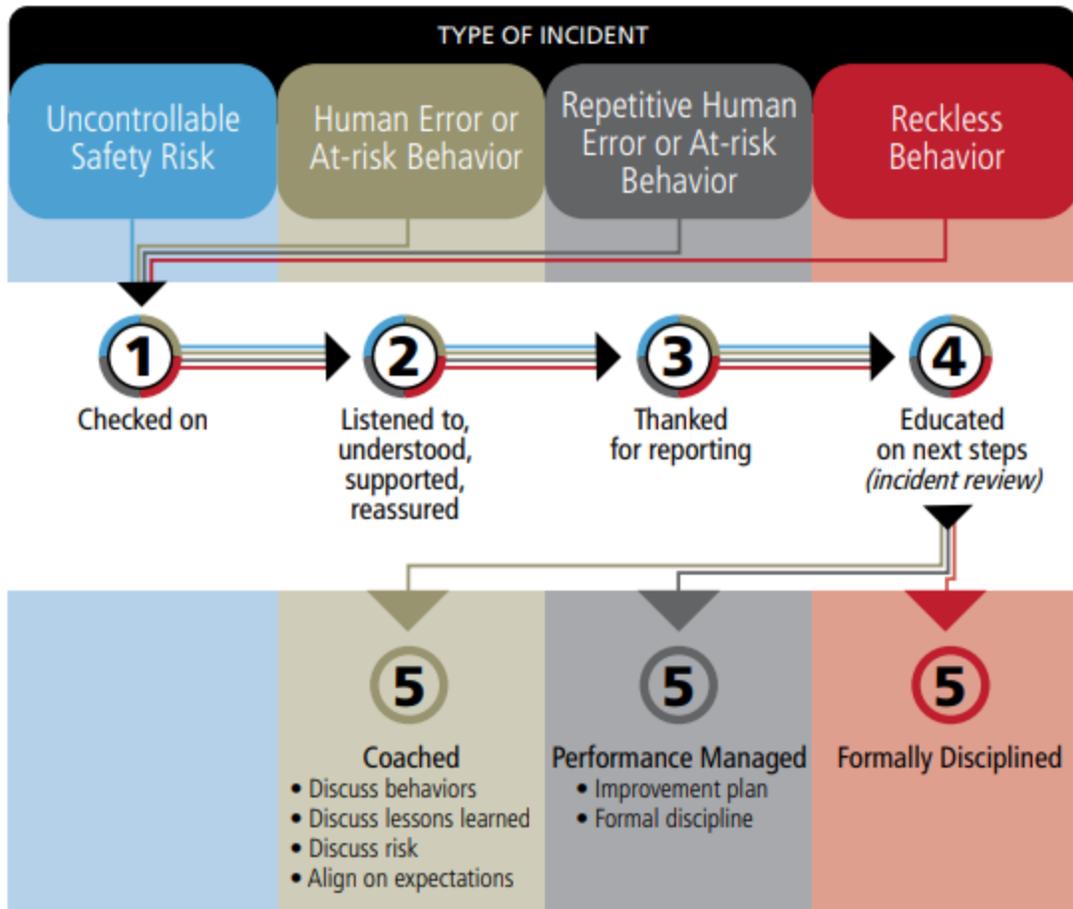
... you are more likely to get hurt.

FOCUS • ASSESS • CHOOSE • SPEAK UP



## Safety Accountability Framework

What you can expect from your leader — and what's expected of you — after reporting a safety incident.



### What's expected of the employee?

In all cases, the company expects the employee to report safety incidents, take ownership of his/her actions and take responsibility to improve or change.

SAFETY ACCOUNTABILITY

