

Psychology Before Procedures[™] The Field Guide

Why every compliance program eventually fails, and what to build instead. The first read for anyone new to the Safety Sense Inc. framework ecosystem.

Janel Penaflor, The Safety Disruptor[™]

Founder and CEO, Safety Sense Inc. · Buckley, Washington

PSYCHOLOGY BEFORE PROCEDURES[™] · PEOPLE BEFORE PAPERWORK[™]

A neuroscience-informed safety system built from more than thirty years in high-hazard work and more than fifty fatality investigations. All frameworks proprietary to Safety Sense Inc.

Why I wrote this guide

I have spent more than thirty years in high-hazard work: oil and gas, mining, nuclear, aviation, chemical manufacturing and transportation. I have conducted more than fifty fatality investigations. This guide is what I wish someone had handed me at the start.

Every one of those investigations began the same way. A binder arrived. It held the procedure, the permit, the training record, the signatures. On paper, the system had worked. Then I started talking to people, and a different story came out. The worker had been quieter than usual for a week. The crew had been finishing that task faster every month. Somebody had noticed something and said nothing because the last person who spoke up got a lecture. None of that was in the binder.

That is the whole argument of this guide in one sentence: **the warning signs were in the psychology, and the procedures never captured them.**

I am not against procedures. I have written hundreds of them and I still believe in them. A good procedure is a gift from the people who came before you. What I am against is the belief that a procedure can carry the weight of a human nervous system. It cannot. A procedure describes the task. It says nothing about the state of the person performing it: tired, pressured, frightened of a supervisor, grieving, bored by a job they have done a thousand times. The procedure is the same on a good day and a bad day. The person is not.

Psychology Before Procedures™ is the order of operations I arrived at after watching the binder fail too many times. Look at the person first. Look at the state of the team. Look at how the organization has taught people to feel about speaking up. Then open the procedure, because now you know what it is up against.

This guide has three parts. The first explains, with the research behind it, why compliance-only programs drift toward failure. The second lays out what I build instead: the Cognitive Reliability Model™ and the frameworks that serve it. The third gives you a thirty-day start. It is written for a safety leader, a supervisor, or anyone who has felt the gap between what the paperwork says and what the floor is telling them.

Read it slowly. Argue with it. Then go stand beside someone on your next shift and watch, before you read anything.

Every fatality I've investigated had warning signs in the psychology that the procedures never captured. Let's find them before they find your workers.

Janel Penaflor

The Safety Disruptor™ · Founder and CEO, Safety Sense Inc.

Why every compliance program eventually fails

I want to be careful with that title. A compliance program does not fail because the people who built it were careless. It fails because of forces that act on every organization, slowly, in the direction of trouble. The research on these forces is strong, and you should know it.

1. Deviance gets normalized

The sociologist Diane Vaughan studied the decision to launch the space shuttle Challenger and found something more unsettling than recklessness. Engineers had seen the O-ring damage before. Each time, they reviewed it, judged it acceptable, and flew again. The abnormal became the expected. She called this the normalization of deviance: a culture in which signals of danger are reinterpreted, step by step, until they are routine [1].

Nobody decides to accept a hazard. They accept a slightly smaller version of it than last time, and last time was fine.

2. Work drifts toward the boundary

Jens Rasmussen described how work in any organization migrates under two constant pressures: the push for efficiency and the push for less effort. Over time, practice moves toward the boundary of safe performance, and because nothing bad has happened yet, nobody feels it moving [2]. The procedure still says one thing. The work has quietly become another.

This is why a site can pass an audit in March and lose someone in June. The audit measured the paper.

3. Work-as-imagined is not work-as-done

Erik Hollnagel draws the distinction I use most in the field: work-as-imagined, which is what the procedure writer pictured at a desk, and work-as-done, which is what people have to do when the valve sticks, the radio dies and the day shift is waiting [3]. He argues that safety grows from understanding why things usually go right, including the adjustments people make every day, as much as from counting what went wrong.

When I ask a crew to walk me through a task "the way it really goes," the gap between the two is where the fatality lives. Treat the gap as information your system has not yet collected. Discipline will only teach people to hide it.

WHAT THESE THREE HAVE IN COMMON

None of them shows up in a compliance metric. Normalization, drift and the imagined-versus-done gap are all invisible to a system that measures signatures, completed training and recordable rates. They are visible to a person who knows how to watch another person.

Human error is where the investigation starts

4. "Human error" is a symptom

James Reason separated two ways of looking at error. The person approach treats unsafe acts as the product of carelessness and answers them with blame, retraining and more rules. The system approach treats error as a consequence of conditions upstream, and asks what defenses failed to catch it [4]. Sidney Dekker goes further: "human error" is a label we apply after the fact, and the useful question is why the person's actions made sense to them at the time [5].

Every report I have read that stopped at "failure to follow procedure" stopped too early. Why did not following it make sense that day, to that person, in that state?

5. Behaviour-based safety has a ceiling

I have run behaviour-based safety programs. Some of them did good things. But the critique matters. Andrew Hopkins reviewed these programs and concluded that they treat unsafe front-line behaviour as the only cause worth targeting, miss accidents that do not involve front-line workers at all, and would do more good if the observations were pointed at managers, since management behaviour shapes the culture [6]. The UK Health and Safety Executive's guidance on human factors makes a related point: behaviour is shaped by the job, the individual and the organization together, and you cannot change one without the others [7].

Observation cards that count "safe" and "at-risk" acts tell you what a person's hands did. They do not tell you what the nervous system behind the hands was doing.

6. Paperwork sits low on the hierarchy of controls

NIOSH ranks controls by general effectiveness: elimination, substitution, engineering controls, then administrative controls, then personal protective equipment. Administrative controls and PPE, the agency notes, "require significant and ongoing effort by workers and their supervisors" [8]. A procedure is an administrative control. So is a permit. So is a toolbox talk. OSHA's recommended practices put the same idea plainly: "Finding and fixing hazards before they cause injury or illness is a far more effective approach" than reacting afterward, and worker participation is a core element of any program that does so [9].

The controls that depend on sustained human attention are the least reliable ones, and they are the controls most programs lean on hardest.

THE HEDGE I OWE YOU

"Eventually fails" does not mean compliance is worthless. It means a program built only on compliance has no instrument for the thing that actually degrades: the human being. Keep the procedures. Add the instrument.

Psychology Before Procedures™

The philosophy is an order of operations. Before you reach for the procedure, you read three things: the person, the team, and the organization's effect on both. Then the procedure, because now you know what it has to survive.

Read the person

What state is their nervous system in right now? Connected and curious, rushed and reactive, or flat and absent? The same procedure performed in those three states is three different tasks.

Read the team

Who speaks and who does not? Whose stress is spreading? What has this crew decided, without ever saying it, about which rules are real?

Read the organization

What has this company taught people to expect when they stop work, report a near-miss or ask a question? That lesson walks into every task with them.

What the investigations kept showing

I will not give you a number here, because I did not count the way a researcher would. What I can tell you is what recurred, case after case, across industries that had nothing else in common:

- **Someone had noticed.** A co-worker, a spouse, a supervisor. The person had been "off." The observation had nowhere to go.
- **The task had been compressed.** A job that used to take a shift was being done in half of one, and the shortened version had become the standard.
- **The paperwork was complete.** The permit was signed. The training was current. Nobody could remember the content of either.
- **Speaking up had a price.** Somewhere in the recent past, somebody had paid it, and everybody remembered.
- **The hazard was known.** It had been discussed, sometimes for years. Familiarity had turned it into furniture.

A composite from several investigations

A night-shift operator at a chemical plant is asked to break a line that has been "mostly" isolated. He has been short with people for a week; his crew lead noticed but figured it was personal. The permit is signed by someone who did not walk the line. The day shift is due in forty minutes and the handover notes are thin. He skips the second verification because the first was fine and because the clock says so. The line is not empty.

Every control in that story was an administrative control. Every warning sign was in a person. A system that reads the person first had five chances to interrupt it. The procedure had none.

The Cognitive Reliability Model™

CRM™ is the operating system. The nine frameworks that follow are the applications that run on it. Five pillars, each with a signal you can hear in the hallway after an incident, and each with the tools built to reach it before then.

PILLAR 1

Neurological Baseline

"He seemed fine. Then it happened."

Chronically tense, reactive or flat workers. High absence. Short fuses when safety comes up.

Deploy: [Vagal Safety Ladder™](#) · [PERSONA™](#)

PILLAR 2

Threat Appraisal Architecture

"They knew the hazard was there."

Known risks underestimated, minor ones overreacted to. Inconsistent near-miss reporting. Precursors unrecognized.

Deploy: [PERSONA SIF™](#) · [The Backpack™](#)

PILLAR 3

Decision-Making Under Pressure

"They rushed it."

Task compression. Time pressure normalized. Verification skipped. "Good enough" decisions accumulating.

Deploy: [Quantum Safety™](#) · [PERSONA™](#) · [ThresholdIQ™](#)

PILLAR 4

Social Reliability Systems

"Nobody said anything."

Deference to authority. Silence in safety meetings. One person's stress spreading. Groupthink on risk.

Deploy: [PRISM™](#) · [BEACON™](#)

PILLAR 5

Communication Fidelity

"I thought they knew."

Toolbox talks that do not land. Permits signed but not read. Observations reported but never acted on. Information lost across shifts.

Deploy: [VOICE™](#) · [NISOS™](#)

Illustration: the five CRM™ pillars with their warning signals and the frameworks that serve them.

How to read the pillars

Notice that every signal is a sentence someone actually says. That is deliberate. After a serious injury, listen to the first explanations people reach for. "He seemed fine" tells you the baseline was never measured. "They rushed it" tells you pressure was invisible to the system until it was not. The pillar names the capability that was missing. The frameworks are how you build it.

You will rarely find only one pillar degraded. They lean on each other. A fear-based culture (Pillar 4) produces workers who conceal their state (Pillar 1), which blinds the organization to their threat appraisal (Pillar 2). Start where the signal is loudest, but expect to visit the others.

Pillars 1 and 2: the state of the person

Pillar 1 · Neurological Baseline

The question behind this pillar is simple: do you know what "normal" looks like for each person, so that you can see the day it changes? Most organizations cannot answer that. They know attendance and certification status. They do not know that a particular rigger goes quiet when he is overloaded, or that a particular operator gets chatty and fast.

The science here is clear enough to act on. Research on stress and the prefrontal cortex, the region associated with planning, working memory and impulse control, finds that even mild, acute, uncontrollable stress can rapidly impair those abilities [10]. Older work on emotion and attention describes how high arousal narrows the range of cues a person takes in [11]. Both findings have a name on the floor: tunnel vision. A stressed worker is a worker whose field of view has shrunk, and carelessness has little to do with it.

MONDAY QUESTION

For each person on your crew, can you describe their baseline in one sentence? If not, that is your first observation task. You cannot see a departure from a baseline you never recorded.

Pillar 2 · Threat Appraisal Architecture

This pillar is about how a person's brain sizes up a hazard, and why two people can look at the same open excavation and feel entirely different things. Appraisal happens below calculation. It is shaped by experience, by what the person has survived before, by what they have been taught to fear and what they have been taught to shrug at.

Two patterns show up most. The first is underestimation of the familiar: the hazard that has been there for years and has become part of the scenery. The second is miscalibration under load: a person who is already stressed either catastrophizes minor issues or stops registering serious ones. The PERSONA SIF™ framework maps how each archetype tends to misjudge threat, and The Backpack™ asks where that tendency was learned.

MONDAY QUESTION

Pick the one hazard on your site that everyone knows about and nobody talks about anymore. Ask three people, separately, how dangerous it is today. The spread in their answers is your threat appraisal problem.

A person's sense of danger was built long before they were hired. Your job is to learn its shape, so you can see when it stops matching the hazard in front of them.

Pillars 3, 4 and 5: pressure, people and signal

Pillar 3 · Decision-Making Under Pressure

A widely used model of human thinking describes two modes, often labeled System 1 and System 2: a fast, automatic mode and a slower, deliberate one [12]. The labels are a simplification, and I treat them that way. The useful point for safety is that pressure pushes people toward the fast mode, and the fast mode is where skipped verification lives. Quantum Safety™ gives supervisors a way to think about the threshold where a reversible decision becomes an irreversible one, and ThresholdIQ™ measures how close to that edge a person habitually operates.

MONDAY QUESTION

Which task on your site has gotten faster every year without a change in method? That is where the pressure has been absorbed.

Pillar 4 · Social Reliability Systems

Amy Edmondson's study of work teams found that the belief that it is safe to speak up, which she called team psychological safety, was associated with learning behaviour in a way that confidence in the team's ability was not [13]. In the field, that belief is built by what happened to the last person who stopped a job, and posters have little to do with it. PRISM™ addresses how a safety message is received and resisted. BEACON™ gives leaders a conversation structure that lowers threat before it asks for change.

MONDAY QUESTION

When did someone last stop work on your site, and what happened to them in the following week? Everyone on the crew knows the answer. Do you?

Pillar 5 · Communication Fidelity

Fidelity means what was sent is what arrived. Most safety communication fails this test quietly: the toolbox talk was delivered, the permit was signed, the observation was logged. None of it was received. VOICE™ works on how a message is carried in the voice itself, pace, pause and tone. NISOS™ gives observers a protocol so that what they record is consistent and includes what they could not see, which is often the most important line on the form.

MONDAY QUESTION

Take yesterday's permit to the person who signed it. Ask them, without the paper, what the three biggest risks on it were. Their answer is your fidelity score.

The ten frameworks on one page

CRM™ is the meta-framework. Nine run beneath it, and ThresholdIQ™ is the assessment tool for Pillar 3. This is the map; the pages that follow go deeper on the four you will use first.

FRAMEWORK	WHAT IT DOES	SERVES PILLAR
CRM™ Cognitive Reliability Model™	The operating system. Five pillars, each with a warning signal, a diagnostic protocol and a deployment chain.	All five
01 PERSONA™	Twelve behavioural archetypes, each with strengths and a characteristic SIF risk pattern. A coaching lens, never a label.	1, 3
02 NISOS™	Neuroscience-Informed Safety Observation System. The O.B.S.E.R.V.E. protocol for field observation.	5 (and 1, 2, 4)
03 PERSONA SIF™	Serious Injury and Fatality precursor framework: the five-stage precursor chain and three intervention windows.	2
04 PRISM™	Psychological Response and Influence Strategy Model: Perception, Response Pattern, Influence Pathway, Safety Integration, Motivation Anchor. Ethical influence only.	4
05 BEACON™	Leadership framework and the six-step BEACON™ Conversation: Build, Explore, Acknowledge, Clarify, Offer, Navigate.	4
06 VOICE™	Vocal Optimization and Intentional Communication Engineering: volume, tone, pace and pause, cadence, emotional resonance.	5
07 Vagal Safety Ladder™	Three nervous-system states and four ladder steps for bringing a person back to a state where they can think.	1
08 The Backpack™	Five layers of script and imprint that shape adult risk behaviour. "Not therapy. Safety intelligence."	2
09 Quantum Safety™	Five physics ideas used as analogies for how observation, teams and thresholds behave in a safety system.	3
ThresholdIQ™	Risk tolerance assessment: how close to the edge a person operates before judgment breaks down.	3 (tool)

Deployment chains

You do not deploy ten frameworks at once. You pick a chain that matches the situation and run it in order.

SIF PREVENTION

PERSONA™ → PERSONA SIF™ → Vagal Safety Ladder™ → NISOS™

CULTURE REBUILD

PRISM™ → Quantum Safety™ → BEACON™ → VOICE™

POST-INCIDENT

PERSONA™ → The Backpack™ → Vagal Safety Ladder™ → PERSONA SIF™

NEW SITE BASELINE

CRM™ audit → PERSONA™ → NISOS™ → PRISM™

On Quantum Safety™: the observer effect, superposition and entanglement are borrowed as analogies for how safety systems behave. They are teaching devices, and I do not claim a worker is a quantum particle.

The three nervous-system states

The Vagal Safety Ladder™ applies polyvagal theory, a model of the autonomic nervous system proposed by Stephen Porges, to the front line [14]. The theory is widely used in clinical and coaching settings and is still debated; a 2023 critique challenges several of its physiological premises [15]. I use it because the three states it describes are the three states I have watched people work in, and because the practical steps that follow from it work whether or not the underlying anatomy is settled.

State 1 · Ventral vagal

Safe, connected, learning

- Eye contact, warm and varied voice
- Asks questions
- Stops work when uncertain
- Can take in new information

State 2 · Sympathetic

Fight or flight, rushed, reactive

- Fast, clipped speech
- Tunnel vision
- Skips steps, irritable
- "Just let me get it done"

State 3 · Dorsal vagal

Shutdown, flat, absent

- Flat affect, monosyllabic
- Compliant but not present
- Signs the form, cannot recall it
- "Fine. Whatever you need."

Illustration: the three states as used in the Vagal Safety Ladder™. A teaching model, simplified on purpose.

State 3 is the one that compliance programs reward. The person agrees to everything, signs everything and argues with nothing. On a card, they are the safest worker on the crew. In my investigations, they are the ones everyone described afterward as "fine."

The four ladder steps

- 1 Recognize the state.** Yours and theirs. Voice, pace, eyes, posture. You are noticing which of the three pictures above is closest. Leave diagnosis to the clinicians.
- 2 Regulate your own state first.** About ninety seconds of extended-exhale breathing before you approach. A randomized study of brief daily breathing practices found that an exhale-emphasized pattern produced the largest improvement in mood and the largest reduction in respiratory rate among the practices tested [16]. You cannot bring someone to a calm state you are not in.
- 3 Activate the social engagement system.** Stand beside them. Face the same direction. Match their pace for a moment, then slow yours. Then the grounding question: *"What's the biggest risk you see right now?"* It is a question only a thinking brain can answer, and asking it invites that brain back.
- 4 Sustain the safe state.** One good conversation does not fix a shift pattern, a bullying supervisor or a chronic understaffing problem. Step 4 is organizational work: remove the stressors that keep pushing people down the ladder.

The twelve archetypes as a coaching lens

PERSONA™ describes twelve patterns in how people meet risk. Each has a strength your crew needs and a way it tends to fail under load. Read the table as a set of starting questions. Nobody belongs in one row.

ARCHETYPE	STRENGTH	PATTERN	SIF RISK
Guardian	Reliability and consistency	Rule-follower, comfort in structure, catastrophizes change	Freezes under novel hazards not covered by procedure
Analyst	Rigor and evidence	Data-driven, decision paralysis under time pressure	Overthinks when rapid response is required
Achiever	Drive and standards	Production-first, cuts steps to hit targets	Rationalizes shortcuts as "experience"
Connector	Cohesion and trust	Team-driven, hates conflict	Will not speak up against the group even when the group is wrong
Adventurer	Energy and adaptability	Thrill-seeker, normalizes risk	The one who "always got away with it" until they don't
Mentor	Transfer of experience	Experience-based, teaches what worked	Passes normalized risk to new workers
Visionary	Systems view and improvement	Systems-thinker, disengages from tactical detail	Misses immediate environmental hazards
Enforcer	Clarity and accountability	Authority-driven, fear-based compliance	Workers hide near-misses
Harmonizer	Steadiness and de-escalation	Conflict-avoider, absorbs stress	Operates impaired by accumulated tension without signaling distress
Skeptic	Critical questions that catch flaws	Questions everything	Creates a permission structure for others to disengage
Pragmatist	Practical problem solving	Gets it done, improvises	Unapproved workarounds become standard practice
Stabilizer	Calm and continuity	Steady under pressure, resistant to change	Misses emerging hazards because routine feels safe

The twelve PERSONA™ archetypes. Website one-liners, Safety Sense Inc.

READ THIS BEFORE YOU USE THE TABLE

PERSONA™ archetypes are a behavioural lens for understanding and coaching. They are never a diagnosis. They are never used to label, rank, hire or discipline anyone. Most people show two or three patterns depending on the day and the load. If you ever hear "he's an Adventurer, so of course he did that," the lens has become a label, and it is time to stop and reset.

Using the lens: from pattern to precursor

An archetype tells you where to look. An Achiever under pressure goes faster and starts calling controls overkill. A Connector under pressure goes quiet and skips the shared break. Same stress, opposite signals. If you only know one picture of "a stressed worker," you will miss half your crew.

The PERSONA SIF™ precursor chain

Serious injuries and fatalities are rarely sudden from the inside. PERSONA SIF™ describes five stages, with a window of time at each where intervention is still possible.



Illustration: the five-stage PERSONA SIF™ precursor chain. Timings are typical ranges from field experience and should be read loosely.

Three intervention windows

- **Window 1 • Early signal recognition** (days to weeks). NISOS™ observation and PERSONA™ mapping. This is where Psychology Before Procedures™ lives: it means starting here.
- **Window 2 • Active precursor engagement** (hours to days). The BEACON™ Conversation, VOICE™ and PRISM™. The person is still reachable through conversation.
- **Window 3 • Critical nervous system reset** (minutes to hours). Vagal Safety Ladder™ and Backpack™ scripts. You are no longer coaching. You are bringing someone back.

What each archetype looks like when the chain is running

ARCHETYPE	OBSERVABLE PRECURSOR	FIRST MOVE
Achiever	Celebrating past shortcut "wins"; dismissing controls as overkill; production-versus-safety tradeoff talk	PRISM™
Adventurer	Near-misses framed as achievements; thrill in the voice when discussing hazardous tasks; increasingly complex workarounds	VOICE™, BEACON™
Harmonizer	Flat affect replacing warmth; agreeing without processing; present but cognitively absent	Vagal Safety Ladder™
Connector	Uncharacteristic quietness; avoiding team interactions; missing shared breaks	NISOS™, BEACON™
Pragmatist	"We can't stop for that"; incremental erosion of non-negotiable controls; complaints about the productivity cost of safety	PRISM™, NISOS™

Five of the twelve are shown. The full PERSONA SIF™ map covers all twelve with their intervention windows.

The O.B.S.E.R.V.E. protocol

NISOS™, the Neuroscience-Informed Safety Observation System, replaces the "safe / at-risk" tally with a seven-step protocol. The difference is where it begins: with the observer's own state, before a single thing is recorded.

- O Observe: prepare yourself.** Before you walk in, notice your own state and your expectations. If you arrive annoyed, you will find things to be annoyed about. If you arrive expecting a "problem crew," you will see one. Ninety seconds of slow breathing at the gate is part of the protocol.
- B Broad scan.** Take in the whole scene before you narrow: people, equipment, conditions, pace. The rule is simple: always scan wide before you narrow. Most observation errors are errors of early focus; you lock onto the first thing you notice and miss the crew lead who is standing too far from the work to see it.
- S Specific focus.** Now examine the areas of concern zone by zone. Look at the decisions being made inside the task, as well as the positions of hands and feet. Where is this person choosing, and what are they choosing between?
- E Evaluate.** Ask what is driving the behaviour. Use the PERSONA™ lens and the person's current nervous-system state. A skipped step by an Achiever in State 2 and a skipped step by a Harmonizer in State 3 need different responses, and the card that says "at-risk act" cannot tell them apart.
- R Record.** Document in a consistent format, with context, and with a line for what you could not see. "Could not see inside the enclosure" is one of the most useful sentences in a safety record and almost nobody writes it.
- V Validate.** Confirm with follow-up questions and other sources before you rely on it. One observation is a hypothesis. Ask the person. Ask the shift before. Check the permit against what you watched.
- E Engage.** Start a coaching conversation suited to the person, using the BEACON™ Conversation on the next page. Observation that ends in a filing cabinet changes nothing. Observation that ends in a conversation is where the system starts to learn.

WHY OBSERVERS GO FIRST

Quantum Safety™ borrows the observer effect as an analogy: the act of observing changes what is observed. A supervisor's presence on the floor is a safety variable in its own right. The O in O.B.S.E.R.V.E. exists because the observer is part of the scene, and an unregulated observer makes the scene worse.

The BEACON™ Conversation

Most safety conversations open with the correction. BEACON™ puts the correction fourth. The first three steps exist to lower the threat level enough that the fourth can be heard. The lines below are illustrative; use your own words.

- B Build rapport first.** Stand beside them. Something true and ordinary: *"Long shift. How's the new rig running?"* You are signaling that this is a person talking to a person, and that nothing bad is about to happen.
- E Explore with curiosity.** *"Walk me through how that job goes on a normal night."* You are collecting work-as-done. Say nothing about the procedure yet. If you flinch at what you hear, they will stop telling you.
- A Acknowledge before you correct.** *"That makes sense given the clock you're working against."* Validation differs from agreement. It is proof that you heard the constraint they are under, and until they believe that, the rest is noise.
- C Clarify with information, at low threat.** *"Here's what I saw, and here's what I'm worried about."* Short, specific, factual. No "you always." No audience. The information lands because the first three steps earned it room.
- O Offer: co-create the solution.** *"What would make the second verification possible when the day shift is waiting?"* The person doing the work knows constraints you do not. A solution they built is one they will use when you are not there.
- N Navigate to a forward commitment.** *"So next time it's tight, you'll call me before you skip it. I'll answer."* Specific, mutual, dated. Then keep your half, because the next conversation is built on whether you did.

Where PRISM™ fits

PRISM™ sits underneath the conversation. It describes the worker's response spectrum, from Shutdown through Resistance, Compliance and Engagement to Commitment, and reminds you that resistance is a threat response before it is anything else: acknowledge it, validate it, then redirect. It also sets the ethical line. Influence that works by lowering threat and building meaning is the job. Influence that works by pressure, fear or manipulation is not, and it does not last anyway.

The correction is the easy part. The three steps before it are the work.

What this looks like on a Tuesday

A composite from several investigations and several sites that did it differently. No single crew, no single company.

A maintenance supervisor at a processing plant walks to the morning briefing. She stops at the gate for ninety seconds and breathes out slowly, because she had an argument at home and she knows what she is like when she carries that onto the floor. That is Pillar 1, applied to herself first.

At the briefing she scans wide before she looks at anyone in particular. The crew is loud, as usual, except one fitter, who is normally the loudest. He is looking at his boots. She has his baseline in her head because she wrote it down three months ago, and this is not it. Signal emergence. Window 1.

She does not call it out in front of the group. After the briefing she finds a reason to walk with him to the job. Beside him, same direction. "Long week?" He shrugs. She asks him to walk her through the isolation the way it will really go today. He does, and in the telling he mentions that the second verification "usually" gets done by whoever is free. She says that makes sense given how thin the crew is. She means it. Then she tells him, in two sentences, what she is worried about. He does not argue, which worries her more. So she asks the grounding question: "What's the biggest risk you see right now?" There is a pause, and then he gives her a real answer, with detail, and his voice changes while he gives it. He is back.

They agree that he will call her before any verification is skipped today, and that she will pick up. She writes the observation in the NISOS™ format, including the line "could not confirm whether the night shift completed the drain-down," because she could not. She validates that line by calling the night lead before the job starts. The drain-down was not completed.

Nothing happened that Tuesday. That is the whole point, and it is why this work is so hard to see from a spreadsheet. The permit would have been signed either way. The training was current either way. The difference was a supervisor who read a person before she read a form.

TRACE IT THROUGH THE MODEL

- **Pillar 1:** she regulated herself, then recognized a departure from a recorded baseline.
- **Pillar 2:** she heard "usually gets done" as a threat-appraisal signal and left the confession alone.
- **Pillar 3:** she found where the time pressure had been absorbed (the second verification).
- **Pillar 4:** she made it safe to tell her the truth, and did not punish it when it came.
- **Pillar 5:** she recorded what she could not see, and validated it before relying on the paper.

Your first thirty days

You do not need a budget, a consultant or a new software platform to begin. You need a notebook and the discipline to watch before you act. Here is the sequence I give every leader I work with.

- Days 1 to 7** **Baselines.** Write one sentence for every person you supervise describing what normal looks like for them: voice, pace, humor, how they handle being interrupted. Do not share these. They are your instrument, and they stay in your pocket. Begin each day with ninety seconds of extended-exhale breathing before you step onto the floor, and notice what changes in what you see.
- Days 8 to 14** **Work-as-done.** Pick the three highest-consequence tasks on your site. For each, ask a crew to walk you through it "the way it really goes." Say nothing about the procedure while they talk. Afterward, lay the two side by side. Every gap is a question to ask before it is anything to enforce. Ask the hallway questions from the pillar pages: when did someone last stop work, and what happened to them?
- Days 15 to 21** **Observe with the protocol.** Run three O.B.S.E.R.V.E. observations, one per shift if you can. Scan wide first. Record what you could not see. Validate each one with a second source before you draw any conclusion. Notice which of the three nervous-system states you find most often, and which one your current observation cards would have scored as "safe."
- Days 22 to 28** **Three conversations.** Hold three BEACON™ conversations, each with someone whose baseline has shifted or whose work-as-done worried you. Build, Explore, Acknowledge before you Clarify. End each with a specific forward commitment that includes something you will do. Keep your half within the week.
- Days 29 to 30** **Name the pillar.** Look back over the month. Which signal did you hear most: "seemed fine," "knew the hazard," "rushed it," "nobody said anything," or "thought they knew"? That is your most degraded pillar. Pick the deployment chain that matches it. That is your next ninety days.

WHAT TO MEASURE

Resist the urge to turn this into a scorecard in month one. The early measures are qualitative: how many baselines you can describe, how many work-as-done gaps you found, how many people told you something they would not have told you a month ago. The recordable rate will follow or it will not; it is a lagging indicator of a system you are only beginning to see.

The companion Safety Culture Diagnostic Checklist, free at safetysenseinc.com/resources, walks all five pillars with thirty observable statements and a scoring grid, if you want a structured way to name the pillar at day thirty.

Sources

Every outside research claim in this guide points to one of the sources below. Field observations and the composite stories are my own and are labeled as such. Where a model is debated in the literature, I have said so in the text.

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A note on what is not cited

The CRM™ pillars, the PERSONA™ archetypes, the precursor chain and the protocols in this guide are proprietary frameworks of Safety Sense Inc., built from field experience. They are offered as practice. They are not validated psychometric instruments, and I have tried to say so wherever a reader might otherwise assume more. Timings in the precursor chain are typical ranges from investigations and have not been measured in a study. The physics terms in Quantum Safety™ are analogies.

If this guide made sense to you

You now have the map, the vocabulary and a thirty-day start. That is enough to begin on your own, and I mean that. If you want company for the next part, here are three doors. None of them are urgent.

HAVEN University™

The education arm of Safety Sense Inc. Eight thresholds, from the neuroscience of behaviour to leadership and certification, with a weekly live session on Thursdays at 5:00 pm Pacific. Certifications include PCP (PERSONA™), NCO (NISOS™), LPI (BEACON™) and QSP (Quantum Safety™).

safetyseinc.com/haven-university

A discovery call

Thirty minutes, no slides. Tell me which pillar signal you heard most this month and what you have tried. I will tell you what I would do next and whether I think I can help. If I can't, I will say so.

calendly.com/janelpenafloro

The books

The Quantum Mind of Safety™ series goes deeper on everything here, including the investigations this guide only gestures at. *The Plastic Organization* is the book that holds BEACON™.

safetyseinc.com/book

Free tools that pair with this guide

- **Discover Your Safety PERSONA™:** sixty questions, twelve to fifteen minutes, radar-chart results, no signup.
- **ThresholdIQ™:** the Pillar 3 risk tolerance assessment, free and without a login.
- **Safety Culture Diagnostic Checklist** and **7 Warning Signs You're About to Have a Fatality:** the two companion downloads, at safetyseinc.com/resources.

Every fatality I've investigated had warning signs in the psychology that the procedures never captured. Let's find them before they find your workers.

Janel Penaflor, The Safety Disruptor™

Founder and CEO, Safety Sense Inc. · Buckley, Washington · safetyseinc.com/contact

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