

IS SAFETY JUST A PLACEHOLDER?

Why the Profession Must Redefine Its Language, Reclaim Its Moral Purpose, and Return Harm Prevention to the Design of Work

A Philosophical and Strategic Companion to Safe Behavior by Design

James White

Abstract

The word safety occupies a dominant position in the professional language of industry. Organizations establish safety departments, implement safety systems, appoint safety leaders, measure safety performance, promote safety culture, investigate safety failures, and declare safety to be a core value. Yet the breadth of this language has not produced equivalent conceptual clarity. Safety may refer to a human right, a legal duty, a technical condition, a management system, a statistical outcome, a behavioural expectation, an organizational value, or a specialist function. These meanings are related, but they are not interchangeable.

This paper asks whether safety has become an organizational placeholder: a generalized category used when leaders cannot, or choose not to, identify the specific failures of design, engineering, planning, maintenance, supervision, governance, control, or judgement that permit harm to occur. It does not argue against worker protection, regulation, management systems, or critical procedures. Rather, it argues that safety should no longer function as an imprecise substitute for operational accountability.

Drawing on safety-science literature and the practical framework established in Safe Behavior by Design, the paper proposes Responsible Operational Integrity as the broader organizational ethos within which protection should be governed. Safe Behavior by Design remains the practical method through which leadership visibility, critical control verification, trust, intervention, and behavioural ownership are aligned around high-consequence work. The central proposition is that safety should remain a fundamental right and intended condition, but its professional use should be disciplined. Protection must be demonstrated through the design, authorization, resourcing, execution, and verification of work—not inferred from slogans, system presence, or the absence of reported harm.

Keywords: safety, behavioural drift, operational integrity, critical controls, zero harm, safety clutter, leadership, fatality and serious injury prevention

Introduction: Has Safety Lost Its Meaning?

Every organization claims to understand safety. The word appears in corporate policies, annual reports, induction programs, contractor agreements, leadership speeches, risk registers, investigation reports, training materials, and signs at the entrance to industrial workplaces. Safety is described as a priority, a value, a responsibility, a condition of employment, a performance measure, a management system, a culture, and a personal obligation.

The word is everywhere. Its meaning is less certain.

When an organization states that safety failed, what precisely failed? Did engineering overlook a credible failure mode? Did procurement select unsuitable equipment? Did maintenance permit a critical

component to degrade? Did operations authorize work without confirming the necessary controls? Did leadership accept a schedule that could not be achieved within established limits? Did the workforce lack the authority, competence, time, or psychological confidence required to challenge the task?

Each represents a materially different failure. Each requires different expertise, accountability, corrective action, and learning. Yet all may be compressed into a single phrase: it was a safety failure.

This compression is not harmless. Language shapes diagnosis. Diagnosis influences ownership. Ownership determines what actions are assigned, what evidence is reviewed, and whether the organization learns anything beyond the immediate event. When a failure is categorized as a safety issue, it can be transferred conceptually and administratively to the safety function. The event may then generate more training, another procedure, a revised checklist, an additional approval, or a renewed instruction to comply. These responses may create visible activity without changing the decisions and conditions that produced the exposure.

The argument advanced here is deliberately provocative but qualified. It is not time to abolish the word safety. The term retains essential meaning as a human right, a desired condition, a legal and regulatory discipline, and a technical concept. In 2022, the International Labour Organization recognized a safe and healthy working environment as a fundamental principle and right at work (ILO, 2022). That commitment should be strengthened, not weakened.

The more consequential question is whether safety should remain the dominant organizing concept for how businesses protect people and govern operational risk. This paper argues that it should not.

Safety should remain where it has bounded legal, technical, or ethical meaning. It should no longer serve as a universal substitute for failures of operational leadership, engineering integrity, work design, planning, maintenance, supervision, procurement, critical control management, or organizational judgement.

The foundational proposition is therefore:

Safety is not a standalone organizational objective. It is evidence of whether the organization possesses operational and moral integrity.

What Is Safety?

The difficulty begins with definition. In ordinary professional use, safety may refer to the absence of injury, freedom from unacceptable risk, a management system, a department, a workplace condition, a personal behaviour, an organizational value, or the capacity to prevent failure. These meanings overlap, but they do not describe the same thing.

A workplace can record no injuries and still contain uncontrolled fatal exposures. A company can maintain a certified occupational health and safety management system while frontline work remains poorly planned or inadequately controlled. Conversely, an organization may report incidents openly while demonstrating stronger learning, transparency, and operational discipline than a company whose statistics appear flawless.

Safety is not a tangible product that an organization possesses because it has a policy, a department, a certificate, an audit score, or an injury-free period. These may contribute to protection. They are not protection themselves.

Safety is better understood as an emergent property of how an organization functions. It arises from the interaction of work design, technical integrity, leadership conduct, competent decisions, worker

participation, control effectiveness, available resources, organizational learning, and the capacity to respond when conditions change.

For the purposes of this paper:

Safety is the temporary and continuously produced condition in which an organization understands its material exposures, maintains the controls necessary to manage them, and possesses the capacity to respond responsibly when conditions depart from expectation.

The words temporary and continuously produced are deliberate. No organization can permanently declare itself safe. Equipment degrades. Contractors change. Knowledge becomes fragmented. Production pressure fluctuates. Procedures lose contact with practice. Controls become unavailable. Informal adaptations emerge. An organization does not become safe and remain safe. It must continually produce controlled work.

This definition also distinguishes the absence of harm from the presence of capability. Safety is not demonstrated solely by a favourable outcome. It is demonstrated by the effectiveness and resilience of the organizational capabilities that prevent exposure from becoming harm.

Safety as an Organizational Placeholder

A placeholder occupies a position until something more specific is inserted. In organizational language, safety frequently occupies that position.

Leaders may state that safety must improve without identifying which operational capability is deficient. Investigations may identify a safety-culture failure without naming the beliefs, incentives, authority structures, or leadership practices that shaped the event. Workers may be accused of unsafe behaviour without examining why the behaviour appeared necessary, rewarded, tolerated, or normal within the conditions of the work.

The broader the meaning assigned to safety, the easier it becomes for every function to support it rhetorically while avoiding responsibility for the decisions that determine it.

Consider the phrase unsafe act. It appears to identify a behavioural defect, yet it tells the organization very little. It does not explain what exposure the behaviour created, which control was defeated, whether the requirement was workable, whether production pressure influenced the choice, whether similar deviations had been tolerated, or whether the behaviour represented routine adaptation to a deficient work system. The label classifies the worker before it explains the work.

The same problem occurs with safety-system failure. A system may be present while its effect is weak. A written isolation standard does not isolate energy. A traffic-management plan does not create physical separation. A critical-control register does not confirm that a barrier is present and effective. A stop-work policy does not ensure that a worker can challenge the task without retaliation.

Documents may describe the conditions required for control. People, equipment, resources, decisions, and behaviours must produce those conditions in practice. The danger begins when the organization treats the description of control as though it were control itself.

This is the distinction between system presence and system effect.

System presence asks whether a policy exists, responsibility has been assigned, training was completed, a procedure is available, and an audit action was closed. System effect asks whether the policy influenced

the decision, the responsible person had adequate authority, the procedure reflected the work, the training developed usable competence, and the corrective action materially reduced exposure.

Both sets of questions matter. Only the second establishes whether the first created value.

Safety as a Placeholder

How a single word absorbs too many meanings and weakens operational clarity



Figure 1. How an overextended safety vocabulary can blur ownership and diagnosis.

Safety Activity and the Illusion of Control

Formalization was necessary. Industrial work exposed people to machinery, hazardous energy, unstable ground, toxic substances, transportation hazards, fire, explosion, and forms of work organization capable of causing serious injury, illness, and death. Legal duties, professional disciplines, management systems, and technical standards translated moral concern into structured obligations.

The problem was not that safety became formalized. The problem was that formalization encouraged many organizations to treat safety as something administratively separate from the conception, authorization, resourcing, supervision, and execution of work.

Safety became a system surrounding operations rather than a property of operations.

This separation often develops incrementally. An incident occurs and a procedure is added. An audit identifies inconsistency and a checklist is introduced. A regulator requests evidence and another approval is established. A deviation occurs and refresher training is assigned. A control is difficult to verify and a form is created to record that verification occurred.

Individually, each response may appear prudent. Collectively, requirements can accumulate faster than organizations retire, simplify, or test them. The organization becomes increasingly capable of showing what people were expected to do and less certain that the expectations remain workable, understood, and connected to current conditions.

Rae, Provan, Weber, and Dekker (2018) describe safety clutter as the accumulation and persistence of safety work that does not contribute meaningfully to operational safety. The problem is not paperwork alone. It is activity whose control value is doubtful, weak, or absent, but which persists because it reassures leaders, satisfies auditors, demonstrates activity, or appears easier to defend than its removal.

A form is not valuable because it is called a safety form. A meeting is not valuable because safety appears on the agenda. A procedure is not effective because it has been approved. A training record does not demonstrate competence. An injury-free period does not prove that serious exposure was controlled.

The professional challenge is not to produce more safety activity. It is to distinguish activity that strengthens operational capability from activity that confirms the existence of the safety apparatus.

Zero Harm: Moral Commitment or Performance Claim?

Zero harm carries compelling moral force. No responsible organization should treat injury, occupational disease, or death as an acceptable cost of production. At its strongest, zero harm communicates a refusal to knowingly trade human life or health for schedule, cost, convenience, or reputation.

That ethical position should remain.

The difficulty arises when the moral aspiration becomes a numerical target and then a performance claim. Zero harm can mean at least four things: a moral belief that harm is never desirable, an aspiration to reduce preventable suffering, a numerical target requiring no recorded injuries, or a claim that an injury-free period demonstrates successful control. These are not equivalent.

Zero harm is strongest as a decision principle. It means the organization will not knowingly subordinate life and health to another objective. It becomes weaker when the number zero is used as proof that the organization has controlled risk.

The absence of a recorded event does not explain why the event did not occur. A worker may repeatedly enter a line-of-fire position without being struck. An isolation may be incomplete without energy being released. A suspended load may not fall. The outcome is favourable. The exposure is not.

Where organizations evaluate only the outcome, luck can acquire the appearance of control.

The management use of zero also creates behavioural risk. When injury results affect bonuses, contractor standing, management evaluation, or public reputation, organizations may influence not only whether injuries occur, but whether they are recognized, reported, recorded, and classified. The existence of this risk does not prove universal suppression. It does establish that injury data is produced within a social and managerial system.

A mature position therefore distinguishes moral commitment from statistical proof:

Zero harm should remain an ethical refusal to normalize preventable suffering. It should not serve as sufficient evidence of operational control.

This distinction aligns with the central concern in Safe Behavior by Design: favourable outcomes do not prove behavioural reliability. The work must be examined for whether it preserved the expected standard, critical control, and exposure boundary (White, 2026).

The Zero-Harm Paradox

A moral commitment can become a distorted performance claim.



Figure 2. Zero harm as a moral commitment versus a performance claim.

The Myth of the Safety Failure

Organizations do not experience abstract safety failures. They experience failures of work design, operational control, engineering, planning, maintenance, communication, supervision, governance, and judgement—some of which result in harm.

The distinction matters because it determines where accountability settles.

Before an event, operational leadership generally controls the work sequence, available equipment, labour allocation, maintenance priorities, contractor arrangements, budget, schedule, and authority to proceed. The safety function may advise, facilitate risk assessment, establish standards, and provide assurance.

After an event, however, the failure can be transferred retrospectively to the safety system. Questions focus on whether the worker followed the safety procedure, whether training was provided, whether the risk assessment was completed, or whether the safety department should have identified the condition.

These may be relevant questions. They can also redirect attention away from the decisions that created the context in which the event became possible.

Operations then owns success while safety owns failure.

That arrangement is structurally incoherent. If the decisions that created or controlled the exposure were operational decisions, accountability must remain with the roles that possessed authority over those decisions.

This does not eliminate accountability for workers or safety professionals. It makes accountability specific.

Engineers own the integrity of technical design. Maintenance leaders own the reliability of maintained equipment. Procurement owns the risk implications of purchasing choices. Operations owns the conditions under which work proceeds. Supervisors own task-level authorization and control verification. Workers own responsible conduct within their authority and competence. Executives own the priorities, resources, and incentives that shape the organization. Safety professionals own the quality and integrity of their advice, challenge, escalation, and assurance.

Protection remains shared. Accountability becomes precise.

Prescription, Judgement, and Operational Maturity

The critique of safety bureaucracy must not become an argument against rules, procedures, or formal controls. Certain boundaries must remain explicit and non-negotiable where failure could produce fatal, life-altering, or catastrophic consequences.

Energy isolation, mobile-equipment separation, ground-control limits, atmospheric entry conditions, fall prevention, pressure containment, lifting capacity, and emergency readiness require disciplined prescription.

The limitation lies in expecting prescriptiveness to manufacture maturity.

A procedure can establish an expected method. It cannot guarantee that the conditions assumed by that method will exist. A checklist can prompt verification. It cannot create understanding. A rule can define a boundary. It cannot ensure that people possess the competence, authority, or confidence required to protect it when reality changes.

Operational maturity requires both prescription and judgement.

The appropriate principle is:

Prescribe what must remain invariant. Develop judgement for what cannot be fully

anticipated.

This is not unrestricted discretion. It is disciplined autonomy: competent judgement exercised within clearly understood technical, ethical, and operational boundaries.

Discipline without autonomy produces dependence. Autonomy without discipline produces uncontrolled variation. Disciplined autonomy enables responsible adaptation.

The distinction between adaptation and drift is therefore important. Responsible adaptation responds to a recognized change, preserves the critical boundary, involves competent judgement, and is communicated or authorized as required. Behavioural drift develops incrementally, weakens the intended control, becomes normalized through repetition, and persists because no immediate consequence has occurred.

The purpose of leadership is not to suppress all variation. It is to distinguish adaptation that protects the work from drift that erodes control.

Safe Behavior By Design As The Practical Counterpoint

Criticism alone is insufficient. If safety language, procedural volume, and injury statistics do not reliably produce protection, the paper must explain what does.

Safe Behavior by Design provides the practical counterpoint.

The book begins from a straightforward premise: reliable behaviour is not created by telling people to be careful. Nor is it created through slogans, posters, procedural issuance, or retrospective blame. Behaviour is shaped by how work is designed, led, resourced, supervised, and reinforced.

This is not a conventional behaviour-based safety model focused primarily on observing and correcting workers. It is a behavioural-design model focused on the conditions within which behaviour becomes likely.

The relevant inquiry is not only why a worker failed to follow the expected method. It also asks whether the method was workable, the critical control was available and effective, the exposure was understood, previous deviations were tolerated, operating pressure influenced the decision, and the worker could raise uncertainty without unreasonable consequence.

These questions do not remove personal accountability. They place personal conduct within the organizational conditions that shaped it.

The FSI Behavioral Alignment System within Safe Behavior by Design identifies five drivers through which leadership intention is connected to field execution:

Leadership Visibility

Critical Control Verification

Trust and Reporting Transparency

Intervention Frequency

Behavioral Ownership

Leadership Visibility requires leaders to engage closely enough with high-consequence work to understand exposure, changing conditions, and barriers affecting control.

Critical Control Verification requires physical confirmation that controls capable of preventing fatal or life-altering harm are present and effective before exposure occurs.

Trust and Reporting Transparency require an environment in which people can disclose weak signals, uncertainty, errors, procedural gaps, and stop-work decisions without expecting arbitrary blame.

Intervention Frequency reflects the organization's willingness to correct weakening conditions before deviation becomes accepted practice.

Behavioral Ownership exists when people protect the standard because they understand the exposure and believe the control matters—not merely because a specialist may be observing them.

These are not five separate safety activities. They describe operational conditions.

They also establish the relationship between the book and this paper. The paper challenges the organizational philosophy that allows safety to become detached from work. Safe Behavior by Design provides the practical method through which behaviour, controls, leadership, trust, and intervention are returned to the work.



Behavioural drift is especially important to this relationship. Drift rarely begins as a deliberate rejection of the standard. It develops through small adjustments: a shortcut saves time, a control is assumed rather than verified, a temporary workaround becomes routine, a supervisor does not intervene, no harm occurs, and successful completion reinforces the practice.

The documented method remains unchanged. The practical standard moves.

The organization may continue to report acceptable safety performance while the conditions through which people are protected weaken beneath the statistical surface.

Safe Behavior by Design makes that movement visible. It asks not only whether work was completed, but whether it was completed in a manner that protected the expected standard, control, and exposure boundary (White, 2026).

From Safety Activity to Operational Integrity

A reframing from administrative evidence to operational capability



Figure 3. The five drivers of the FSI Behavioral Alignment System.

Responsible Operational Integrity

The alternative proposed by this paper is not the elimination of safety and not the creation of another safety program.

Responsible Operational Integrity is the organizational ethos within which Safe Behavior by Design can be applied.

It is defined as:

The demonstrated alignment between an organization's declared values, operational decisions, technical requirements, critical controls, leadership conduct, and treatment of people in the conception, authorization, resourcing, performance, and review of work.

The definition establishes clear boundaries.

Responsible Operational Integrity is not a replacement label for safety. It is not a separate management system, branded initiative, or new layer of governance. It is the standard against which existing business decisions are examined.

Its purpose is to test consistency.

Does the organization's stated commitment to people correspond with the conditions it creates? Do procedures reflect workable methods? Are control requirements supported with resources? Does leadership maintain the standard when production, cost, schedule, or reputation comes under pressure? Can people raise uncertainty without unreasonable personal or commercial consequence? Does credible learning change the work?

Responsible Operational Integrity can be considered through six practical tests:

The Design Test: Was the work designed so the required controls, competence, time, access, and resources could realistically be provided?

The Authorization Test: Did the person authorizing the work understand the material exposure, required controls, and conditions that would invalidate the plan?

The Resource Test: Did the organization provide what was required to perform the work within its stated boundaries?

The Pressure Test: Did the standard remain stable when competing objectives intensified?

The Voice Test: Could people report uncertainty, stop work, and challenge decisions without unreasonable consequence?

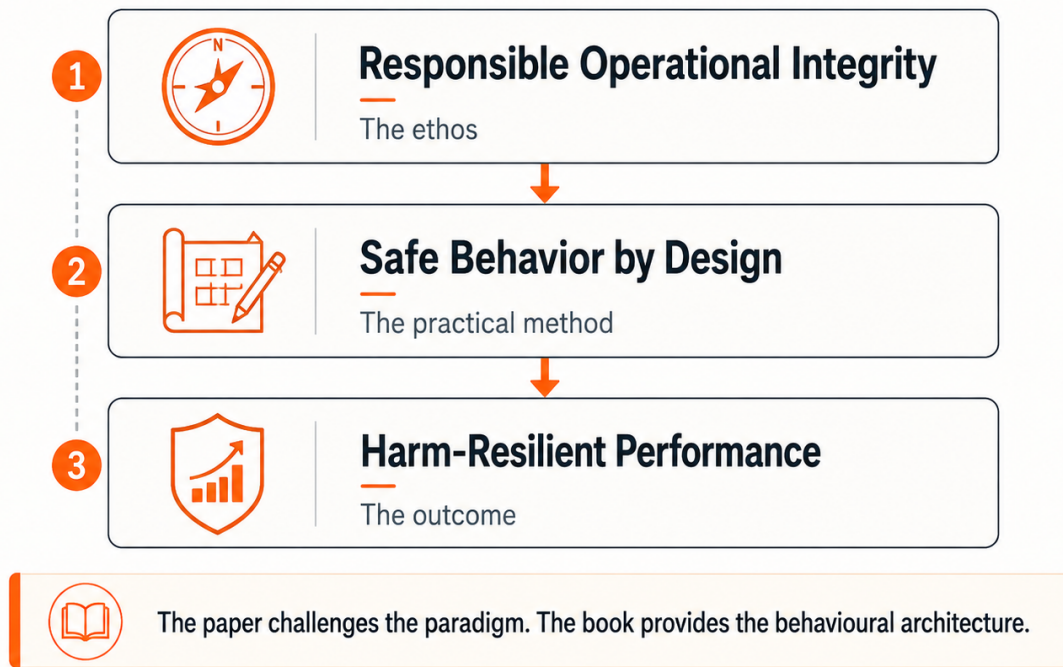
The Learning Test: Did the organization change work, controls, decisions, or conditions when credible evidence showed the arrangement was weak?

These tests are not proposed as another audit protocol. They are a discipline for examining whether the organization's declared values and actual decisions remain aligned.

Responsible Operational Integrity is the ethos. Safe Behavior by Design is the behavioural operating method. The FSI Behavioral Alignment System is the field alignment mechanism. Protection from serious harm is the intended result.

Companion Framework

How the paper and the book align



 The FSI Behavioral Alignment System connects leadership intention to field execution.

Figure 4. The companion framework: ethos, method, and intended outcome.

Discussion

The professional safety vocabulary developed for legitimate reasons. It created visibility, specialist competence, legal accountability, technical standards, and structured methods of prevention. The argument is not that these developments were mistakes.

The concern is that the institutional success of safety also created the possibility of separation. Safety became a recognizable organizational domain, and the protection of people could be treated as a function adjacent to operations rather than a defining property of competent operations.

This separation appears in language. Leaders refer to safety performance as though it were distinct from operational performance. Incidents are categorized as safety failures even when they arise from engineering, maintenance, planning, supervision, or production decisions. Workers are instructed to own safety while authority over equipment, schedules, resources, and work design remains elsewhere.

The resulting ambiguity can serve several organizational interests. It allows every function to endorse safety while leaving ownership unclear. It produces visible activity that can be counted, audited, and reported. It provides an administrative response after events. It also risks confusing evidence that safety work occurred with evidence that material exposure was controlled.

The paper does not reject management systems. ISO 45001 and ILO guidance explicitly support leadership, worker participation, risk management, continual improvement, and integration with broader organizational processes. The problem is not the formal intent of these systems. It is the possibility that

organizations treat certification, procedural completeness, or audit performance as evidence of control without adequately examining work as performed.

Nor does the paper reject zero harm. It retains zero harm as a moral refusal to normalize preventable suffering. It rejects only the use of zero as sufficient statistical proof.

Nor does it reject rules. It distinguishes critical prescription from procedural excess and combines non-negotiable boundaries with disciplined autonomy.

Nor does it absolve workers. It aligns accountability with authority and recognizes the reciprocal obligations of every level of the organization.

The conceptual reframing is therefore narrower than a wholesale rejection of safety practice. It calls for professional precision.

Where safety has bounded legal, technical, or ethical meaning, retain it.

Where safety conceals a specific operational failure, name the failure.

Where safety activity is performed, test its effect.

Where injury statistics are reported, examine exposure and control.

Where workers are asked to own behaviour, ensure the organization owns the conditions shaping it.

Where leaders declare values, examine the decisions made when those values carry a cost.

Conclusion: Safety Must Return to the Work

The word safety should not disappear from professional vocabulary. It should lose its role as an organizational catch-all.

Safety should continue to describe a fundamental human right, an intended condition, a legitimate technical discipline, and a moral commitment to prevent avoidable harm. It should no longer serve as a vague substitute for failures of operational leadership, engineering, planning, maintenance, supervision, critical control, or judgement.

The central question is not whether an organization can prove that safety activity occurred. It is whether the organization can explain how people are protected.

That explanation must be found in the work: —

- in how tasks are designed;
- in whether material exposure is understood;
- in whether critical controls are present and effective;
- in how leaders respond to pressure;
- in whether workers can speak up;
- in whether drift is interrupted;
- and in whether credible learning changes decisions and conditions.

Safe Behavior by Design provides the practical method for creating those conditions. Its focus on leadership visibility, critical control verification, reporting transparency, intervention, and behavioural ownership makes protection observable at the point of work.

Responsible Operational Integrity provides the broader ethos. It asks whether the organization's values, authority, resources, technical standards, and conduct remain aligned when objectives conflict.

The relationship is direct:

Responsible Operational Integrity is the ethos.

Safe Behavior by Design is the method.

The FSI Behavioral Alignment System is the field mechanism.

Reliable protection from serious harm is the intended outcome.

An organization does not demonstrate integrity because it recorded zero injuries, passed an audit, completed a campaign, or maintained a certified system.

It demonstrates integrity when it understands its exposure, maintains the controls upon which lives depend, welcomes information that challenges confidence, acts before drift becomes normal, and chooses protection when protection carries a cost.

Safety should not be abolished.

It should be returned to where it always belonged: inside the design, leadership, governance, and everyday performance of work.

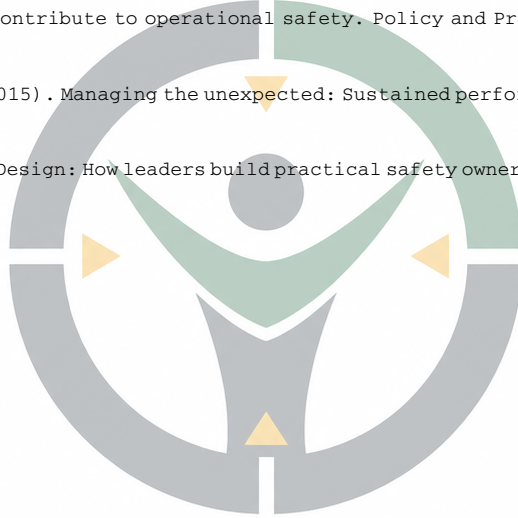


SafetyCentrics

— Advancing Fatality and Serious Injury Prevention —

References

- Dekker, S. W. A. (2017). Zero vision: Enlightenment and new religion. *Policy and Practice in Health and Safety*, 15(2), 101-107.
- Hollnagel, E. (2014). *Safety-I and Safety-II: The past and future of safety management*. Ashgate.
- International Labour Organization. (2001). *Guidelines on occupational safety and health management systems: ILO-OSH 2001*. ILO.
- International Labour Organization. (2022). *A safe and healthy working environment is a fundamental principle and right at work*. ILO.
- International Organization for Standardization. (2018). *ISO 45001:2018—Occupational health and safety management systems: Requirements with guidance for use*. ISO.
- Rae, A. J., Provan, D. J., Weber, D. E., & Dekker, S. W. A. (2018). Safety clutter: The accumulation and persistence of “safety” work that does not contribute to operational safety. *Policy and Practice in Health and Safety*, 16(2), 194-211.
- Weick, K. E., & Sutcliffe, K. M. (2015). *Managing the unexpected: Sustained performance in a complex world* (3rd ed.). Wiley.
- White, J. (2026). *Safe Behavior by Design: How leaders build practical safety ownership before drift becomes disaster*. Author manuscript.



SafetyCentrics

— Advancing Fatality and Serious Injury Prevention —