The Beauty of Intervention

Kitty Genovese story is a call to action for SH&E professionals

By James V. Kulis

AS BIG AS NEW YORK CITY IS, it is composed of many small neighborhoods. I grew up in the borough of Queens, NY, in a section called Richmond Hill that borders on another section called Kew Gardens. When you're 10 years old, as I was in 1964, no matter where you are, the known world is really no larger than a bike ride. The library, the corner store, the hobby shop and schoolyard marked the four corners of the earth.

On March 13, 1964, some 5,000 feet north of my bedroom window, Kitty Genovese was raped and murdered in Kew Gardens. A man named Winston Moseley stabbed her first at around 3:15 am as she walked from her parked car to her apartment. She screamed and neighbors heard her. Lights went on. One man yelled to leave her alone and the attacker actually retreated as instructed.

Five minutes later, as Genovese lay bleeding, Moseley returned and stabbed her again. Several more neighbors opened their windows to watch and again the attacker left. A 10-story apartment building is located across the street from where the initial attack occurred (see photo at right). During the 10 minutes Moseley was gone, Genovese dragged herself around to the back of her apartment building and entered a hallway, where she collapsed. Moseley returned. He later told police, "I came back because I knew I'd not finished what I set out to do." He followed the blood trail, found his victim, cut off her clothes, raped, robbed and killed her.

Popular versions of the story say that 38 neighbors watched the entire episode. Detailed analysis of the crime scene and witness statements reveal that this is not entirely accurate. One account says an elderly couple shut off their lights, parted the curtains and pulled chairs up to the window so they could see better. The fact of the matter is many people knew something was wrong that night, yet did nothing.

A Call to Action & Improvement

The story of Kitty Genovese presents SH&E professionals with a call to further action and a recommendation for the improvement of excellence. All professionals are exceedingly busy, yet often feel, "I could be doing more."

PHOTO COURTESY JOSEPH DEMAY JR.

The scene of the first attack on Kitty Genovese—Austin Street looking toward Lefferts Boulevard.

"Could do" usually turns into "could have done" after an accident when hidden root causes suddenly emerge. "If only we had seen. If only we had ventured into that unfamiliar or uncomfortable territory where the components of the accident or incident lay waiting." This article examines why people may not go the "extra mile," and provides a strategy for noticing and preventing impending incidents.

The Stages of Intervention

Research triggered by the Genovese murder explored why people often do not spring into action or act effectively when help is needed. Darley and Latane discussed the bystander effect and diffusion of responsibility in 1968. The basic tenet is that the presence of other people decreases the probability that any one individual will help—the belief being that someone else will surely rise to the occasion. One's own responsibility to act simply slips away into the crowd of onlookers (Darley and Latane 377). The modern SH&E professional must set the example and act when needed.

Much of the literature on the bystander effect refers to emergency response. The Genovese murder was dramatic and disturbing. The deliberate, brutal and fatal abuse of a human being constitutes the direst possible emergency. What goes through a person's mind? What prompts action? How does the potential Good Samaritan behave at the threshold of crisis?

Latane and Darley developed a decision tree that describes five stages leading to intervention:

- **Step 1: Noticing.** Simply realizing that something out of the ordinary is actually happening.
- **Step 2: Interpreting.** Realizing that the event is an emergency.
- **Step 3: Taking responsibility.** Identifying yourself as the one who will act.
- **Step 4: Deciding how to help.** What to do.
- **Step 5: Providing help.** Actually doing it [Latane and Darley(b) 31].

Although their research focused on crisis situations, it is useful to base one's daily posture toward safety and organizational well-being around these action stages. Anyone who has worked in safety and industry can relate to the term "threshold of crisis." Controlling safety in

Intervention Game Plan: The Five Steps in Action

Noticing

Ask all line and field supervisors to describe—weekly—an area of the operation about which they have safety concerns (hotspots). Their answers might take the form of, but are not limited to:

- acceptance of shortcuts;
- malfunctioning or poorly maintained machinery;
- ineffective employee training;
- unrealistic deadlines or production schedules;
- uneven work flow;
- low morale and apathy;
- confusion about generic or ambiguous policies.

Interpreting

Form a team of two line employees, two supervisors, an SH&E professional and manager to analyze the hotspots reported by supervisors. The goal is to have the group work together, while allowing members to speak freely from their specific perspectives. A team composed of members from different levels of an organization is a powerful alloy. It is a tool for enlightenment of all parties and can effectively generate and complete action items. It is much stronger than a homogenous group working alone. Management might be unaware of a shortcut that employees accept as a best practice. SH&E personnel might not be aware of specific deadlines or production schedules in all parts of an operation. Working together, the team should analyze hotspots and determine priorities.

Taking Responsibility

Taking responsibility means making responsibility. Once the team has analyzed hotspots and set priorities, management should assign action items that specific team members will carry out.

Deciding How to Help

The best compass in deciding how to help is to play to the team's strengths. In other words, assign action items on the basis of where a team member functions within the organization.

Providing Help

Develop a concrete timeline of who will perform what action when. Post the timeline in the team's meeting room and/or training room so that team members and their fellow workers remain aware of it.

an organization is not easy. A body of workers performs millions of hand motions and makes millions of decisions. Any one of those actions or decisions can result in an injury or fatality. Almost any point in any day can be described as the threshold of crisis. Yet, not every day presents actual accidents, incidents or crisis situations. These events should be rare and are becoming even more rare as safety efforts continue to improve. The SH&E professional must be in position at the window, with curtains parted, watching for signs of trouble.

Step One: Noticing

Noticing requires remaining alert to every possible indicator of trouble. This may include visual observations, written reports from supervisors, formal conversations, gossip, feedback sessions in safety meetings, audits and gut feelings. Think about a typical safety training video. When an accident is depicted, the main event—such as an electrician standing in a bucket of water while reaching for a junction box—is usually foretold by ominous music. The viewer knows what's coming.

During my safety career, I have often heard that music playing in my head weeks or months before an incident. It's a feeling often expressed during accident investigations: "I knew there was going to be an accident," followed by an explanation of exactly why that was the case.

Investigator: "How did you know Joe was going to have an accident?"

Coworker: "He used to fall asleep where he was standing."

Investigator: "Standing?"

Coworker: "Yeah, it would happen even if he was walking."

Investigator: "What did you do?"

Coworker: "We used to kick him in the pants. He would wake up and keep moving just as if nothing had happened."

Investigator: "How long did this continue?"

Coworker: "For about two months."

Investigator: "And then he finally fell down the garbage chute?"

Coworker: "Yeah, I knew he was gonna."

Noticing is not difficult, especially when there is a dedicated network of observers in the workforce. People must feel free to speak when they suspect a problem. The "Intervention Game Plan" sidebar (left) outlines a strategy for formalizing this observation network and targeting hotspots.

Step Two: Interpreting

Darley and Latane also cite pluralistic ignorance. If no one is acting, then nothing must be wrong (Darley and Latane). Here is where the SH&E professional does not sit back and blend in. Experience, training and site-specific job knowledge simply do not allow it. If no one is acting, it is because the SH&E professional is not acting.

Consider the story of the emperor's new clothes. When his pretended weavers show him a cloth so fine that a simpleton cannot see it, he wonders:

> "What is this?" thought the emperor, "I do not see anything at all. That is terrible! Am I stupid? Am I unfit to be emperor? That would indeed be the most dreadful thing that could happen to me.
>
> "Really," he said, turning to the weavers, "your cloth has our most gracious approval" and nodding contentedly he looked at the empty loom, for he did not like to say that he saw nothing. All his attendants, who were with him, looked and looked, and although they could not see anything more than the others, they said, like the emperor, "It is very beautiful" (Andersen).

The SH&E professional must trust his/her own judgment and watch for pretended weavers, which may take many forms—manipulated statistics, "yes" men, polished and painted equipment ready to fail—that do not deserve complete approbation. If the looms are empty, the SH&E professional must not be convinced by anyone that they are not. Interpreting is easy when members from different areas of the organization gather and examine a potential problem from many sides.

Step Three: Taking Responsibility

Diffusion of responsibility occurs when the number of bystanders is high and the number of victims is low. This high/low ratio also describes the relationship of non-

injured to injured in an organization. The likelihood of getting hurt is relatively small. A modern SH&E professional legitimately empowers those around him/her to take responsibility. Most current safety philosophies and programs stress employee ownership under the guidance of a manager who is personally involved. In essence, the manager is the program. In many cases, it is simply a matter of giving the go-ahead to a dedicated employee who already has the problem half solved.

Step Four: Deciding How to Help

With respect to the Genovese case, most people are shocked that it took so long just to call the police. People in the neighborhood said, "Even if they didn't want to go out in the night themselves, they could have called the cops!" The attacker had a knife and a clear intent to do harm. No one expected the elderly couple or other witnesses to dart out into the street and jump Moseley. They didn't have the skills and the personal risk was too great. Confined space and first-aid training stresses the need for a trained rescuer. There is great wisdom in calling for specific help. Collectively, the members of the organization understand the environment and know how to improve it.

Step Five: Providing Help

The strategy outlined in the "Intervention" sidebar calls for creating a team to work through the five steps leading to effective intervention. The "Line Leak Team" sidebar (right) explains how a team made up of a manager, SH&E professional, two supervisors and two employees tackles a sample problem. The team moves through the five steps as a group, providing each other with analysis and resources. Once the members notice and understand the problem, they can solve it.

The Beauty of Intervention

Providing help in the manner described requires discipline because the payoff is not immediately apparent. When applying the principles of noticing, interpreting, taking responsibility, deciding to help and providing help, nothing happens, and that's just the point—nothing bad happens. The example team was nearly an accident investigation team analyzing a catastrophic line leak. Intervention is the easier route.

After an incident or accident, there is often an overwhelming desire to rewind the film. It is usually possible to pinpoint the moment when things went awry. It is up to SH&E professionals to be vigilant in noticing, listening to and never disregarding the inner voice that warns of imminent danger.

Kitty Genovese was just one person, yet her death has taken on tremendous meaning and social significance. From 1992 to 2001, an average of 6,200 people died per year as a result of workplace injuries (BLS). From 1980 through 1995, at least 93,338 workers in the U.S. died as a result of trauma on the job (NIOSH). Each of those deaths should touch people as deeply as Genovese's did. Death in the workplace is senseless. The only possible meaning it can have is to indicate where the system failed. Listen for the scary music and vigilantly work toward improving workplace safety.

Line Leak Team: Preventing Disaster By Taking Action

Team:

Lease manager: Jeff	Employee I: Fred
Supervisor I: Darlene	Employee II: Janet
Supervisor II: Tom	SH&E professional: Gary

Noticing

The team receives the following supervisor hotspot report: "We discovered a small leak near the ground where a six-inch oil-gathering line exited to surface." Investigation revealed that the entire weld was worn away. The only thing preventing the line from rupturing was the cement insulation inside.

Interpreting

The team discussed the supervisor's concern. Janet noted that the pipe was prone to rust at exactly the point where it entered the ground because of movement and moisture. She hadn't seen it before on this lease, but at another facility it happened all the time.

Jeff added that as far as he knew the gathering lines haven't been replaced since he installed them as a roustabout 35 years ago. Darlene said that inspecting the lines used to be part of her crew's daily routine but may have been dropped when they went from six to four operators.

Taking Responsibility

Tom offered to run a fieldwide check of all gathering lines if that was all right with Jeff. Jeff agreed. Fred and Janet said that they would like to be part of the project.

Deciding How to Help

The team decided that Fred and Janet would conduct a fieldwide sweep of all gathering stations and inventory the condition of the lines. They would note any defects and report immediately if a line was in poor condition. Jeff asked to accompany them to the first gathering station and the crew agreed.

Providing Help

The team determined that Fred and Janet would check all gathering stations in four days and provide a report on the condition of the lines. As it turned out, 30 percent of the lines needed attention.

Jeff decided to overhaul the lines. He asked Gary to work with engineering and a permitting agency to investigate installing cathodic protection and soil treatment to protect all the lines in the field.

References

Andersen, H.C. "The Emperor's New Suit." 1837.

Bureau of Labor Statistics (BLS). "Census of Fatal Occupational Injuries." Washington, DC: U.S. Dept. of Labor, BLS.

Darley, J.M. and B. Latane. "Bystander Intervention in Emergencies: Diffusion of Responsibility." *Journal of Personality and Social Psychology.* 8(1968): 377-383.

DeMay, J. Jr. "Kitty Genovese: What You Think You Know." A Picture History of Kew Gardens, NY. <http://www.oldkewgardens.com>.

Gado, M. "A Cry in the Night: The Kitty Genovese Murder." Court TV's Crime Library: Criminal Minds and Methods. <http://www.crimelibrary.com>.

Latane, B. and J.M. Darley(a). "Group Inhibition of Bystander Intervention in Emergencies." *Journal of Personality and Social Psychology.* 10(1968): 215-221.

Latane, B. and J.M. Darley(b). *The Unresponsive Bystander: Why Doesn't He Help?* New York: Appleton-Century-Crofts, 1970.

NIOSH. "Traumatic Occupational Injury." Atlanta: Centers for Disease Control and Prevention, NIOSH. <http://www.cdc.gov/niosh/injury/trauma.html>.

James V. Kulis, CSP, *is a safety specialist with Pool Well Services Co. in southern California, where he has worked since 1983. He holds a master's in German from San Francisco State University. Kulis is a member of ASSE's Los Angeles Chapter.*