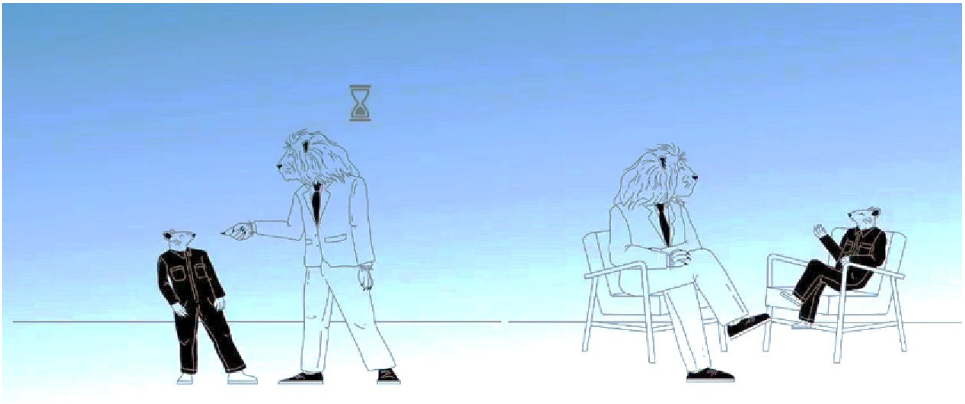
From Power to Personhood



After experiencing a near-collision at sea, Dr Nippin Anand developed a lifelong passion for event investigation, focusing on how failure can be turned into opportunities for learning and change. Through his examination of the 2012 Costa Concordia accident, and his exclusive interview with the Captain who was vilified for the unfolding events, he asks if we are truly learning from accidents or whether scapegoating provides more comfort and certainty to society rather than learning. To promote better learning, should we not be taking a more transdisciplinary approach? Safety Sciences is inherently embedded in Material Ethics (i.e. Deontology, Behaviourism, Positivism and Empiricism), which reduces human beings to objects and hazards. In this article Nippin discusses the need to embrace the Ethics of Personhood.

Amongst the many theories that explain why we mock at others. I find the work of French Philosopher Henri Bergson's to be the most powerful of all.

We mock at others when we realise that we have reduced the spontaneous and organic nature of living and being into a mechanistic object. Bergson referred to this phenomenon as 'how the mechanistic encrusts upon the living.'

The picture opposite came from my own experience of working at sea nearly three decades ago. I see it as a beautiful example of the wisdom of Henri Bergson.



Humans are not objects to be measured or hazards to be controlled. Our being is fallible, mortal and whole. We must learn to relate with other human beings as whole persons if we want to learn from accidents. We can see people as "it", objects to measured, hazards to be controlled. When accidents are investigated the objectives are often "to extract data" or "to collect data" and there is a loss of being able to relate or connect to people (I -> it).

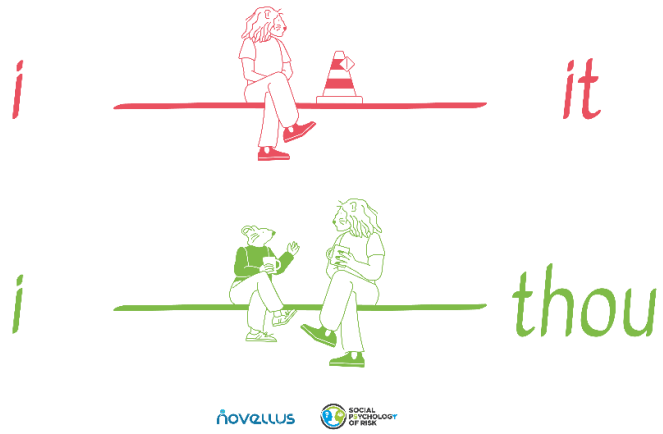


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There is immense power in being able to look at people as a full person (I -> thou), to relate to them and being able to learn from them.

We can run away from our words but we cannot run away from our images. Notice the cover of the books in risk, safety and human factors. What do you notice?



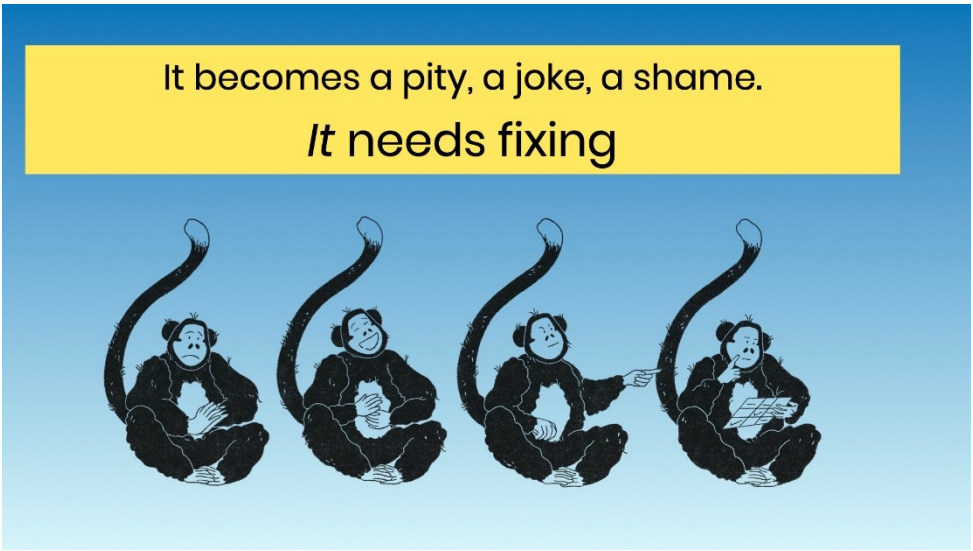
Martin Buber was right. We treat everyone as an object to serve our agenda. We see everyone as *It*. It is so obvious that we don't even see *It*.

When *It* Goes Wrong



In January 2012, the passenger ship Costa Concordia ran aground off the coast of Italy. 32 people died in one of the worst accidents in passenger ship history. Coincidentally, the accident happened 100 years after the sinking of the Titanic.





Watching the Captain being vilified reminded me of Martin Buber: Human Factors and the culture of an entire industry in action. What happens when humans cannot be factored in the system? What happens when *It* does not serve the system?

Seeing Beyond *It*



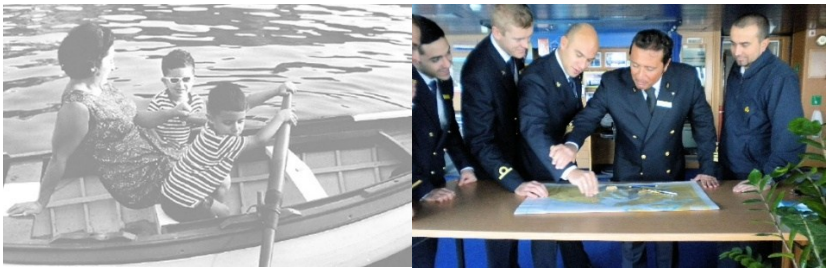
In March 2017, I contacted Francesco Schettino, the captain of the Costa Concordia. I requested a meeting with him to understand his perspective and what I could learn from him. Francesco agreed to meet me. At the time of our meeting, Francesco was under house arrest in his hometown Sorrento in Italy.



Those were his first few words when I met him in person. Imagine even after five years of the accident, no one from the industry ever spoke to him but every 'expert' had a view on the accident. More specifically, everyone had a view about 'Captain Coward' who ran away from the ship before all the passengers were evacuated.

What started as a casual conversation between us became an intense discussion. Francesco and I spent three days together and recorded more than 12 hours of video footage. He gave me many insights about what went wrong and how we can become better at managing passenger ship safety.

But I was more interested in understanding Francesco as a person. What did I learn about him?



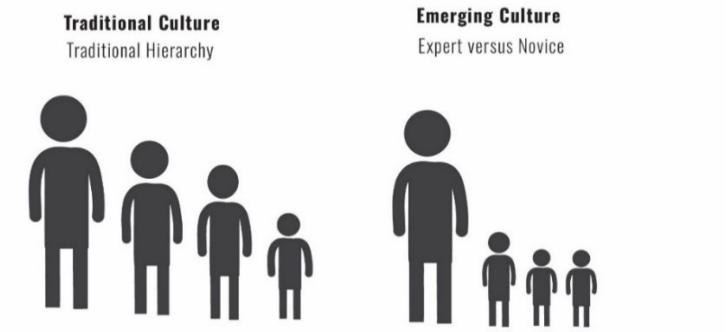
Francesco Schettino was born into a family of seafarers. His grandfather was a fisherman and his father was a marine engineer. His brother works as a first officer at sea. Fishing was his passion since he was a young boy. He had worked on tanker ships, ferries and gas turbines. He had been involved in building passenger vessels in shipyards in France; a staff captain for 6 years, a ship captain for 5 years and appointed as a safety representative for his company. Just this short biography should tell us he is not the 'Chicken of the Sea'.

Language of the Soul

I did not begin with investigating the accident. I started by relating with Francesco as a whole person. And in so doing, Francesco connected with me and gave the gift of his spirit. Galileo referred to this as the 'language of the soul'.

Throughout our three days of interactions, Francesco was highly critical of the quality of new recruits at sea. According to him, the junior officers lack the professionalism and the competence of a mariner.

The maritime industry has always been hierarchical but there is a new pattern of hierarchy we are noticing with there being an expert 'silo' surrounded by very junior novices. Despite there being five people on the bridge when the ship was heading towards rocks, none of them felt they could speak up and tell the Captain.



Why people don't speak up?

In one of our exchanges, the Captain revealed that when he asked his junior officers to put some salt tablets in the jacuzzi to turn the water saline, the officer added 'three salt tablets'. According to Francesco, someone who does not understand the basic principles of salinity and the Archimedes Principle of floatation and density does not deserve to be an officer at sea.

This story later became a turning point in my book, Are We Learning from Accidents [1], to dig deeper into systemic problems of training and competence in the maritime industry. The book, written after six years of contemplation and research into transdisciplinary areas, touches upon several aspects of risk and safety. I challenge the construct of 'soft skills'; 'non-technical skills' and 'psychological safety'. Deep and systemic issues of competence and expertise are often masked under a multi-million dollar industry that is inclined to reframe systemic problems as dearth of 'soft skills' or a 'lack of psychological safety'.

Several learnings surfaced during our deep discussions. Francesco, during his house arrest, was undertaking rigorous research to question everything from design, operations, company and regulatory standards of passenger ships. He was asking fundamental questions about fire safety, passenger evacuation, ship construction and stability. The systemic failures following the accident have led to many policy interventions in the maritime industry, but it has also given a new meaning to Francesco's quest for truth.

For a more detailed overview, here is the video link [2].

What is 'normal work'?

I also found how experts, on a daily basis, walk the difficult line between satisfying different competing and conflicting needs of the organisation, but it only takes a couple of hours to turn an expert into a criminal. The seemingly reckless close-pass of Giglio Island that led to the grounding is known as a "Salute" in the industry, and it is common practice to promote the image and commercial interests of the cruise industry.



Every day we are fed with meaningless jargon – 'learning from normal work'; 'learning from what goes well'; and 'learning from success'.

We should learn to slow down, pause and reflect on these constructs. Do we care to understand what is good, normal and successful from the perspective of the others?

Prior to the capsizing of Costa Concordia, sailing close to islands was considered a normal practice. How many risk and safety managers would be comfortable calling it 'normal work?' One person's normal is another person's catastrophe.

Such words have no meaning if we don't care to understand the subjective and hermeneutic nature of risk. Where do we discuss risk perception in risk and safety books, models, methods and methodologies? The industry lacks the ethics of personhood.

"Where do we discuss risk perception in risk and safety books, models, methods and methodologies? The industry lacks the ethics of personhood"

What is missing in emergency processes and contingency plans?

Emergency procedures are written in a very logical systematic and analytical way and fail to address the chaos and messiness that follows during an accident. Not only do these procedures belie an unrealistic fantasy of expected behaviours of pressurised and traumatised individuals but are actually used as the basis to criminalise participants.

Can there be a no-blame culture?

Francesco Schettino was also accused of leaving the ship before everyone was rescued. This is a baseless story that begs critical thinking and questioning. Several researchers and authors, including my own work, have questioned these allegations.



During evacuation, he was forced to jump once the ship started to list heavily towards one side. His presence of mind to land on a lifeboat that was stuck under the ship whilst instructing the coxswain to ease on the engine throttle to release the boat hook attached to the ship saved hundreds of people from being crushed under the boat. But this story never made it to the press. Instead, our quest for a scapegoat following an accident, led to the 'Captain Coward myth'. But such a myth is not uncommon when humankind seeks meaning in misfortune.

In Francesco's scapegoating lies the redemption of the cruise industry. Imagine what would happen if there was no one to scapegoat on that night?

Be careful when you hear the word, 'Blame fixes nothing'. Humans have not evolved to get rid of scapegoating. It is how we have always found meaning in accidents and disasters.

Long live scapegoating, who cares to learn from accidents?

The Ethics of Personhood

Once we turn people into 'objects' their state of mind, anxiety, distress and trauma hardly matters. What matters is extracting data, writing reports and releasing safety alerts. We call it 'lessons learned.'

It is no surprise that people involved in accidents often say this to me: going through the investigation was far worse than the actual experience of the accident. Many don't come out of their trauma for the way they were treated as part of the investigation process.

There is no humanistic ethics in investigation or for that matter in the safety industry; there need not be because that is not important. What is important is preventing harm. The end justifies the means.

In pursuit of Zero Harm human beings are brutalised and reduced to *It*.

The real question therefore is not the why, the what or the how? The question is: Who needs to learn from accidents?

That is where I spend a lot of time educating the investigators, auditors and safety inspectors. Unless we acknowledge the hidden dogma and indoctrination within the risk and safety industry there is no way we can learn from accidents.

Unless we learn to see another person as a whole person, there is no way we can learn from accidents.

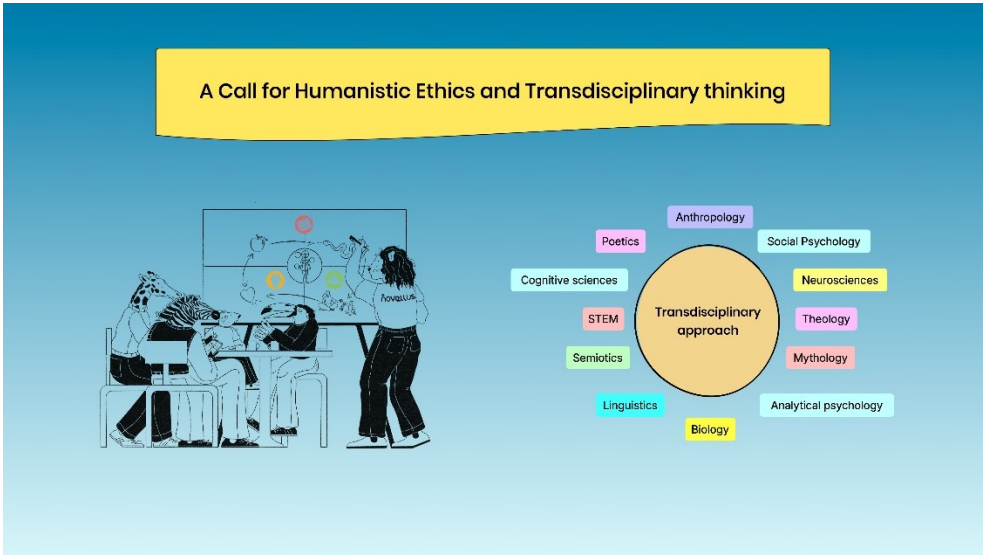
Embracing Fallibility

Several insights came out of our interactions, but more importantly, meeting with Captain Francesco Schettino has transformed me as a person. This is my most profound learning from accidents.

I don't look for perfection anymore; I am at ease with imperfection and fallibility. This inner journey has helped me to live a more fulfilling life. I see every day as a gift and every social interaction as a unique opportunity to learn about myself and others.

Transdisciplinary methods beyond STEM Sciences

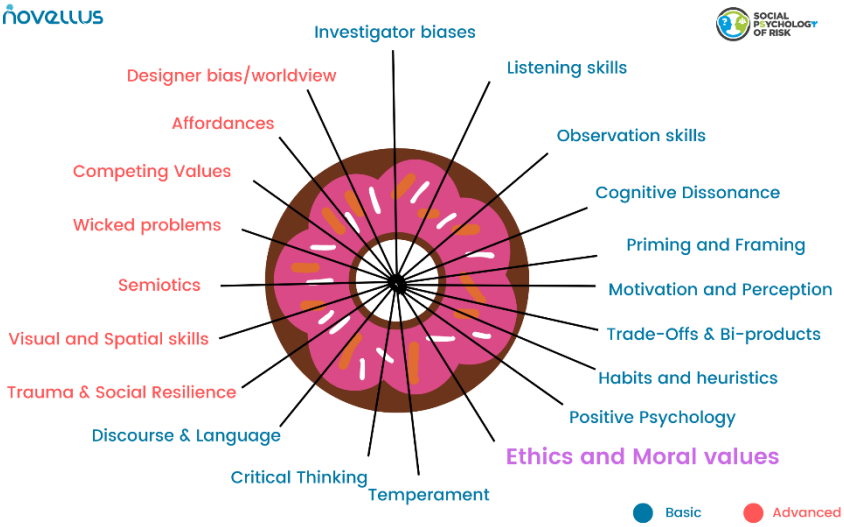
Broader questions about human behaviour require broadening our understanding. These questions cannot be answered within the realms of Science, Technology, Engineering and Mathematics (STEM). We must learn to embrace other disciplines both academic and otherwise. That is where the future of learning needs to go.



For that we need to embrace the Ethics of Personhood and semiotic methods to learn from another human person.

At Novellus we encourage semiotic methods within Social Psychology of Risk (SPoR) – a Transdisciplinary body of knowledge developed by Dr Robert Long in Canberra, Australia. One such method for investigations is called the iCue engagement process. These methods bring in not only the rational and logical analysis of a human but also incorporates decision making from experience-based heuristics as well as automatic non-rational 'gut thinking' intuition. (You can view several examples of the iCue method by visiting this link [3].)





SEEK (SOCIAL EVENT EXPLORATION KNOWLEDGE)

Accident Investigation Programme

These use visual (semiotic) tools to help organisations learn from events, improve decision making and achieve culture change. I invite you to watch my talk (Keynote at EU Rail Safety days) [4] for my personal presentation on the topics covered in this article.

References

[1] "Are We Learning From Accidents, A quandary, a question and a way forward", Novellus, 25th April 2024, ISBN: 978-1738560301

[2] Why don't people speak up? The Power of Framing (Learning from Accidents Ep.1), https://www.youtube.com/watch?v=JJ5E95nuR9E, accessed May 2026

[3] The iCue engagement program™, https://www.youtube.com/playlist?list=PLUmJhx2rt4T01AuD3x-5vXM5lE6mtQ0dl, accessed May 2026

[4] Learning from accidents: a call for humanistic ethics (Keynote at EU Rail Safety days), https://www.youtube.com/watch?v=QGXL2Pq2F1A, accessed April 2026.

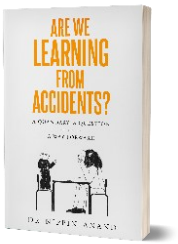
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Dr. Nippin Anand, Founder and CEO of Novellus Solutions



Nippin is a consultant specialising in human-centred approaches to learning, risk and social decision making. He is a former master mariner with an MSc in Economics and a Ph.D. in Social Sciences and Anthropology. Nippin brings a Transdisciplinary lens to the challenges of work and organising spanning: the humanities, social psychology, mythology, semiotics, anthropology and philosophy.

As a former subject matter expert at DNV, Nippin asks challenging questions about the role of ethics, care, helping, moral meaning, emotions and trauma in the discourse of risk and safety. In so doing, he seeks to help the industry to become more person-centric and ethical when it comes to risk management.



Dr Anand is the author of three books 'Are We Learning from Accidents?', 51 Stories in Culture and Three Semiotic Walks. He is also the host of the podcast Embracing Differences, and a frequent writer, well known for transforming complex ideas into practical insights accessible and actionable for safety-critical industries.

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