

Challenges to OHS-Operational perspective

In 2005 the author developed the paper “Challenges for Occupational Health & Safety 2005” (refer to web-site ohschange.com.au). This paper took a strategic view. Three years on the current paper explores the author’s beliefs about the Occupational Health & Safety operational challenges. Through a process of critical reflection on the theory he has been exposed to and his practical experiences in Qld industry, the author explains what he considers are the major operational obstacles to safety progress in Queensland industry.

Operational obstacles to the introduction of excellent Safety Management Systems Terminology

Probably the best example of a lack of scientific discipline in OHS lies in the terminology “accident”

The term “accident” implies carelessness (whatever that means), lack of ability to control its causation, an inability to foresee and prevent and a personal failure. How can we make meaningful progress on a major cost to Australian industry if we persist with such, sloppy, unscientific terminology? The term “accident” affects how the general population perceives damaging occurrences and the people who suffer the personal damage, inferring the event is “an act of god” or similar event beyond the control and understanding of mere mortals. (Geoff McDonald)

The term “accident” is best replaced by the term “personal damage occurrence”. Instead of talking about “permanent disability” we should be talking about “permanent life-altering personal damage”

There is a poor understanding in the community of the reasons why personal damage occurs. We are quick to make the assumption that the worker was careless, when one examines personal damage carefully one will also identify a range of work system factors that played their part as well. Most of these work system factors are the responsibility of the employer at both common and statute law. Blaming workers for their careless behaviour is an emotionally appealing approach that is usually not all that productive in the bigger picture of preventing personal damage at work. It is often technically wrong and associated with “blame”

People talk about “accident” “causes” (another emotionally laden term) Investigating personal damage occurrences thoroughly will reveal at least 30 “essential factors” (an essential factor is one without which the final personal damage could not have occurred)

Focus on Class 1 Damage (Geoff McDonald)

A method of classifying personal damage that seems appropriate is the following-

CLASS 1-Damage that permanently alters a persons life e.g. death, paraplegia, amputation of a leg, severe psychological damage.

CLASS 2- Damage that temporarily alters a person’s life e.g. fractured leg that repairs with no lasting impediment, deep laceration that has no underlying tissue damage and repairs without significant scarring

CLASS 3 insignificantly alters a person’s life

The report of the Industry Commission 1995 indicates that safety in Australia is fundamentally a class 1 problem (13% of occurrences were class 1 with 82% of cost.) Most safety management systems in Australian industry focus on lost time accidents within the organisation. Greater reductions in personal damage will be gained by focusing on Class 1 damage in the companies industry or Australia-wide. We must lobby for government to improve methods of collecting, disseminating and analysing personal damage occurrence (accident) data. Collection of personal damage occurrence (accident) data on an industry-wide basis is essential.

Lost Time Injury Frequency Rate

The Lost Time Injury Frequency Rate impedes progress in safety (Refer to the paper The Lost Time Injury Frequency Rate by this author) The Lost Time Injury Frequency Rate predominates discussions about safety performance. How can a company be proud of a decrease of L.T.I.F.R. from 60 to 10 if there have been 2 fatalities and 1 case of paraplegia amongst the lost time injuries? The L.T.I.F.R. trivialises serious personal damage and is a totally inappropriate measure of safety performance.

General management effectiveness

It is the author's experience that general management effectiveness is not high in a number of organizations, this impedes the introduction of excellent approaches to safety.

Nepotism

Nepotism can be a problem in organizations with the friends and relations promoted beyond their capacity and protected when they do not perform.

The compliance with statute law

It is interesting to note that, in the authors experience, there are many organizations, and not only small ones, that do not comply with safety legislation. There also seems to be a widely held belief that complying with safety legislation is all you have to do to have an excellent Safety Management System. Putting this into perspective some OHS professionals suggest only 20% of personal damage occurrences (accidents) will be prevented by compliance with legislation.(Canadian Centre for Occupational Health & Safety discussion Forum, September 2008)

The Compliance with Common Law

It is the author's experience that the implications of common law are often not well understood.

There are four basic duties under common law :

- A) To provide and maintain competent staff.
- B) To provide and maintain a safe place of work.
- C) To provide and maintain safe plant and appliances.
- D) To provide and maintain a safe system of work

The above duties contain few words but the meaning is quite significant. The employers really have to do everything reasonably and practically that they can do. Many would suggest they then have to go a few extra steps. Managers and supervisors really need to be trained in common law duties to fully realise the impact of this important area on how they manage safety.

. Highly visible demonstrated commitment to health and safety on behalf of Senior Management

There is no shortage of companies that talk a lot about safety but do not actually do a lot. It is not unusual in companies with high profile safety management systems for senior and middle management personnel to spend over 30% of their time directly on OHS issues. Key personnel conduct safety meetings, they personally participate in safety inspections in their area of responsibility, they have safety as a first high-profile agenda item of every meeting they conduct and they make it clear that they expect those below them to place a high priority on safety. It is not enough for top management to be committed to safety; it must be a clear and high profile demonstration of commitment that is followed up by the organisation of effective action. - you get the performance you demonstrate you expect. This is one area where positive action by management can have an overwhelming influence on the culture of the organisation.(Refer to the paper “Safety culture & how to improve it” by this author) A detailed Safety Responsibilities / Accountabilities matrix for management and supervision is appropriate.

Risk Assessment

Notwithstanding the popularity of risk assessment techniques there are some limitations to the techniques that need to be realised. The author has always been of the view that what you do to control risk as a result of a risk assessment exercise is more important than the risk rating. Placing too much emphasis on comparison of risk ratings will lead to inappropriate priorities. The reality is that without an excellent system of Class 1 personal damage occurrence data in Australia estimates of probability and consequence in risk assessment exercises are often subjective. A lot of the risk analysis in industry consists of slightly informed guesswork from stakeholders, the term “consignorance” applies (what happens when you use consensus to combine ignorance) (Source-Geoff McDonald) The lack of a National Class 1 data base is a major impediment to progress.

Safety Learning

Every task that needs to be done by people must be done

- Safely
- Effectively
- At the right cost
- At the right quality
- In the right quantity

With appropriate consideration for people, for the community and for the Environment
(Competency-Based Learning)

Detailed task analysis must take place to recognise the safety competencies required to perform all tasks (including supervisory) where gaps exist between required competencies and current competencies appropriate training may be the most appropriate solution. Lecture style presentations and “Death by Power-point” (where the presenter has a whole series of power-points and reads them out to the audience) is a problem. Putting into practice Action and Experiential learning models with lots of interaction, discussion, case studies, practical exercises etc. is preferred

Quality Assurance

Utilise the advantages of a Quality Assurance approach to OHS without succumbing to the blind unthinking devotion to the Quality movement that is evident with some Quality Assurance practitioners. Quality Assurance can add some rigor to a safety management system provided it is not over-done

Safety Procedures

The commonest mistake the author has seen with Safety Management Systems is the development of extensive safety procedures that the workers do not know about, care about or use. The procedures sit on the supervisor's bookcase or a computer program and are rarely referred to. The job safety analysis technique must be used to develop safe working procedures and involvement of the workforce is crucial. If your safe working procedures are over 2 pages in length worry about whether they will ever be used. Use flow-charts, pictures and diagrams in your safe working procedures and base them on a very basic level of English. The K.I.S.S. principles applies..

Even when the safe working procedures are appropriate it is easy to unduly rely on them.

Communications

From the author's studies of Management of Organisational Change he adopts a communications and management philosophy that "People Support What They Create"

While with B.H.P. the author worked with Professor T.J. Larkin of Harvard University analysing safety communications in the company. There were 3 main messages to come out of this research-

Use face-to-face communications,

Use the supervisor to communicate and

Frame messages relevant to the immediate work area.

With written communications the author aims to be succinct, have an appropriate structure and utilise management summaries with major reports. He uses photographs, diagrams, flow-charts etc. to illustrate main points. Important written communications must always be followed up by a face-to-face meeting. The BHP guideline for general correspondence is that if it takes more than 2 pages to write it is too much for busy people to write and read. The world of safety is famous for well-meaning, ponderous, glossy publications that no one really knows about, cares about or uses. Safety communications are also famous for the use of "weasel-words". "Weasel-words" promise a lot but deliver little.

. Professor T.J. Larkin says "If it is not face-to-face it is not communication".

Role of the safety professional

Shortsighted companies think they employ safety people and these people will look after safety. The more progressive companies often do not have many dedicated OHS personnel, management and supervisors are so well trained and effective in safety that few dedicated safety personnel are required. Safety personnel should report to the senior officer so the function has some chance of being perceived as being of importance. The danger when you have too many safety people is that line management abdicate management of safety to the

safety people. Safety is a line management function and safety personnel should be seen as specialist adviser. A real concern is the people who attend a statutory Workplace Health & Safety Officer's course and think they are instant experts.

Leadership

Excellent safety management systems demand excellent safety leadership.(Refer to the "OHS Leadership" paper by this author)

Safety management often requires unpopular decisions by leaders, do not shrink from demanding high safety standards from all those around you, take positive action with those who do not meet expectations.

Complexity

Many organizations have safety standards, special emphasis programs, policy and safe working procedures that are very thorough and detailed. Unfortunately in the quest for thoroughness the number of words becomes immense and difficult to decipher. It ends up being an immense task for even the most dedicated to wade their way through the paperwork. There is room for succinct summaries of major approaches. OHS professionals should not be judged by the number of words they create.

A.S. / N.Z.S. 4801 Safety Management Systems

A number of the author's professional acquaintances are critical of this standard. The author is of the opinion that implementing a Safety Management System that meets the identified needs of your organization is appropriate, this will usually exceed the less stringent requirements of 4801.

Fire / Emergency Procedures

The Qld Building Fire Regulations provide a number of requirements about fire / emergency procedures, fire drills and fire training. The author is amazed by how many organizations ignore these requirements. The requirements are relatively simple and make sense to the author. Fire is responsible for a number of deaths in our community.

Safety committees

The author has seen a number of safety committees that are basically a whinge-fest. Instead of managing safety on a day by day basis items are saved up for the safety committee meetings, Safety committees need substantive tasks and members need to be trained. Often the only tasks the health & safety reps. perform is to attend safety committee meetings

Hazardous substances

There is a Code of Practice for Hazardous Substances under the Workplace Health & Safety Act. Many organizations give scant attention to this. The requirements are relatively simple and make sense to the author.

Conclusion

The above is based on practical experience in safety in Qld. in recent years. Some of the ideas presented challenge the traditional wisdom in Safety

