WorleyParsons: building a business of safety

How OHS leaders can work with boards & directors
Climbing the safety ladder: Professor Patrick Hudson
The third industrial revolution: revolutionaries and WHS
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How to engage with boards on safety: Boards are sometimes uncertain about practical measures they can take to improve safety governance and what indicators they should rely on in the process
Leading safety by example

The importance and significance of strong safety leadership and the work that OHS professionals perform should not be underestimated, writes Craig Donaldson

In the seven plus years I have been editing OHS Professional magazine, how I think and feel about the work I do on the publication has changed significantly. In the early days it would be fair to say it was just a job, and one I enjoyed. Being a professional journalist and editor, I always liked the process of writing about OHS, and the content was interesting and engaging enough.

But when you see the results of strong safety leadership in organisations, and the benefits this results in – namely, less fatalities, injuries and incidents – one cannot help but be touched by how important and significant the work is that OHS professionals perform.

This is reinforced every time I speak with executives and OHS leaders who do genuinely believe in the importance of safety – and put it right up there with commercial priorities. A great example of this can be found in the cover story for this issue, which is about WorleyParsons’ integrated and holistic approach to workplace health and safety. The global project management and engineering firm, which generated revenues of $5.89 billion last financial year, regularly records some of the best safety results out of all ASX-listed companies. For example, last financial year saw its total recordable case frequency rate per 200,000 man-hours reduce from 0.12 to 0.07. In the feature, WorleyParsons’ APAC assurance director, Luc Herwin, who oversees HSE in the APAC region for the company, says: “We believe there is no proprietorship on safety, so we collaborate with clients, subcontractors and joint venture partners to deliver meaningful and positive HSE outcomes.” For the full story turn to page 18.

Similarly, our leadership feature for this edition focuses on how OHS leaders and functions can better engage with their boards of directors. Boards can play an important role in safety as they influence what executive leaders focus on, but they need to be informed by the right safety metrics and measures. However, there is a great deal of uncertainty in boardrooms about what makes an effective leading indicator when it comes to effectively gauging just how well organisations are tracking in safety. Traditionally, there is a much greater focus on lag indicators because they are familiar and certain, but lagging indicators do not help to guide the future outcomes in a business. In this feature (beginning page 28) we explore just what metrics, KPIs and indicators OHS leaders can adopt to better guide their board in making more effective decisions around safety governance – and generating better results for their annual reports and shareholders.

Speaking of more enlightened approaches to safety, the strategy feature for this edition focuses on the “safety differently” approach to OHS. Daniel Hummerdal explains that in this approach, organisations shift their focus to enabling as many things as possible to go right. This goal not only changes the definition of safety, but also how safety is understood, assessed, communicated and practised. For the full article please turn to page 25.

Craig Donaldson, editor, OHS Professional

“One cannot help but be touched by how important and significant the work is that OHS professionals perform”
Quad bike manufacturers lambasted over poor safety standards
The Australian Centre for Agricultural Health and Safety recently criticised quad bike manufacturers for poor safety standards, off the back of statistics which show there has been little change in the number of on-farm fatal injuries for the first quarter of 2017. “No deaths are acceptable, as these events are almost always preventable,” said Dr Tony Lower from the Centre. “The unenviable safety record of quads is again being highlighted as they top the list with six fatal on-farm cases, two of which involved children,” said Lower, who pointed out that quads also make up 33 per cent of the total number of non-fatal incidents reported in the media. “While quad manufacturers always point to rider error to avoid any implications regarding the safety of their product, with over 60 per cent of deaths in Australia involving rollovers, the lack of a lateral stability standard and crush protection means not only do they roll all too easily, but when they do, the consequences are often fatal.”

Proactive work health and safety interventions on the rise
Work health and safety regulators have increased proactive workplace interventions in recent years, according to new Safe Work Australia data. The 18th edition of the Comparative Performance Monitoring (CPM) report found that in 2014-15 there were almost 190,000 workplace interventions by jurisdictional work health and safety regulators. Almost 100,000 of these interventions were proactive, which compares with around 86,000 proactive interventions in 2012-13. In releasing the report, Safe Work Australia chair Diane Smith-Gander recognised the importance of remaining vigilant to ensure workplaces understand and comply with their work health and safety obligations. “Australia’s regulators are proactively addressing work health and safety issues,” said Smith-Gander. “The culture of safety within workplaces improves when there is open workplace engagement. Safe Work Australia members are working together to minimise injuries and time off work.”

First category 1 prosecution under QLD safety laws
Two family-owned businesses and their respective directors have been committed to stand trial following a Workplace Health and Safety Queensland investigation into the death of a 62-year-old roofer. These are Queensland’s first category 1 prosecutions under work safety laws, with the companies, if found guilty of the alleged offences, facing possible maximum fines of $3 million, and the two directors facing fines of up to $600,000 each and maximum jail terms of five years. The defendants, Lavin Constructions and Multi-Run Roofing, and company directors Peter Raymond Lavin and Gary William Lavin, have been charged for contravening Section 19 (2) and/or s20 of the Work Health and Safety Act 2011. Whareheepa Te Amo, who only started the job four days earlier, fell almost six metres to his death while working on the edge of a roof without protection. Te Amo was one of five roofers working on an industrial shed at Lake MacDonald in the Sunshine Coast Hinterland on 29 July 2014, when he fell.
It’s complicated… or is it?
There are five key structural projects which provide the basis for an OHS profession that can grow and develop within a sustainable and robust framework, writes Dave Clarke

It takes a complex blend of knowledge and experience, as well as science and psychology, to have well-tested safety systems in place and a diverse workforce thinking and acting safely, with smart health and safety practitioners and professionals working at all levels of the company to keep it that way. It is a sophisticated and challenging task requiring a wide range of skills, capabilities, teamwork and shared commitment from people in the organisation at all levels.

This is what the profession is all about: from the practitioners working at the coalface implementing strategy, through management and right up to the head of health and safety and environment talking to their board of directors – not just about compliance and statistics, but organisational culture as well. It’s also not a project with a beginning and an end – it’s a job that ever ends.

Professions with such sophisticated tasks in which the schools of thought vary and the needs of people at different levels are wide-ranging, require a structured and equally sophisticated approach to their development as a basic prerequisite for success. In the field of health and safety, this structure is being put in place. Throughout the last decade, the Safety Institute of Australia and its many partners have been working on and continuing to refine them:

1. Core knowledge base: Underpinning professional knowledge, providing a strong evidence base for the work of the profession, and a body of work which can guide formal education. Our profession now has this in the form of the OHS Body of Knowledge, developed over the last decade.

2. Education assurance: Providing confidence in the consistency and standard of the formal education people receive. Today, this is assured at university level through the work of the Australian OHS Education Accreditation Board (AOHSEAB), with most of Australia’s bachelor degree or post-grad OHS courses accredited. There are still challenges to address the quality of VET courses (Diploma and Advanced Diploma WHS), and the Institute has been undertaking advocacy on these and hopes for significant changes in the near future.

3. Capability/role framework: The recent publication of the OHS Global Capability Framework, supported by the Institute, now provides for the first time an international framework which describes roles across the spectrum of OHS work, and the skill/knowledge requirements at each level.

4. Capability assurance, promotion and status: The new certification program, articulated against the Global Capability Framework, is now well established and will be strongly promoted to industry in the next two to three years.

5. Ongoing learning and professional development: After recently introducing a CPD planning tool and sector-wide mentorship program, the Institute is now focused on seeking to bring some order to the current cacophony of health and safety training and professional development in the market. Training organisations need greater clarity and advice about the kinds of ongoing training the profession needs, and the health and safety profession needs to be able to plan and get access to a range of training better focused on their needs.

These five key structural projects provide the basis for a profession which can now grow and develop within a framework that can absorb the complexities of the tasks and give each member of the profession at each level a greater understanding of their role within the larger framework, and for all people in the profession, provide pathways for development and learning. Just like a good health and safety system, a sophisticated and well-designed structure, applied properly and fit for purpose in a complex environment, can ultimately make everything simpler.
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- Cancer Council Australia
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- Congress of Occupational Safety and Health Association
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- Environment Institute of Australia and New Zealand (EIANZ)
- Human Factors and Ergonomics Society of Australia (HFESA)
- Industrial Foundation for Accident Prevention (IFAP)
- International Network of Safety & Health Practitioner Organisations (INSHPO)

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A ccidents leading to work injuries cost an estimated $57 billion in Australia, however, workplaces are unlikely to be adequately addressing injury prevention because management decisions are informed by inaccurate data, according to a new research report by the University of South Australia's Asia Pacific Centre for Work Health and Safety.

The study linked confidential surveys of hospital employees to register-reported injuries, and found large discrepancies. On average, only 4 per cent of work injuries were registered, compared to those reported in the confidential survey, said lead researcher Amy Zadow, PhD candidate and registered psychologist/research assistant.

The study suggests that psychological injuries are much more likely to be unreported: while 73 per cent of workers stated that they reported physical work injuries, only 35 per cent of workers stated that they reported their psychological injuries (such as PTSD following an encounter with a violent patient or depression developing from work pressure).

"In workplaces, if psychological injuries are not reported it is more difficult for workplaces to manage them effectively and they will potentially become worse or problems will manifest in other ways, such as reduced productivity, higher absenteeism and more work injuries," said Zadow, who observed that modern workers are often given temporary work and put under work pressure with the expectation that they can be "thrown away" and replaced when they wear out.

"Workers in work groups with a low psychosocial safety climate and high levels of emotional exhaustion have more work injuries but are also much less likely to report them. This is a big problem with injury prevention, because if we do not know what injuries are experienced, then efforts to prevent them will be misdirected leading to more injuries and increasing costs."

Improving the psychosocial safety climate
The study is unique because existing research focuses almost exclusively on physical injuries, rather than in combination with psychological incidents. "Research across Australia and Malaysia shows that the psychosocial safety climate – which we refer to as PSC – in organisations is typically lower than poor psychosocial safety climates cost employers $6 billion

Productivity losses associated with low levels of management commitment to psychological health and safety in the workplace cost employers an estimated $6 billion per annum, according to Safe Work Australia research. It found that workers in low psychosocial safety climate workplaces had significantly higher sickness absence and presenteeism than those in high psychosocial safety climate environments – taking more sick days per month, with a higher performance loss at work, equating to $1887 per employee per year in cost to employers.

The research, Psychosocial safety climate and better productivity in Australian workplaces: cost, productivity, presenteeism, absenteeism, also estimated the impact of poor mental health on organisational productivity. It found that workers with severe depression took 20 times more sick days per month and had a substantially higher performance loss than those without depression. Depressed workers cost employers, on average, between $2791 per year (mild depression) and $23,143 per year (severe depression).

In addition, the cost of workers experiencing psychological distress is estimated to be $1 billion. "These findings provide a compelling argument for the importance of maintaining a good psychosocial safety climate, as by doing so, organisations may be able to avoid these substantial productivity losses," said Safe Work Australia director of research and evaluation, Dr Fleur de Crespigny.
“Workers in work groups with a low psychosocial safety climate and high levels of emotional exhaustion have more work injuries but are also much less likely to report them”

The Productivity Commission has found that psychosocial factors at work are not given the same attention in legislation and by health and safety inspectors as physical hazards. However, Zadow said it is anticipated that over the next three to five years psychosocial risk prevention in workplaces will become more important. “In particular multilevel approaches, dealing with the work system including management and organisational approaches, combined with the individual work conditions and the characteristics of individual workers, will receive much greater research attention,” she said.

OHS and the psychosocial safety climate
Measuring the PSC of an organisation requires attention to four domains: senior management support and commitment to psychological health, the priority of psychological health over productivity, the extent and effectiveness of communication about issues related to psychological health and safety, and the participation of all stakeholders in relation to matters of psychological health and safety (Dollard & Bakker, 2010). “Assessing how well workers perceive that these domains are being addressed in the organisation, identifying a range of strategies to improve areas that are perceived as low, then evaluating and monitoring progress, would be a useful first step,” said Zadow.

She recommended OHS leaders should put in place processes to measure psychosocial factors in their workplaces, including the psychosocial safety climate (management and organisational structures that are in place to support worker psychological health) and the individual psychosocial risk factors (e.g. low job control, high work pressure, poor social support).

“Understanding where additional attention is required, developing collaborative interventions involving stakeholders to develop strategies to address these areas, and evaluating and monitoring progress towards identified goals, would greatly assist in the development of a mentally healthy work environment,” she said.

8 Victorians killed at work for every 1 reported workplace death

Official statistics grossly understate workplace fatalities in Victoria, counting only one in every eight deaths due to injury or illness sustained at work, according to the Victorian Trades Hall Council (VTHC). A VTHC analysis found that in 2016-17, over 200 Victorians died as a direct result of workplace injury or illness, although the government’s official tally for the year was just 26.

This tally does not account for the deaths of transport workers or others killed in road accidents, workers who died from illness sustained at work (especially work-related cancers), or suicides related to workplace psychological injuries like PTSD, stress and bullying. The discrepancy relates to state government jurisdictional boundaries and statistical reporting methods that obscure the causes of death, said the VTHC.
The third industrial revolution: revolutionaries and work health and safety

The WHS regime must be reworked, not only to better protect workers and others, but to contain the costs that flow to the health system, writes Siobhan Flores-Walsh

The harmonisation of our work health and safety laws did not produce sufficient substantive reform to effectively respond to the third industrial revolution. This revolution has arrived (at least in part); manufacturing has gone digital and services are king. The revolution is changing how, where and for whom we work, as well as the health risks and benefits that work delivers.

Current WHS laws are based on traditional workplace concepts, and although the primary duty holder – namely, the person conducting a business or undertaking (PCBU) – is a broad concept, regulators still prosecute PCBUs primarily in their traditional roles as employers and contractors. For example, prosecutors rarely prosecute “upstream duty holders” such as the person who commissions a construction project (i.e. the client). Instead they prosecute the person who builds the project (i.e. the design and construct contractor), who is usually prosecuted in their role as employer or contractor of labour. This means that clients are not prosecuted for decisions during the “pre-construction phase” which negatively affect construction phase safety, even though there is power to do so. Should clients be held accountable for work-related injury and disease that is caused, or contributed to, by their decisions before construction commences?

In light of the third industrial revolution, we should revisit the “fundamental safety question” raised by Neil Gunningham in his research on OHS regulation: “Who should be responsible for mitigating the incidence of work-related injury and disease?” Unless that question is consciously answered, the default position will likely be the position suggested by The Economist (April 2012): “As the (third) revolution rages, governments should stick to the basics: better schools for a skilled workforce, clear rules and a level playing field for enterprises of all kinds. Leave the rest to the revolutionaries”.

Regardless of our answer to the fundamental safety question, there is an emerging view that the harmonised WHS regime is proving deficient in that it is perceived as:

• inadequately protecting workers and others from fatal and serious injury, including “workplace mental health”
• not regulating “WHS experts” who, particularly in the workplace mental health space, proffer sometimes “random” solutions that are, at best, ineffective, and at worst, do harm
• not sufficiently integrated with other worker protection regimes such workers’ compensation and industrial relations (IR), and this in turn leads to compliance confusion and gives support to the “safety red tape” argument – namely, WHS laws are a regulatory cost burden on industry
• not functioning as a seamless national WHS system – it suffers from jurisdictional differences that undermine the “harmony” of the WHS laws, their enforcement processes and penalties regimes, and this in turn bolsters the “safety red tape” argument
• not adequately integrated (if integrated at all) with the public health systems into whose care injured workers are delivered.

Inadequate protection for workers?
The rate of fatality and serious injury in our workplaces during 2017 suggests that not all (if any) were caused by “workers on a frolic of their own”. Rather, it strongly suggests that work systems are causing injury and the systems in place to protect workers are failing. According to Safe Work Australia statistics:
• As at 26 April 2017, 51 Australian workers have been killed at work in 2017. If we continue at this rate, 153 people will die at work this calendar year.
• There were 107,355 serious workers’ compensation claims in 2014-15, which equates to 6.5 serious claims per million hours worked. The only major condition to show an increase in the number of serious claims was mental disorders.

The tsunami that is “workplace mental health”
The fact that mental health disorder is the only major condition to increase in terms of serious
“The fact that mental health disorder is the only major condition to increase in terms of serious workers’ compensation claims is important”
workers’ compensation claims is important. We can assume that the statistics are understated given the stigma often associated with mental health conditions, which in turn means such conditions are likely to be under-reported.

There is confusion among our clients as to “the nuts and bolts actions” they should take in relation to workplace mental health, and there is little guidance from the courts. Beyond understanding that they are required to ensure the health and safety of workers and others (including their psychological health and safety) by taking all steps reasonably practical, nearly all struggle to identify those “reasonably practical” steps.

**There are four facts that promote this confusion:**
1. First, on its face, the model WHS regime appears to exclude “psychological” risks at work from consideration – for example:
   a) Clause 36 of the WHS Regulation provides that when a risk to health and safety cannot be eliminated (which is the norm) then the duty holder must minimise risks, so far as is reasonably practicable, by doing one or more of the following:
      i) substituting (wholly or partly) the hazard giving rise to the risk with something that gives rise to a lesser risk
      ii) isolating the hazard from any person exposed to it
      iii) implementing engineering controls.
   b) The three actions listed are commonly referred to together as the “hierarchy of control”. Noticeably absent from the hierarchy are any controls that apply to psychological health risks – it assumes only physical health risks. Professor Maureen Dollard and psychologist Tessa Bailey of the University of South Australia have designed a psychosocial hierarchy of control tool to address psychosocial risks. This hierarchy has not been adopted by any legislature.
2. Second, the lack of focus on psychological health in the WHS statutory regime is echoed by a lack of enforcement action by our regulators. There are few prosecutions that relate to mental health issues, and those that have occurred almost always involve a level of physical abuse such that the matter could have been prosecuted under mainstream criminal laws – the point being that these prosecutions are not dealing with the systemic and relationship issues that cause and exacerbate mental health conditions in the workplace.
3. Third, most of us are (in my view) largely in breach of our legal duties in relation to workplace psychological health, and it is challenging to become legally compliant – put simply, compliance threatens many business practices (tight deadlines, competitive environments, tight budgetary restraints, long hours, etc). This “predisposition” against compliance has been mostly tolerated by WHS regulators until recently, and most legal action is still left to individuals to initiate through civil systems. WHS regulators are now investigating more psychological injury complaints and are providing excellent advisory services (certainly Inspector Alexa Wray from SafeWork NSW is a strong advocate in this space). However, this is not enough:
   a) Risk assessments about the structural and relational issues that cause psychological injury and the design and implementation of controls are required and must be taken seriously.
   b) Our current focus on the individual must be balanced by a systems focus – we should stop asking workers to become more resilient, stop asking them to attend wellness and mindfulness courses in a day that is already packed, and perhaps abandon (my favourite) the colouring-in room, where we ask workers to “colour away the stress”.
   c) We can look to the Canadians who acted decisively on these issues with their voluntary Mental Health Standard, which is supported by a strong systematic framework and implementation tools – no colouring-in books in sight, just a commonsense risk assessment approach and strong implementation.
4. Fourth, the application of workplace disciplinary law to a worker who suffers (or may suffer) from mental illness is complex.

**Poor regulation of “WHS experts”**
The skills and qualifications of those who provide WHS compliance services vary. Some are excellent while others are not. This has led to a proliferation of advice about WHS compliance that is inadequate. There are many examples. One is the provision of advice that the model WHS laws expressly impose “Verification of Competency” (VOC) duties; those giving that advice then sell programs to assist duty holders to comply with VOC duties. In fact, VOC is not a specific WHS duty; the term simply refers to taking reasonable steps to ensure that workers have adequate skills and knowledge.

Those who provide advice about WHS laws and do not hold a legal practising certificate breach the Legal Profession Act. To the extent that their advice is incorrect, they also distract duty holders from focusing on WHS duties that do exist. The decision that the harmonised WHS laws would not include a discrete duty on those who provide WHS professional services appears to have been an error.

**Poor integration of WHS laws with other workers’ protection laws**
The overlap between WHS, workers’ compensation and IR laws is striking, but compliance is confusing with multiple statutes.
imposing similar safety duties that are not integrated.

Of particular note is the anti-bullying jurisdiction of the Fair Work Commission, which has proven to be an ineffective mechanism to stop workplace bullying (i.e. a prime cause of psychological injury). It is only available to a person after they have already been bullied. Further, individuals must bring a complaint and it will initially be subjected to efforts to “mediate or conciliate the complaint away”, and those efforts are usually successful. By contrast, a prosecution under WHS laws for bullying is initiated by the regulator with a view to producing systematic change, not simply a resolution for an individual. The Fair Work anti-bullying jurisdiction would probably produce better outcomes if it had been integrated with WHS laws.

Increasing jurisdictional differences in statutory content and enforcement

In 2010, the Education, Employment and Workplace Relations Legislation Committee discussed the emergence of jurisdictional differences in the harmonised WHS laws due to their state-based structure. WHS has always been regarded as peripheral in labour circles compared to IR, which has had the benefit of national legislation, national enforcement and a national tribunal/judicial system since 2009 (in the Fair Work Act 2009). If a national IR regulatory regime could be agreed by our federation of governments, such agreement can, and should, be achieved for safety.

The “harmony” of the model WHS laws was undercut from their commencement in 2012, due to the inclusion of 58 jurisdictional notes and the NSW government’s inclusion of union-initiated prosecutions (even though the removal of such prosecutions was regarded as a key feature of the harmonised WHS laws).

Roll forward five years to 2017 and we see (among other things):

• Queensland’s recent announcement of its intention to significantly review its WHS statute with a view to introducing the offence of “gross negligence causing death”
• mounting concerns about penalties – again, Queensland is considering increasing maximum penalties to improve deterrence (and yet the maximum penalty has not yet been ordered against any duty holder in any of the model WHS law jurisdictions – this suggests that state-based pressures to respond to particular incidents (in this case, the Dreamworld incident) will result in the further diminishing of harmony in the harmonised WHS Laws)
• a recognition that the WHS regulators all have a different “regulatory personality”, which means that duty holders are being distracted by the need to understand different approaches to the use of coercive information-gathering powers, mental health issues, the regulators’ exercise of their (very important) discretion to prosecute and attitudes to enforceable undertakings
• public prosecutors in South Australia will establish a protocol for ensuring consideration is given to launching manslaughter prosecutions after a workplace death, under a recommendation from a South Australian inquiry.

Poor integration with public health systems

Health and safety at work is managed “on a silo basis” as if it is disconnected from our non-working lives. There is also a lack of connection between the workplace and mainstream health planning and systems. This contributes to increases in the cost of our health and social security systems and onerous personal costs for the injured. The Economist (April 2012) says that during the third industrial revolution “…governments should stick to the basics: better schools for a skilled workforce, clear rules and a level playing field for enterprises of all kinds. Leave the rest to the revolutionaries”. However, revolutionaries generally do not pay for damage caused to individuals during a revolution. Governments ultimately pay to repair those injuries unless we decide otherwise.

What must be done?

Our WHS regime must be reworked, not only to better protect workers and others, but to contain the costs that flow to our health system from physical and (increasing) mental health injury at work. The starting point remains answering that fundamental question: “Who should be responsible for mitigating the incidence of work-related injury and disease?” Everything else will flow from our answer.

Siobhan Flores-Walsh is a partner in the workplace relations and safety practice group of Corrs Chambers Westgarth, and a member of OHS Professional’s editorial board.

“The lack of focus on psychological health in the WHS statutory regime is echoed by a lack of enforcement action by our regulators”

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Climbing the safety ladder

Craig Donaldson speaks with Professor Patrick Hudson from The Netherlands’ Delft University of Technology, about the evolution of OHS, safety leadership and how OHS leaders can use the concept of the “safety ladder” to advance safety outcomes

What was your motivation for getting into OHS in the first place, and your ongoing personal drivers for being part of contributing to the OHS profession?

Shell head office knocked on our door in Leiden, in the Netherlands, and asked us for help – it turned out they had been considering the human factor for some time – and took us seriously when we suggested that they needed to manage the organisational causes of accidents. This has led to Swiss Cheese, the Organisational Accident model, and the Hearts and Minds program.

Sometimes it is motivating to know you have made a difference – the statistics don’t lie even if we don’t know who benefited, only the names of those where we still failed.

My final driver is the fact that I do not feel that I have spoken the last word and that there is a lot more to do. Safety provides a fascinating intellectual challenge, and the discipline is alive and kicking.

Where is the “low-hanging fruit” for the OHS profession currently, in terms of safety wins and better OHS outcomes?

We already know how to be safe; at least we have multiple examples of millions of man-hours without injury in major petro-chemical construction sites. The low-hanging fruit is no more than doing what we know we need to do – you do your job and I’ll do mine. The problems centre on getting all parties to recognise and then accept their responsibilities.

How does Australia compare with regards to the rest of the world when it comes to OHS practice?

Australia is, in many ways, a very good example for the rest of the world. OHS is taken seriously and backed up in law. In my experience the Australian workforce is quite compliant, which provides a counterweight to the frontier mentality. Sometimes Australia reminds me of Texas, but more obedient.

My worry is that the compliance may too often be superficial – no country that I know of is so well supplied with high-visibility clothing, but is that enough? I suspect that recent hard legislation may have been necessary to provide an adequate counterweight, but the ideal would be the opposite – to have no need for legislation because organisations and their people did the “right thing” naturally. In practice there has to be a balance, as entry to high-hazard activities needs...
to be clearly regulated while good performance should be rewarded by a lighter regulatory load.

**What are the three most common psychological shortcomings you see in both leaders and employees when it comes to safety?**

These three may seem a bit abstract and far-fetched, but I have increasingly come to believe that they represent issues that underlie how we believe accidents are caused and who is responsible for ensuring that the best safety performance is achieved.

**Attribution:** The fundamental attribution error consists of attributing the shortcomings of others to their internal weaknesses – in short, blaming them as individuals when they do something wrong – while at the same time we attribute the reasons for things that we personally get wrong to the outside environment. There is an inverted bias when things go well; we attribute our own successes to our personal abilities and superiority while the successes of others are felt to be the result of luck and outside forces.

The fundamental attribution error interacts with hindsight bias to lead managers to believe that they personally would never have had an

“All too often safety, as well as environmental and occupational health issues (note not problems), are still chucked over the fence to the ‘safety guy’ to fix while people get back to the real business”
incident, so the incident must be due to individual shortcomings of employees. The reality is that both our successes and our failures have a mixture of causes, both internal and external; understanding this can help us understand why we seem to get continuous differences of opinion about who and what causes incidents and what can be done about it.

“There is an inverted bias when things go well; we attribute our own successes to our personal abilities and superiority while the successes of others are felt to be the result of luck and outside forces”

Accountability: Who is responsible for ensuring that incidents don’t happen is all too often unclear. Today we hold the person who is the last to touch the equipment etc accountable, and we have added to the top of the organisation as well, but in between there is a lot that should happen that escapes attention. Employees need to know exactly what it is that they, and only they, can control to ensure safe work and can be called to account for if they don’t do it. But in high-hazard environments this requires support, such as adequate training, provision of necessary equipment and manpower, proper work planning and competent supervision etc – all of which are the responsibility of someone else, higher up the food chain.

Senior executives have to provide the conditions under which safe work is possible, but to actually ensure and then assure themselves that they have done what is required of them, they require lower levels, middle management and front-line supervisory staff who in their turn should be made accountable for ensuring that finally employees at the front line have all they need. Accountabilities at these middle layers is often poorly understood and weakly implemented.

The “clay” or the “mud layer” is often blamed nowadays, but this is at least in part because we trust them implicitly rather than task them explicitly, which becomes a problem when we also ask them to set the balance between production and protection. At the same time, a well-equipped and adequately supported front-line workforce needs to step up to the plate and accept that there are, especially in the case of personal safety, situations when they, and only they, can keep themselves and their colleagues out of harm’s way.

Authority: I have come to realise that, at least in hazardous industries, a strong technical authority is essential. This includes a number of components, including the setting of standards, drawing the line when exceptions are proposed and internal audit to assure the top of the organisation that the standards – technical and procedural – are being adhered to. It is really all about how we, as an organisation, wish to run our business, a component of governance.

The best organisations set high standards, they do not rely on the legal minimum if they feel it is the right thing to do, then they ensure that those standards are met and provide the assurance to senior management that that is what is actually happening; they are uncompromising. Less advanced organisations may have standards, but this does not mean that they always live up to them. One of the indicators of strong technical authority is provided by the way in which internal audits are perceived and carried out: is audit a boring minority activity or a way of ensuring that the business is being run as expected without having to have incidents?

What can OHS leaders do to address these shortcomings in practice?

Attribution bias is hard to manage because it is built into human nature, but there is evidence that in less individualist cultures the effect is less. The best approach is probably to address issues like blame in advance, setting clear rules and consequences before any individual makes an error or violation, and then having the self-discipline to stick to them: a just and fair culture helps manage attribution bias even if it doesn’t make it go away. Accountability needs to be clearly defined from top to bottom; common practice is to leave it to the commonsense of supervisors and middle managers, but commonsense goes out of the window when things go wrong. For example, working at heights requires proper support such as scaffolding and fall arresters, as well as adequate planning that ensures work is only dangerous when absolutely necessary. The individual worker cannot be held accountable for the provision of scaffolding, fall arresters and a good plan, that is for those higher up and elsewhere to be made accountable for. The worker can and should be held accountable for what they themselves can and do control, such as using what is provided. All too often we look to the worker and not to the totality of the working environment when talking about accountability.

Authority needs to be identified in advance and recognised to be an integral part of governance and, therefore, the responsibility of senior management. They may delegate technical issues, but they need to realise that the authority is itself a senior role.

All three issues can be done in advance of anything going wrong; in fact, they are better not done reactively after problems have been
What do you consider your three greatest professional achievement(s)?

1. The Hearts and Minds program. After more than 10 years there is little I would want to change except for making it computer rather than paper based.

2. Having the culture ladder picture become nearly as well known as the Swiss Cheese picture (that I had a hand in as well).

3. Having the runway designator painted with white numbers on red on nearly every taxiway in the world to help prevent runway incursions (I never got a penny for it, but so what!).

discovered because of one or more incidents. To do so is characteristic of the proactive safety culture, not to do so in advance is definitely reactive. Not to take account of these issues at all is definitely pathological.

What would you say has been your greatest professional challenge(s)?

Getting management to understand what we are actually saying, not using my advice to justify what they want to do – which is usually to beat up the worker who is so inconvenient to have had an accident on their watch. My greatest reward is being trusted that what I have proposed is worth doing, and doing properly.

How can organisations and OHS leaders use the concept of the “safety ladder” to advance safety outcomes?

The ladder provides a roadmap showing, at a broad-brush level, what different cultures look like. You can use the ladder’s descriptions to get a picture of what your own culture is, not as a unique step on the ladder but as a footprint that may extend a bit below and, hopefully, a bit above the step on the ladder that best describes the culture. Often this measurement is all that is ever done, possibly in response to a regulatory demand to “measure the culture” – as if that is all that is needed.

The real power of the ladder comes from helping to identify more advanced standards and common practices that are characteristic of cultures higher up the ladder. Once you identify where you aspire to (no one ever seems to want to go down the ladder!) and have measured where you are now, you have performed a gap analysis. Organisations can use this approach to identify how they can look in the future; OHS leaders can make things happen. What appears to be the best approach is to use both “feel” and behaviours to identify where the organisation currently is, but to concentrate on behaviours, driven by processes, to move upward.
“There is no proprietorship on safety, so we collaborate with clients, subcontractors and joint ventures to deliver meaningful and positive HSE outcomes”
WorleyParsons: 
building a business of safety

Global project management and engineering firm WorleyParsons takes a holistic and integrated approach to HSE – with impressive safety results to show. Craig Donaldson explores how the firm achieves these results through driving safety leadership at every level of the company.
WorleyParsons is a global ASX-listed company that delivers projects, provides expertise in engineering, procurement and construction management, and offers a wide range of consulting and advisory services. It covers the full lifecycle, from creating new assets to sustaining and enhancing operating assets in the hydrocarbons, minerals, metals, chemicals and infrastructure sectors. It employs about 24,500 people in 118 offices across 42 countries, and last financial year it generated revenues of $5.89 billion across its three business lines of Advisian, Services, and Major Projects and Integrated Solutions.

WorleyParsons takes an integrated and holistic approach to workplace health and safety and regularly records some of the best HSE results out of all ASX-listed companies. According to Citi’s most recent Safety Spotlight report into ASX100 companies, WorleyParsons recorded some of the lowest lost time injury frequency rates and total recordable injury frequency rates.

The company is committed to a vision of zero harm to people assets as well as zero environmental incidents. Last financial year saw its total recordable case frequency rate per 200,000 man-hours reduced to 0.07 from 0.12.

“We believe there is no proprietorship on safety, so we collaborate with clients, subcontractors and joint venture partners to deliver meaningful and positive HSE outcomes,” says WorleyParsons’ APAC assurance director, Luc Herwin, who oversees HSE in the APAC region for the company. To achieve the vision of zero harm, strong expectations around behaving safely are set. Herwin says these include the recognition of, and intervention against, unsafe acts and unsafe conditions. “Going forward, our focus is to increase more positive messaging around HSE. Traditionally there has been a ‘negative’ focus on HSE as part of completing root-cause investigations into incidents to find out what went wrong. Our plan is to investigate those activities that actually achieve zero harm and share these positive findings with other teams and projects to enable them to follow the same success factors,” he says.

The WorleyParsons Group’s HSE committee determines a specific number of priorities for each financial year. These priorities are based on the highest identified risks to employees and contractors, and Herwin says the three most significant risks are in the areas of vehicle and land transportation, working at height, and project startups. Each of these priorities is supported by a number of HSE initiatives which are rolled out globally and also linked back through personal Key Performance Indicators for all leadership levels in the organisation. This ensures the right focus is given to these identified risks, according to Herwin.

**Vehicle and land transportation risks**

“WorleyParsons’ staff drive a lot on company business, and some years ago a number of horrendous incidents occurred related to driving,” says Herwin. As a result, the group established a road safety program which focuses on nine key safe driving behaviours, and every month one key driving behaviour is focused on. These behaviours are accompanied by pictograms and “OneWay safety moments” – which every leadership meeting starts off with to keep safety top of mind.

Supporting this are several levels of training requirements for drivers. Every employee who drives under 7000 kilometres per year is required to complete an online driver training module, while those who drive more than 7000 kilometres also need to do a practical test and further training. “This is done in situ, so whether it’s offroad, in the desert or in the snow, or driving a four-wheel drive, bus or heavy transport, this training is very specific to where they actually drive,” says Herwin.

In addition, company-owned vehicles are required to have a minimum NCAP five star safety rating, while employees who drive their own vehicle for company business are required to have a minimum of an NCAP four star rated vehicle before they can claim expenses for kilometres driven. Furthermore, each vehicle also has an in-vehicle monitoring system, and this comes with a driver management program so that the company can analyse how employees are driving. “We’re able to monitor hard braking, fast cornering or other potentially unsafe driving behaviour, so we can correct this through the training processes,” says Herwin. “We also have a consequence management program if we see driving behaviour needs to be corrected. We use the fair consequence model for this process together
with prior established and communicated safety parameters such as speeding over certain levels.”

**Working at height risks**

Another category of prioritised HSE risks within WorleyParsons involves working at height. The company has a number of extensive working at height processes guided by critical risk controls, which define safe working at height practices. As one of the only project management and engineering companies, WorleyParsons has determined what its “fatal risk controls” are based on analyses of incident data collected over many years. Projects with a field component are required to follow a “Good to Go” process as part of planning their mobilisation. As part of that process the project identifies any foreseeable fatal risks and the associated critical controls.

Analysis has identified the following serious injury and fatal risks as being most applicable to WorleyParsons:

- Land transportation
- Working at height
- Excavations
- Confined spaces
- Lifting operations
- Energy isolation
- Marine operations.

Depending on the project scope, additional serious injury and fatal risks may apply. A risk assessment is conducted to identify these, and this includes consideration of local legislation and client requirements.

For example, WorleyParsons’ assisted with the construction of ExxonMobil’s Hebron, a heavy oil field project located in the Atlantic Ocean, 350 kilometres off St John’s in Newfoundland, Canada. “On the project, there were more than 40 million man-hours worked, without a lost day work case. This was a tremendous feat, as WorleyParsons was one of the EPC contractors for the Hebron Project where we managed the build of the 47,000 tonne topsides for the offshore platform,” says Herwin.

“Newfoundland has a culture of high risk tolerance in the fabrication yards and an ageing workforce with an average age of 54, so from day one we needed a high focus on safety. We

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**Case study**

In its work on the ConocoPhillips brownfield contract, WorleyParsons received a HSE excellence diamond award for 10 years recordable case free working. This is all part of leadership engagement from the top down, according to Herwin.

“All folks helped identify operational issues, and they have very high quality safety behaviours and observation processes that enabled the project to achieve a 10-year injury-free environment,” he says.

“When you see that those leading indicators are pointing in the wrong direction, it’s time to start the engagement processes.”
WorleyParsons’ OneWay

OneWay is WorleyParsons’ enterprise-wide integrity management framework. It consists of simple statements that describe expectations for the way its people work across key areas of its business. In meeting these expectations, WorleyParsons aligns its business and establishes the foundation for achieving its vision of industry leadership in zero harm.

1 LEADERSHIP AND GOVERNANCE
We are fully-committed to zero harm at all levels of our organization. Our leaders put clear strategies in place that progress us towards this goal. Effort is prioritized based on compliance and risk exposure.

2 RISK MANAGEMENT
We apply effective risk management principles and processes to enhance decision making, leverage opportunities and assist in reducing threats for all existing and planned activities.

3 CARING FOR OUR PEOPLE AND THE ENVIRONMENT
Our people are visibly and actively committed to healthy, safe and environmentally responsible workplaces and activities. We understand and manage our potential impacts on people’s health and safety as well as on the environment.

4 SELECTION AND COMPETENCY
We select and recognize people who demonstrate competence and a deep commitment to our vision of zero harm.

5 WORKING WITH OUR CUSTOMERS
We understand customers’ expectations, which we meet or exceed. We build strong customer relationships and utilize customers’ proven standards and processes where they are consistent with our expectations.

6 ENGINEERING
Engineering develops solutions that meet our company’s requirements and are compliant with our customers’ needs. Design and planning minimizes risk in later phases.

7 WORKING WITH THE SUPPLY CHAIN
Goods and services provided to us or our customers meet required standards and reflect our corporate social responsibilities.

8 FIELD ACTIVITIES
We execute field activities using strategies and methods that are defined, risk assessed, understood and communicated to those involved and deliver plant that meets design requirements.

9 MANAGEMENT OF CHANGE
We manage change in our organization, throughout projects and complete asset lifecycles. Effective change management principles are used to identify, assess, approve and implement changes.

10 CRITICAL INCIDENT AVOIDANCE, RESPONSE AND RECOVERY
We prepare for and manage critical incidents.

11 INCIDENT AND BEHAVIOR ANALYSIS
We report and investigate at-risk behaviors, incidents and near misses to identify causes. We take steps to prevent their recurrence.

12 ASSESSMENT AND IMPROVEMENT
We assess our performance and take action to continuously improve.
achieved a step change with a focus on those near-miss events that, if it were not for luck, someone would have been hurt. The lessons learnt from these incidents reaped benefits, reducing the potential for future occurrences. We developed a PEER assist program, where we would place our safety management alongside contractor management to help focus on safety initiatives that would yield maximum impact. We piloted the Safe Choice program to educate field level supervision to make the right choice in the field and we used drones to photograph the yard each day and allow us to plan work safely, minimising man-machine interfaces."

**Good to Go, Good to Continue, and Good to Finish**

A third major HSE risk identified by WorleyParsons’ HSE committee is in the area of project start-ups, and the three critical risks stages associated with project executions. To address these different risk stages, WorleyParsons has developed a safety leadership program under the umbrella name of “Good to Go” (G2G), which is designed to align the senior leadership and CEOs of contracting companies involved in each project. G2G incorporates three individual programs for different project phases: “Good to Go”, “Good to Continue” and “Good to Finish”.

G2G is unique to WorleyParsons and was developed and tested by the company in Australia, before being rolled out in the rest of the global operations. “These programs are designed to encourage managers to start conversations at all levels that reinforce safe behaviours, discuss the inclusion of safety in the design of work assets, systems and processes, and challenge personnel and contractors on unsafe acts or conditions,” says Herwin.

“Before a contractor actually comes to site, we already have established compliance processes, training processes and new engagement processes. We have established the culture that we would like to see on the project – before we have actually started the project. By people knowing what senior managers have aligned themselves to, it sets very clear expectations on how the rest will follow, all the way to the effectual workforce in the line of fire. That’s done through induction processes, facilitating training processes and engagement processes.

“When we start a project there are new sites, new people who have never worked with each other, new contracts in place and new relationships being developed with clients, and so on. The first couple of months of a project are when incidents are most likely to occur, so we have focused a lot on reducing these by the initiation of the G2G program.

“And then through the course of a project we sometimes start to see vigilance dropping off, so we engage again with the top levels of leadership and draw those safety messages down to the front-line workforce. We have processes around auditing and verification or assurance, to pick up when we actually need to start doing those engagement processes. When you see the first hint of those leading indicators pointing in the wrong direction, it’s time to start the engagement processes. We monitor that all the time, so we hit the sweet spot before things start going wrong.”

“And then we have the Good to Finish processes focused at the back end of a project. As a project reaches its end, people tend to start looking for their next project and this is when the risk goes up quite significantly. This is particularly the case in high-risk greenfield hydrocarbons projects, because that’s when we start to introduce live environments and we need all minds focused at all times. During these times we need highly dedicated and experienced teams. We need to introduce very specific controls so all workers are aligned and take it day by day, as there needs to be a heightened focus through the close-out stages of a project,” he says.

**Driving safety leadership**

G2G was introduced in WorleyParsons’ ongoing pursuit of attaining better alignment between customers, project teams and contractors with respect to the vision for HSE performance on the project, leadership actions, and KPI targets to which the project will commit to in order to achieve their zero harm vision. “This leadership alignment and early contractor engagement program is tailored towards each customer’s specific needs, based on their existing HSE culture and value system. We firmly believe that the early alignment of the project team and contractors around this vision of superior safety, health and environmental practices has been shown to deliver the required results,” says Herwin.

Such safety leadership programs provide a holistic view of safety, according to Herwin, who explains that they are about giving leaders the tools to deal with all the different perspectives of safety. “The knock-on effect of the safety leadership programs is about narrowing the disconnect between senior managers and operating conditions onsite, and allowing management to better understand the challenging conditions that onsite personnel are faced with,” he says.

“For example, the G2G program involves the personal engagement of CEOs, middle management, supervisors and all staff from project pre-tender stage right through to in-field activities. The deployment of programs such as the safety leadership program and G2G, among others, has resulted in better risk management, better quality and cost management, and has provided for broader contractor acceptance as well as providing improved results for contractors.
For example, this year we’re focusing on the global leadership team and the regional leadership teams around the world. Each of them needs to complete 12 HSE leadership activities a year. These will contribute to nearly 40 per cent of their HSE KPIs. Those leadership activities can be anything from having active discussions, active involvement in project HSE start-ups, site visits with specific project safety and design initiatives, and participation in assessments and investigations – you earn points, and there is a system to capture this for analyses, of course.”

This is also for legal and compliance, as Herwin says it demonstrates they are actively participating in safety. “They can show what they’ve done, how they’ve done it, and what type of engagement they have in safety,” he says.

The implementation of WorleyParsons’ vision of zero harm and associated safety programs, as well as a number of incident reduction strategies since 2013, has reduced its total recordable injury frequency rates from 0.34 in 2007 to 0.14 in 2016 (which includes WorleyParsons, direct contractors and JV partners). “Over the years, this approach to safety leadership has definitely driven down the frequency rate, even though we still engage in a lot of high-risk activities, especially in our brownfield operations where the risks are very high – as you might find in hydrocarbons or power generation and maintenance environments. Our overall safety strategies are paying dividends, evidenced by our low incidence frequency rate. This is across all WorleyParsons employees, contractors, joint ventures and partners – both in the office and in the field.”

WorleyParsons is now putting more focus on what went right instead of just focusing on what went wrong after an event, incident, near miss or high potential. “We have many, many countries with zero incidents,” says Herwin. “We have many projects – even very large, mega-construction ones, with fewer incidents. So we’re looking at these and comparing them to those that do have incidents, and identifying what they are doing differently. We’re learning from that. It’s about root-cause analysis and picking up on those critical components that are going right, and then bringing these over to projects that are not up to par, or projects that need some special attention.”

Over the coming 12 months, Herwin says the plan is to look at doing safety differently from how it has traditionally been approached. “Looking at the leading indicators in past years has worked tremendously, because we identified that once you pick up a leading indicator going forward, you can then start putting in your strategies for acting on lagging indicators. You basically stop those – excuse my language – ‘Oh shit!’ moments – those one-off, out-of-the-blue big incidents happening, because you can pick up the leading indicators when things start dropping off, which might point to a potential big bang happening. We need to prevent those from happening,” he says.
Understanding and managing safety differently

Safety differently encourages organisations to shift their focus away from avoiding things that might go wrong, to enabling as many things as possible to go right, writes Daniel Hummerdal

Traditionally, safety has been about the elimination of unwanted outcomes such as injuries, incidents and illnesses. This goal of ensuring a state in which as few things as possible go wrong restricts organisations to two main avenues to improve safety: learning from what has gone wrong, and constraining performance to ensure that unwanted deviations do not happen.

For example, that which has gone wrong is examined through accident investigations, and the probability for things to go wrong again is understood through risk assessments. To prevent such things from happening or recurring, organisations implement or improve barriers that separate people and processes from danger – barriers, procedures, margins and other functions that will enable improved control and predictability of that which is dangerous. People, with their autonomy and capacity for creativity, are from this perspective primarily seen as a liability or a hazard.

While many organisations have seen their safety records improve while using this approach, they have also experienced that this approach becomes increasingly problematic the harder they try. It locks organisations into a reactive safety management mode, where future success is taken to come from preventing the deviations from the past. But even organisations that are ambitious in this approach still suffer fatalities and disasters.

This approach also feeds an ever-increasing need for control and compliance. As a consequence, organisations seeking to eliminate everything that goes wrong are likely to generate a negative culture around safety and create solutions in which people are seen as a problem to control.

A number of organisations and thinkers have developed an approach to understand and manage “safety differently”. Essentially, this approach deals with the following three issues:

- the definition of safety
- the role of people
- the organisation’s responsibility for safety.
“Organisations managing safety differently see safety as an ethical responsibility down”

Safety is about enabling positive outcomes
One of the central aspects of the safety differently movement, developed primarily in Australia since 2012, is that organisations shift their focus to enabling as many things as possible to go right. This goal not only changes the definition of safety, but also how safety is understood, assessed, communicated and practised. While traditional safety is focused on managing constraints and preventing deviations, the safety differently perspective suggests that organisations should focus on understanding and addressing what helps and hinders performance.

Safety differently thus requires an interest in how normal work occurs – how tools, resources and strategies enable people to achieve outcomes across varying conditions, and the conditions and constraints that make this difficult. From this perspective, organisations can learn and improve from any event/outcome, not just incidents and injuries. When the safety differently lens is applied to incident investigations the goal is not to explain how people went wrong or what defences failed, but rather to understand how actions and decisions made sense, or how things normally go right, in order to understand how the capacity to handle demands was limited.

People are the solution
Things go right because people adapt and adjust their performance to changes, inefficiencies and surprises in the workplace. To enable more things to go right, organisations can invest in the capacity of people and practices to achieve desired outcomes. People, with their capacity to adapt and learn, are in this perspective a critical resource for organisations to harness in order to both understand how work gets done and develop solutions to improve performance.

Every day, people manage to get work done. More often than not this entails variations from procedures or how work was imagined to happen. Organisations that manage safety differently routinely engage with their people to understand the demands of normal work. They have some version of appreciative investigations in place – ways to learn from normal work. As they do this, they also tap into the frustrations and ideas that their employees have. Front-line employees have the experience and expertise to know where sensitivities, dependencies and good practices can be found. Then they allow these people to contribute with solutions that can improve how work happens.

To see people as the solution means that you try to engineer your organisation to enable people to perform well, rather than trying to engineer people to comply.

Safety as an ethical responsibility
Accountability for safety is traditionally distributed into the various roles of employees. Safety has gradually become something that employees owe to the organisation – to fill out Take 5 cards, to ensure work complies with legislation, to enact the values of safety culture programs etc. This way, safety has turned into something you do to look good to external parties (clients, regulators, competitors, your boss etc). Put differently, safety has become a bureaucratic accountability up.

However, using such external drivers for safety shifts ownership and the focus of safety away from serving those who are the recipients of the risk and troubles in the workplace.

To reverse this situation, organisations managing safety differently see safety as an ethical responsibility down. In other words, safety is a service that they provide to their employees. This shifts the role of, for example, a safety management system from being around controlling what happens, to being about supporting people. This way, safety is restored to being about caring about people and enabling people to successfully tackle the risks they face in their workplace.

In practice, this view has led some organisations to completely revamp their induction programs. While these in the past were lengthy sessions with lots of presentation slides to ensure that newcomers were aware of everything, they now start by asking the inductees about what they need to know and what they normally find difficult when they come to a new site, and otherwise seek direction for their induction by building relations with the new people through knowledge. This also allows them to capture good ideas and practices from other sites.

Some organisations have also developed new safety metrics based on the idea that safety is an ethical responsibility. Asking people, “How likely (on a scale from 1 to 10) are you to recommend the way safety is managed on this site, to a friend or colleague?” fundamentally shifts how organisations try to find their direction for safety. While it’s not a matter of disregarding compliance, this measure drives organisations to do what is right by their employees.

Safety differently – when safety is about doing more good (rather than less bad)
To manage safety differently does not mean that organisations should do away with any traditional safety activity. Activities such as audits, incident investigations, risk assessment, implementations of safety controls and inductions, still need to be done. However, safety differently suggests that organisations can and should use a different lens when they go about such activities, and broaden their focus from prevention of negatives to enabling good performance under a wider set of conditions.

Safety differently can be defined as a shift in the basic assumption we hold about what safety is, the role of people, and how responsibility for safety is
organised. Shifting the definition from preventing negative outcomes to enabling positive outcomes drives organisations to pay closer attention to everyday performance. This way they are more likely to capture and address issues proactively, even before they become safety issues.

If organisations want their employees to be intelligent collaborators of safety, productivity and efficiency, they need to start approaching people as a resource to harness, rather than a problem to control.

To overcome the “Looking good index” and “tick and flick” disease that has gradually taken over the world of safety, safety needs to be considered an ethical responsibility down – an expression of care from the organisations to the people for whom it matters the most.

**Starting the transformation**

Do not wait for something bad to happen in order to learn and improve, but try to understand what actually happens when nothing out of the ordinary seems to take place. You can find out more about what helps and hinders performance by asking your employees some of the below suggested questions:

- What day last month was work (performance) the best? What happened on that day?
- Can you tell me about a time when your work was difficult?
- What are you most dependent on to be successful in your work? What happens when that resource isn’t available in the way you need?
- If you had $50,000 (or other sum) to make this a better place to work, how would you invest it?

Organisations that have implemented safety differently practices have found ways to integrate such questions into various information-gathering mechanisms. These can be focus groups, end-of-day debriefs or during executive site visits. Following collection, the information is analysed and subsequently fed into various improvement programs. Also, some have developed measures of performance variability, for example, measuring the ratio between planned and reactive work.

**Dampen the sources of variability**

Equipped with information about sensitivities, dependencies and frustrations, you can invest in boosting the resources and methods to better match conditions.

Examples of how organisations have dampened variability include:

- reorganising stores to have more frequently used material closer to the checkout area
- improving lighting so people can see rocks, signage and other vehicles on the road
- having dedicated laydown areas and making work areas more predictable
- installing rain/shade covers to even out the effects of weather/temperature
- installing a barcode scanner to keep track of tools.

**Increase the capacity to handle variability**

Some challenges cannot be eliminated. Heavy things need to be lifted, and tedious and repetitive tasks need to be carried out over and over again. However, organisations can invest in the capacity to deal with variability by:

- supporting the development of expertise and autonomy
- leaders and front-line employees co-generating solutions
- making clear what resources are available for people if they need help
- reducing unnecessary bureaucracy/increasing clarity of purpose.

Some organisations have invested in site improvement teams to increase local capacity. These teams consist of five to eight front-line employees who, together with a senior manager (not their direct supervisor), develop ideas and solutions that can improve their capacity to deliver. The ideas are analysed from a cost-benefit perspective and implemented after approval.

Other organisations have started “decluttering initiatives”, asking their employees:

- What is the most stupid thing you have to do around here?
- What procedures don’t really support your work?

**The different assumptions**

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<thead>
<tr>
<th>TRADITIONAL SAFETY</th>
<th>SAFETY DIFFERENTLY</th>
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<tbody>
<tr>
<td>The system is safe</td>
<td>The system is not safe in itself</td>
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<tr>
<td>Accidents happen because of unsafe acts/rare deviations from plan</td>
<td>Accidents happen when resources are not enough to deal with the demands</td>
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<tr>
<td>Variability is a threat</td>
<td>Variability is inevitable</td>
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<tr>
<td>People are a threat</td>
<td>Only people can adapt, accommodate, absorb and respond</td>
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<tr>
<td>Procedural compliance is mandatory</td>
<td>Success comes from people being able to adapt successfully</td>
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<tr>
<td>How can we change people?</td>
<td>How can people be supported to adapt successfully?</td>
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You may also want to read more of the literature that has informed the safety differently movement. Anything by Professor Sidney Dekker and Professor Erik Hollnagel is a good starting point. Or you can attend a training session on safety differently, or learn how to do appreciative investigations. For more information see www.artofwork.solutions

“*How likely (on a scale from 1 to 10) are you to recommend the way safety is managed on this site, to a friend or colleague?”*
How to engage with boards on safety

Safety governance is considered a key remit of boards. However, boards are sometimes uncertain about practical measures they can take to improve safety governance and what indicators they should rely on in the process, writes Craig Donaldson.

Boards can play an important role in safety as they influence what executive leaders focus on. However, for board directors to effectively guide leaders in the right direction when it comes to OHS in particular, they need to be informed by the right safety metrics and measures. However, it is not common for boards and directors to have well-developed WHS knowledge and skills, according to Safe Work Australia. This means that safety leaders, especially in complex organisations and those operating in high hazard environments, play an increasingly important role providing information about contemporary issues, says Dr Peta Miller, director industry policy and special adviser WHS policy and strategic engagement for Safe Work Australia.

“WHS professionals can do a lot to help their leaders focus on WHS risk and ensure they build in appropriate accountability and resourcing. They can encourage their leaders to have an appropriate ‘chronic unease’, which is a healthy preoccupation with the possibility of work health and safety failure,” she says.

When this occurs, the organisation is more likely to seek and respond to WHS indicators and recognise them as opportunities to avert human and financial disaster. “Boards and directors can influence the operations and culture of the organisations they oversee. Their decisions on business priorities, organisational structure, operational policies and procedures and day-to-day resource allocations can directly and indirectly support worker health and safety,” says Miller.

Safety leadership expert Peter Wagner observes that both the levels and quality of OHS governance among boards vary widely, depending on each organisation. “In some cases, where the
board has a good grasp of safety, the relationship is highly functional and much can be achieved to support better safety and business outcomes,” says Wagner, who believes this is generally improving as many organisations now structurally report safety directly to the CEO as a symbol of the significance safety plays in the success of that particular business.

“However, in many cases safety is still struggling to establish an effective dialogue with the board,” he says. “There are many reasons for this. Sometimes it is about the ability of safety to converse at a level appropriate for a board; in others it’s about the board still seeing safety as a compliance issue and not being sufficiently versed on the correlation between good safety and good business, beyond a superficial level of understanding.”

Australian Institute of Company Directors (AICD) general manager of advocacy, Louise Petschler, says a crucial step for the OHS function is to make sure that it is providing meaningful reports to the board, and adds that more information doesn’t necessarily equal valuable information. “What this looks like will differ between sectors and individual organisations. This responsibility isn’t just on management, it’s also the role of the board to identify the information they need and the most meaningful format and detail. So making sure OHS governance is strong is a collaborative and shared responsibility,” she says.

“Strong OHS governance is about much more than the number of incidents or near-misses recorded. What it really comes down to is how a safety culture is instilled in the organisation. Practical examples of how this is being done are crucial, as part of organisational culture. OHS should also be a key review issue for the board, not an afterthought that is discussed before the board meeting concludes.”

Common OHS gaps and challenges
There are a number of common issues for both OHS leaders and board directors in the above. For example, Miller says OHS may be given a lower priority due to business pressures, especially during times of crisis, or a focus on performance metrics may create incentives to not report or to distort WHS data.

In addition, key personnel (such as HR, IT and procurement officers) may not always have a clear understanding of the WHS impacts of their decisions. “For example, the failure to adequately consult and provide training before the introduction of a new IT system might mean creating unacceptable workloads and stress,” she says.

“Business leaders may have a limited understanding of WHS issues, or they may rely on superficial platitudes to change culture without backing it up with appropriate resource allocation,” says Miller, who adds that WHS professionals may not be skilled at communicating with business leaders and often use overly technical language. “WHS professionals must learn to communicate succinctly with business leaders and develop robust arguments about the return on investment,” she explains.

Wagner observes that dialogue between safety and the board tends to be most effective when there is a mature understanding of what “good” looks like, the strategies required to support such a state and how progress will be measured.

“Often, we hear that safety is perceived to be too compliance driven and acting as a blocker to business goals and objectives. In these situations, safety comes across as transactional and therefore doesn’t always get the airplay it deserves,” he says. “From the safety professional’s point of view, there is often a view that business leaders do not take sufficient accountability for managing safety and become overly dependent on the safety professional for support and advice. This can place enormous pressure on limited safety resources.”

“In many cases safety is still struggling to establish an effective dialogue with the board”

To overcome these issues, Wagner says it is important for the CEO and executive team and safety function to collaboratively agree on expectations and develop a very strong vision of what “good” looks like. “For example, safety success is broader than whether or not we experienced injury today, last week, last month, or last year. What business really wants to know is, ‘Are we doing enough of the right things to prevent injury tomorrow?’ To understand that question the business needs to develop a clear picture of risk, accountabilities, capabilities, user-friendly systems and resources, leadership and coaching qualities and so on. It is the sum of all these things that shape what ‘good’ should look like, and therefore it becomes easier to understand when the business is on track.”

Reporting, metrics and KPIs
Board director Kirstin Ferguson believes there is a great deal of uncertainty in boardrooms about what makes an effective leading indicator. As such, she says boards generally need assistance in understanding the difference.

“As a result of the lack of certainty with regards to lead indicators, there is a much greater focus on lag indicators because they are familiar and certain – they say what has happened and so give a sense of surety in knowing what has happened in the past reporting period. The challenge is
Boards, reporting and mental health

Supporting a safe and healthy workplace is about more than meeting legislative requirements, according to AICD general manager of advocacy, Louise Petschler, who explains that there’s a difference between compliance reporting, which centres on regulatory rules, and performance reporting, where OHS considerations are integrated into matters for board decision.

“Unfortunately the emphasis is sometimes, and somewhat understandably, placed on compliance over performance,” she says.

It’s also easy to think about OHS as purely about physical risks in the workplace, especially in industries that have real and significant physical risks for employees that need to be proactively managed, Petschler adds. “However, mental health and safety at work is a key part of OHS and should be on the agenda for boards,” she says. “For obvious reasons that is much harder; you can’t easily report mental health near-misses. So while Australian companies have seriously improved safety practices, we are still coming to terms with how to best ensure the mental wellbeing of staff at work. In fact, discussion around this area and ensuring there is visibility of mental health risks often comes up among participants in the company directors course, who compare and contrast the strengths and weaknesses of their own organisation’s approaches.”

that they are not helping to guide the future outcomes in a business and while lead indicators are by no means a guarantee, they do let boards know that training is being done, for example, or preventative measures are being taken,” says Ferguson, who serves as executive director & people committee chairman for the ABC, non-executive director & remuneration committee chairman for SCA Property Group as well as non-executive director & remuneration committee chairman for Hyne Timber.

OHS professionals play a key role in introducing to their boards different lead indicators to see what will work best in their organisational context, according to Ferguson. “Test them with the board and see which ones are most meaningful for them and then stick with them until you can develop some kind of trend line to give meaning to whether the situation is improving or declining. I don’t expect we will see organisations moving completely to lead indicators, regardless of the maturity of their safety processes or systems, since it is still important to understand what has occurred within a reporting period. But there does need to be a balance, and only looking backwards (and not ahead) is not giving a full picture of safety performance,” she says.

Wagner says that many organisations have become overly obsessed with basic measures such as Lost Time Injury Frequency Rate (LTIFR), Total Recordable Injury Frequency Rate (TRIFR), positive audit results, number of training programs, risks identified and closed out, and similar measures. “At times this leads to organisational frustration when the LTIFR actual rate of say 1.3 is achieved against a target of say 1.1,” he says. “The reality is that the differential is really inconsequential and instead of focusing on the story that goes behind the numbers, the conversation is about how we get to be 0.2 lower as if that of itself denotes a successful safety outcome. Keeping in mind that a low LTIFR rate doesn’t mean there were no fatalities or permanent disabling injuries.”

Wagner notes that a lot of organisations are now engaged in the conversation of developing a generative safety culture, as per the Hudson Safety Culture Maturity Model. While there are differing views about the appropriateness of the Hudson model, Wagner says the conversation is nonetheless an important one. “It encourages executive teams and boards to consider safety effectiveness beyond simple measures and to consider other dimensions of good safety such as efficacy of work design, safety culture, individual and team risk awareness and so forth. This enables senior management teams and boards to develop a more sophisticated view of safety and in particular how safety can be used as an enabler to improve business performance as well as reduce the likelihood and incidence of significant injury,” he says.

Similarly, Miller says that leading boards and directors should be looking for metrics that include any KPIs relating to critical controls that seek to eliminate or minimise work health and safety risk, and should include lead and lag indicators of selected critical risk-control activities.

Safe Work Australia’s recent Measuring and reporting on work health and safety report, says that at a minimum, WHS reports to a board of directors should always include a “new top three (or five)” section, to help raise awareness and due consideration of emerging threats or examples of potentially significant regulatory/operational issues identified via external scanning, and KPIs may be included for context. This section should also include a risk update which is designed to raise/maintain awareness of an organisation’s critical risks and highlight any significant changes in the organisation’s injury or risk profile. Other information to include should be the organisation’s WHS position (a summary of the organisation’s success in meeting its obligations to ensure workers’ health and safety), WHS performance (a summary of the PCBU’s risk management efforts and the subsequent injury and illness outcomes), and WHS assurance (an overview of the systems that seek to ensure WHS, with KPIs related to governance processes).

What to include in annual reports?

Despite the rising trend of corporate social responsibility reporting influencing shareholder investment decisions, Wagner says safety discussions in annual reports remain relatively basic and most often is confined to statements about LTIFR performance and progress against high-level action plans or statements of intent.

Despite external organisations such as Monash Accident Research Centre introducing corporate social responsibility comparative performance indices, he observes that shareholder interest remains relatively mute — though environmental considerations are gaining much more momentum in recent times.

“Possibly there is an opportunity to better link safety performance to operational efficiency gains,” he says. “For example, redesigning work to make it safer should also lead to productivity improvement. If these can be quantified, it would become a more compelling story for shareholders who will no doubt appreciate organisations that can demonstrate the correlation between good safety improvement and business improvement.”

In 2008, Goldman Sachs produced a study which demonstrated that companies who get safety right outperform their competitors on share price value on average by 11.6 per cent. “This is a compelling story for the safety case. However, since then there has been little follow-up research to confirm the Goldman Sachs study,” says Wagner.

In terms of building a strong internal business
case for safety, safety professionals could link in with management accountants and operations efficiency experts to demonstrate how safety can improve the bottom line. “In one organisation I was able to work with the accountants to develop a Net Present Value (NPV) business case showing a return on investment of seven times within a four-year period. When the CFO reviewed the business case, needless to say he quickly became a key advocate for making changes to safety,” he says.

“Safety professionals should also consider the concepts of change readiness and stakeholder engagement when preparing safety strategies. The human resources and communications departments can help to ensure key stakeholders have appropriate levels of understanding, buy-in and commitment to change. Major change is never easy and needs thorough planning in order to execute successfully.”

Advice for OHS professionals
There are a number of steps OHS leaders can take in order to improve reporting within the OHS function as well as the working relationship with board directors. Forward-thinking boards and OHS leaders go beyond the legislative OHS requirements and towards ensuring there is a safe and healthy workplace, according to Petschler, who says proactive boards will make themselves aware of the safety culture of the organisation and regularly review the organisation’s approach.

“If safety isn’t embedded in the decisions that the board takes across a range of areas, not just those relating directly and obviously to the OHS function, the importance of safety won’t be truly embedded in the culture of an organisation,” she says. “Ignorance isn’t an excuse in the area of OHS, and directors need to be cognisant of that. If an incident happens, as a director you’re responsible. But moving from a compliance focus to one where OHS is embedded in culture and practice – where the commitment to a safe and healthy workplace is a true strategic priority – takes a partnership approach.”

Miller says it is important to try to show directors the advantages of open and transparent reporting, and counsel them strongly against the use of rewards for safety performance as this can lead to the encouragement of dubious reporting practices that are selective or inconsistent.

“Encourage your organisation to initiate risk mapping exercises to identify and integrate work health and safety risks into broader corporate risk management practices,” she says. “Encourage senior executives to undertake work health and safety due diligence training, not just focusing on minimising legal exposure, but improving understanding of work health and safety and how organisations can verify their work health and safety due diligence requirements.”

Miller said it is also important to highlight the potential shareholder investment advantages of keeping KPIs on work health and safety governance, information, such as management’s commitment to work health and safety, and evidence regarding the effectiveness of their work health and safety management efforts.

Wagner observes that most university courses prepare safety professionals to manage the technical elements of safety very well. However, as safety professionals move up the corporate ladder, he says these skills become less important than understanding how to successfully navigate their way through the business and into the boardroom. These skills include:

• ability to coach and influence others’ thinking
• ability to integrate safety activities and actions into mainstream business activities that makes safety friction free and an enabler to better business outcomes
• ability to summarise complex concepts and ideas that can be easily understood at all levels of the business. “This means adapting the pitch to suit different audiences from board to shopfloor,” says Wagner
• recognising board members’ safety capabilities and knowledge may be limited (even though they may not always admit it), there is an education process that often needs to be undertaken
• knowing the drivers of the business and how they connect to safety. “This is more than simply understanding what the business does, but what makes it work,” he says
• resilience – not everything happens first go. Sometimes it takes lots of persistence and consistency of message to make the big breakthroughs.

“Safety leaders need to become true general managers, they need a diversity of technical, business and leadership skills in order to be effective in their roles,” says Wagner.

Demonstrating safety value to shareholders
Engaging shareholders in health and safety is a challenging issue, according to board director Kirstin Ferguson, who says many shareholder groups now consider environmental, social and governance (ESG) in their investment decisions. In other instances, she believes it is instructive to look at the financial outcomes for those organisations where a significant safety incident/s occurred. “Often a social licence to operate is lost, considerable media attention impacts the reputation of the organisation, morale is low and tenders or clients can be lost. Irrespective of that, the moral obligation is keeping those who come into contact with your organisation safe,” she says.
The recent SIA Visions Conference featured a range of high level, contemporary keynote speakers along with WHS regulators and industry experts discussing current industry topics.

The 25th Annual Occupational Health and Safety Visions Conference, held in Toowoomba from 21-23 May 2017, has a long-standing reputation for being an event with a special blend of networking, socialising and exploring new and developing trends in work health and safety, for both the people making safety work on the ground as well as those leading in the field.

What’s next for OHS compliance & risk management?
Speaking at this year’s event was Aaron Anderson, partner at Norton Rose Fulbright Lawyers, who observed that while there has long been a strong focus on the development and implementation of safety management systems, more is needed in order to take the next step in improving safety outcomes within organisations.

“I am seeing OHS professionals looking for the next horizon when it comes to developing improved ways to manage WHS risk and achieve legal compliance. There is certainly a continued trend in the business community towards the development of safety leadership programs and other initiatives that are designed to assist leaders to discharge their due diligence obligations under WHS laws. I have also seen a focus on the development of initiatives designed to improve worker engagement, particularly as the challenges associated with the work expectations and attitudes of the millennial generation are better understood,” he said.

Anderson also observed that from a regulator’s perspective, there seems to be an increased number of prosecutions under the “harmonised” WHS laws and a move towards accepting enforceable undertakings as an alternative to court outcomes in some jurisdictions. “Sadly, though, we are still seeing too many workplace fatalities and serious incidents that are occurring out of risks that should be well known by duty holders,” he said.

One of the most challenging aspects for OHS professionals over the coming years will be to find a balance between the development of new and effective initiatives that better engage workers and improve safety outcomes, while satisfying executives and board members that changes to well-known approaches to safety management will continue to ensure that the business remains compliant.

“No doubt the use of technology to manage safety will be an important factor for business as an increased number of the millennial generation enter the workforce,” he said. “However, technology comes at a price, and there will be the inevitable tension between the introduction of technology and the cost-benefit analysis of doing so.”

There are a number of implications in this for OHS professionals, and Anderson said that leaders in particular will “simply need to embrace change and technology”. “It has been well known for some time that there is a greater risk to young workers in the workplace, and the work expectations and attitudes of the millennial generation will create challenges for business that need to be met. The traditional paper-based focus on safety management must be challenged by leaders. There will no doubt be reluctance to change as there remains a strong focus by regulators on the existence of paperwork to demonstrate compliance.”

However, Anderson added that the effectiveness of existing safety management systems and approaches to safety must be challenged, otherwise leaders will lose touch with emerging trends and improved ways to manage safety. “This can only over time have a detrimental impact on injury outcomes and legal compliance,” he said.

Anderson also stated that OHS professionals can take a number of steps in response, and cited the report delivered by Mr Ian Hanger QC following the Royal Commission into the Home Insulation Program, which noted that OHS leaders and professionals need to be “frank and fearless”.

“They need to be frank about the need to accept the challenges that exist with the changing demographic of the future workforce and fearless about understanding...
the different expectations and attitudes that young workers have to the way they go about their work,” he said. “OHS leaders and professionals will need to ensure a high level of engagement with the new generation of workers and be prepared to accept that different communication and management strategies will be needed to get the safety message across to them.”

How OHS can increase influence and authority
Also speaking at the conference was David Provan, general manager health, safety and environment for Origin Energy, who said that while OHS leaders have traditionally focused on formal hierarchies and processes to enable safety decision making, a greater opportunity to influence safety outcomes lies within organisations’ informal social systems.

“All organisations are foremost complex networks of relationships between people,” he said. “OHS leaders need to invest the time and energy in understanding the informal organisational networks – where, how and through who business decisions get made.”

Provan observed that this understanding comes from individual relationships built at all levels of the organisation, which provides the OHS leader with context and influence. “OHS leaders need to be emotionally and socially skilled to navigate their way through the organisation in a way that continually builds trust and credibility,” he said.

The starting point for safety professionals should be that ultimately, any decision made anywhere in the organisation can impact safety outcomes. “What we learn from reviews of major accidents is that it’s typically not the ‘safety’ decisions that have the most impact on safety,” he said.

The decisions that are more likely to impact safety, both positively and negatively, are those related to the core operation of the organisation, such as project...
schedules, maintenance budgets, asset operations and contracting strategies. “Typically, OHS leaders may find it difficult to influence these business decision-making processes based on the way that their role is shaped – organisationally, socially and individually.”

Some researchers and educators believe that OHS leaders increase their effectiveness through formal authority, technical skills and independence, Provan observed. The counter approach – relationships, interpersonal skills and involvement – leads to OHS leaders having greater influence in decision-making processes.

“OHS leaders need to understand that they will not be given a ‘seat at the table’ for many of these decisions, instead they need to earn it through their recognition as someone that adds value to the decision-making process in many different ways, not just by passively providing a narrow ‘safety’ viewpoint,” he said. “OHS leaders need to make sure they are able to create opportunities to be involved where and when business decisions are being made with a relationship that enables them to influence.”

Improving OHS through good work design

Sara Pazell, a professional ergonomist, registered occupational therapist and PhD candidate with the University of Queensland Minerals Industry Safety Health Centre, also spoke at the conference. She said that organisations and OHS professionals need to take a human-centred approach to the design of work, and this approach will yield both better OHS outcomes and business results.

When workers are involved in work redesign, the very nature of their daily tasks becomes more meaningful, she said. “They become architects of superior work design, as long as they have the support of a well-informed design strategy and mechanism for change coupled with knowledge of human performance technology. The solutions are likely to be resilient; human-centred design provides an evidence-based medium to reduce injury, severe disablement, injury and illness, as well as to advance social connection, health, productivity, inclusivity and sustainability,” she said.

Pazell also said that existing safety management systems typically encourage compliance, not creativity and innovation. “The identification of hazards and determination of risks at work is necessary, but unlikely sufficient to inspire meaningful change or work redesign in a business. “We need to recognise what else is required for good work design. Our leadership systems may not encourage work teams to seek innovation through diversity, work with others, or seek design-based ideas from outside the industry,” she said.

Rather, Pazell stated that an integrated approach to safety, health and wellbeing is required. “Too often, safety is separated from health promotion, and wellbeing is governed separately by human resource activities,” she said.

If a business or industry wishes to make radical change and improvement, Pazell said radical steps are required. “A complete turnaround of resources is required so that investment is heavier in good work design versus injury treatment.”

Pazell gave the example of Rio Tinto Weipa’s bauxite aluminium mining operation, which committed to a program approximately seven years ago to address musculoskeletal disorders and hand injuries.

The program included the implementation of a comprehensive participative ergonomics program, and their methods included training a lead co-ordinator and hosting train-the-trainer sessions so that at least 20 key staff members were trained in good work design through participative ergonomics. The workforce consisted of 1200 regular full-time staff and seasonal workforce of 200 contractors.

“This is significant when you may consider that only one full-time equivalent employee manages the injury treatment and occupational rehabilitation program,” said Pazell. “They have invested in work improvement, health, and injury prevention, far more heavily than treatment, reflecting their commitment to change for the positive. They set lead indicator benchmarks among each of six key business units to achieve at least five design improvement changes annually, of which at least 60 per cent must also address hand injury risk, and they have met and exceeded this target of at least 30 work (re)design improvements per year.”

While it did not target lag indicator measures at the onset of the program, it has achieved a reduction in hand injuries annually over this time, from approximately 20 per annum to one. Musculoskeletal disorders have also reduced to less than 25 per cent of previous records, and it has had a significant reduction in injury frequency rate, statutory claims, WorkCover costs and common law claims,” she said.

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