



+IMPAC

Less risk, safe people, better business

HEALTH & SAFETY CORE COMPETENCIES



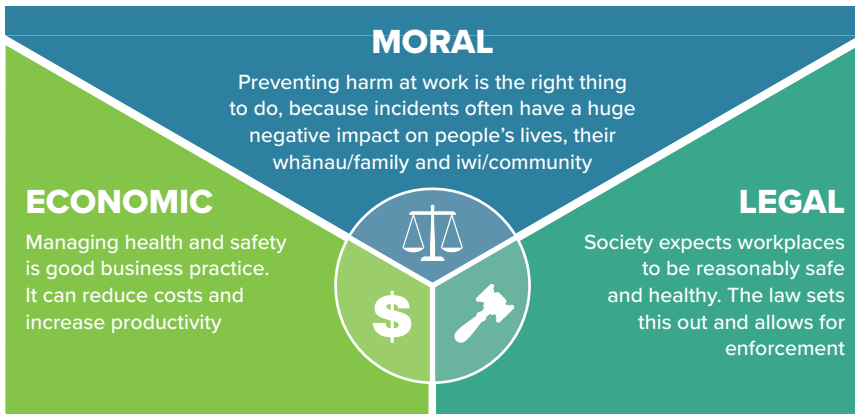
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DRIVERS AND RESPONSIBILITIES

REASONS FOR MANAGING HEALTH AND SAFETY AT WORK

There are key reasons why health and safety management is important in your workplace. These are:



Not harming other people is a basic human value we can all agree on. In the workplace, there is a moral duty of care for management and business owners towards workers, and for workers towards themselves and others.

Safe and healthy work is good business management. It leads to a good reputation, a productive workforce, innovation and profitability. Incidents at work can be very expensive. There are financial costs to the injured person, their employer, and to society as a whole.

Societies make laws to set shared boundaries about what is acceptable and what is not. Health and safety laws are no different in that respect; they set out minimum requirements for workplaces to get the balance right between getting things done, and keeping workers safe and healthy.

THE HEALTH AND SAFETY AT WORK ACT 2015

The Health and Safety at Work Act (HSW Act) 2015 (and its amendments) is the key work health and safety law in New Zealand and covers nearly all work and workplaces.

The HSW Act came into effect on the 4 April 2016.

PURPOSE OF THE HSW ACT s3

The main purpose of this Act is to provide for a balanced framework to secure the health and safety of workers and workplaces by:

- 1 Protecting workers and other persons against harm
- 2 Providing for fair and effective workplace representation, consultation, and co-operation
- 3 Encouraging unions and the PCBU organisations to take a constructive role
- 4 Promoting the provision of advice, information, education, and training
- 5 Securing compliance with this Act through effective and appropriate compliance and enforcement measures
- 6 Ensuring appropriate scrutiny and review of actions taken by persons performing functions or exercising powers under this Act
- 7 Providing a framework for continuous improvement and progressively higher standards of work health and safety.



KEY POINT

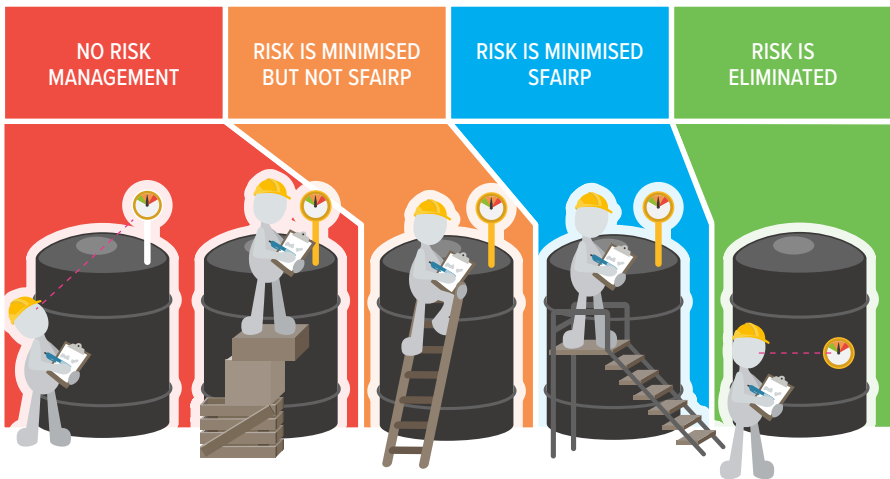
The HSW Act is underpinned by the principle that workers and other persons should be given the highest level of protection against harm to their health, safety, and welfare from hazards and risks arising from work.

DUTY TO MANAGE RISKS s30

Where risk management duties are set out, the duty holder is required:

- 1 To eliminate risks to health and safety, So Far As Is Reasonably Practicable (SFAIRP); and
- 2 If it is not reasonably practicable to eliminate risks to health and safety, to minimise those risks so far as is reasonably practicable.

A duty holder is expected to manage risks to the extent to which they have, or would reasonably be expected to have, the ability to influence and control the matter to which the risks relate.



In the diagram above, there is a risk to the worker of a fall. A short-term solution could be to provide a ladder and a rule that the ladder must be used. But to minimise the risk so far as is reasonably practicable (SFAIRP) will require an engineered control, and in the future, risk elimination through design.

THE STANDARD OF 'REASONABLY PRACTICABLE'



Most duties in the HSW Act must be carried out by the duty holder 'so far as is reasonably practicable':

- + Something is 'practicable' if it is possible or capable of being done
- + 'Reasonably' means that it should also make sense - it should 'stand to reason'.

Under the HSW Act, 'so far as is reasonably practicable' means action which is, or was, at a particular time, reasonably able to be done in relation to ensuring health and safety, taking into account and weighing up all relevant matters, including:

- 1 Likelihood of the risk occurring
- 2 Degree of harm that might result
- 3 Knowledge about the hazard or risk, and risk control measures
- 4 Availability and suitability of risk control measures
- 5 Cost of risk control measures, including whether the cost is grossly disproportionate to the risk.

If something is possible to do, but the time, cost, effort and trouble to do it is a lot more (a gross disproportion) than the benefits to be gained, then it is probably not 'reasonably practicable' to do it, and so not legally required.



KEY POINT

The best way to work out 'reasonably practicable' risk control is to look at what the relevant approved codes of practice, guidelines and standards say, and to talk to the people who are doing the work. Part of the idea of 'reasonably practicable' is keeping up-to-date with the state of knowledge about hazards and risks, how they cause harm and how best to control them.

DUTY HOLDERS UNDER THE HSW ACT 2015

WHAT IS A PCBU? s17



PERSON

A legal entity



CONDUCTING

Best placed to influence the control of hazards and risks



BUSINESS

A enterprise or organisation that does things to make a profit



UNDERTAKING

An enterprise or organisation that does things but not primarily to make a profit

The PCBU has the **primary duty** to ensure health and safety at work as it is considered to be in the **best position to control the health and safety risks of work**. PCBUs have an influence over the health and safety of **workers** and **other people even if they are not its direct workers**.

“Person” in legal terminology is a **legal entity**, rather than a person, which means that PCBU refers to the business or organisation, represented by its management. A self-employed person’s business identity (e.g. JB Plumbers, where Jane Brown is the plumber) is a PCBU. ‘PCBU’ does not include a worker, officer, director, volunteer association, or occupier of a home.

DUTIES OF THE PCBU

PRIMARY DUTY OF CARE s36



PCBU PRIMARY DUTY OF CARE

- + Make sure that while work is happening, workers and others affected by the work stay healthy and safe, so far as is reasonably practicable

The primary duty of care requires all PCBUs to ensure, so far as is reasonably practicable, the health and safety of:



WORKERS

(Including contractors and sub-contractors on site, and those volunteering or on internships or apprenticeships) while they are working



OTHER PEOPLE

(E.g. visitors and customers) who could have their health and safety put at risk by the work activities.



A self-employed person is also a PCBU. In addition to the same primary duty of care, a self-employed person must ensure their own health and safety at work.

SPECIFIC OBLIGATIONS TO MEET THE PRIMARY DUTY OF CARE



SPECIFIC PCBU OBLIGATIONS

- + Work environment free of risks
- + Safe systems, plant, structures and substances
- + Adequate welfare facilities (toilets, hand washing, rest break areas etc.)
- + Information, training, instruction, supervision
- + Monitor worker health and workplace conditions.

To make sure that workers and others are healthy and safe while at work or impacted by work, the PCBU must, so far as is reasonably practicable:

- + Provide and maintain a work environment, plant and systems of work that are without risks to health and safety
- + Ensure the safe use, handling and storage of plant, structures and substances
- + Provide adequate facilities at work for the welfare of workers, including ensuring access to those facilities
- + Provide information, training, instruction or supervision necessary to protect workers and others from risks to their health and safety
- + Monitor the health of workers and the conditions at the workplace for the purpose of preventing risk.



OTHER PCBU DUTIES

- + Workplaces and getting to and from work
- + Fixtures, fittings and plant
- + Designing, manufacturing, importing and supplying plant, substances or structures
- + Installing or constructing plant or structures.

WORKPLACES s37

PCBUs must ensure, so far as is reasonably practicable, that the workplace, the entry and exit to the workplace and anything arising from the workplace does not put anyone's health and safety at risk.

FIXTURES, FITTINGS AND PLANT s38

PCBUs must ensure, so far as is reasonably practicable, that the fixtures, fittings and plant do not put anyone's health and safety at risk.

DESIGNING, MANUFACTURING, IMPORTING AND SUPPLYING PLANT, SUBSTANCES OR STRUCTURES s39, 40, 41, 42

PCBUs must ensure, so far as is reasonably practicable, that whatever is designed, made, imported, or supplied for use at a workplace is without risks for people constructing or using, maintaining, cleaning etc. the equipment or plant.

INSTALLING, CONSTRUCTING AND COMMISSIONING PLANT OR STRUCTURES s43

PCBUs must ensure, so far as is reasonably practicable, that the plant or structure is without risks for installation, use, cleaning, decommissioning, and for people in the vicinity.

OFFICERS s18

Officers are people with significant influence over the management of the business or undertaking (the PCBU), such as Directors, Chief Executives and Partners. If a PCBU has a duty under the HSW Act, an officer of the PCBU must exercise due diligence to ensure that the PCBU complies with that duty.

Due diligence means taking reasonable steps to:

- + Know about work health and safety matters and keep up-to-date with changes
- + Gain an understanding of the operations of the PCBU and the hazards and risks generally associated with those operations
- + Ensure the PCBU has appropriate resources and processes to eliminate or minimise those risks.

DUTIES OF OFFICERS s44



- + Exercise due diligence regarding health and safety
- + Keep up-to-date with health and safety knowledge
- + Understand PCBU operations
- + Ensure PCBU has resources for managing risks
- + Ensure PCBU has processes for managing risks
- + Ensure there are compliance processes
- + Verify resources and processes.

WORKERS

A worker is a person who carries out work in any capacity for a PCBU, including:

- + An employee
- + A contractor or subcontractor
- + An employee of a contractor or subcontractor
- + An employee of a labour hire company
- + A homeworker (person who works from home)
- + An apprentice or trainee
- + A person gaining work experience
- + A volunteer
- + A manager.

DUTIES OF WORKERS

Workers are operators, managers, supervisors, and anyone else doing work for the PCBU. While at work:

- + Look out for your own health and safety
- + Look out for the health and safety of others
- + Comply with reasonable instructions about health and safety from the PCBU
- + Co-operate with any reasonable health and safety policy or procedure of the PCBU.



OTHER PERSONS s46

An 'other person at the workplace' is someone at the workplace who is not a worker or PCBU.

Other persons at workplaces can be visitors eg:

- + People shopping (ie the shop is the workplace)
- + People visiting the PCBU or its workers, eg for meetings.

Other persons at workplaces can also be people who pay the PCBU (with money or something else) to do something at the workplace eg:

- + People attending a concert
- + Clients or customers of companies providing adventure activities.

Other persons may also be casual volunteers at workplaces (not volunteer workers).



DUTIES OF OTHER PERSONS s46

While at a workplace:

- + Look out for your own health and safety
- + Look out for the health and safety of others
- + Comply with reasonable instructions about health and safety from the PCBU.

OVERLAPPING DUTIES s34



OVERLAPPING DUTIES

- + With other PCBUs
- + Consult, co-operate, co-ordinate.

The idea of overlapping duties is a key part of the design of the HSW Act 2015. PCBUs will have a duty to all workers affected by their work (their sphere of influence), including the workers of other PCBUs in some cases. PCBUs will need to work together to meet their overlapping duties.

Two or more PCBUs shouldn't have to duplicate what they are doing. They need to consult, co-operate and co-ordinate activities to meet their shared responsibilities. The duty to consult, co-operate and co-ordinate activities sits only with the PCBU, not with all duty holders.

Once the PCBUs agree on reasonable activities to manage their overlapping duties, they will have to monitor each other to make sure everyone is doing what they agreed to do.

There are four main points to remember about overlapping duties:

1

You have **a duty to consult, cooperate with and coordinate activities** with all other PCBUs you share overlapping duties with, so far as is reasonably practicable.

2

You **can't contract out of your health and safety duties**, or push risk onto others in a contracting chain.

3

You can enter into **reasonable agreements with other PCBUs** to make sure that everyone's health and safety duties are met.

4

The **more influence and control** your business has over a workplace or a health and safety matter, the **more responsibility** you are likely to have.

WORKER ENGAGEMENT AND PARTICIPATION

All PCBUs must have worker engagement and participation practices, regardless of their size, level of risk or the type of work.

PCBU DUTIES



TO ENGAGE WITH THEIR WORKERS



s58 on H&S issues that may impact on them, and other workers who may be affected.



TO HAVE WORKER PARTICIPATION PRACTICES



s61 so that workers can have a say on H&S issues that impact on them, and opportunities to help improve H&S in the workplace.

ENGAGEMENT AND PARTICIPATION PRACTICES

Together with workers, PCBUs can determine the best way to meet these two related duties. What is reasonable and practicable will depend on workers' views and needs, the size of the business and the nature of its risks. The law enables flexibility and innovation: the focus is on effectiveness rather than whether any particular system is in place.



KEY POINT

A workplace can have HSRs, one or more Health and Safety Committees, or both – or neither. If HSRs are chosen, the Health and Safety at Work (Worker Engagement, Participation, and Representation) Regulations will apply. HSRs who have attended and passed specified training courses have additional powers.

RIGHT TO STOP OR REFUSE TO CARRY OUT WORK

One way that workers can keep themselves safe at work is to use their right to **stop or refuse to carry out unsafe or dangerous work**. Workers must however report the situation immediately to management and try to work together to resolve the issue.

‘Unsafe work’ is any work the worker believes on reasonable grounds would expose them or any other person to a serious risk to health or safety. ‘Reasonable grounds’ includes advice from their HSR.

A worker may continue to refuse to carry out the work if:



- 1 The worker attempts to resolve the matter with the PCBU as soon as practicable after first refusing to do the work; and
- 2 The matter is not resolved; and
- 3 The worker believes on reasonable grounds that the work is still unsafe.

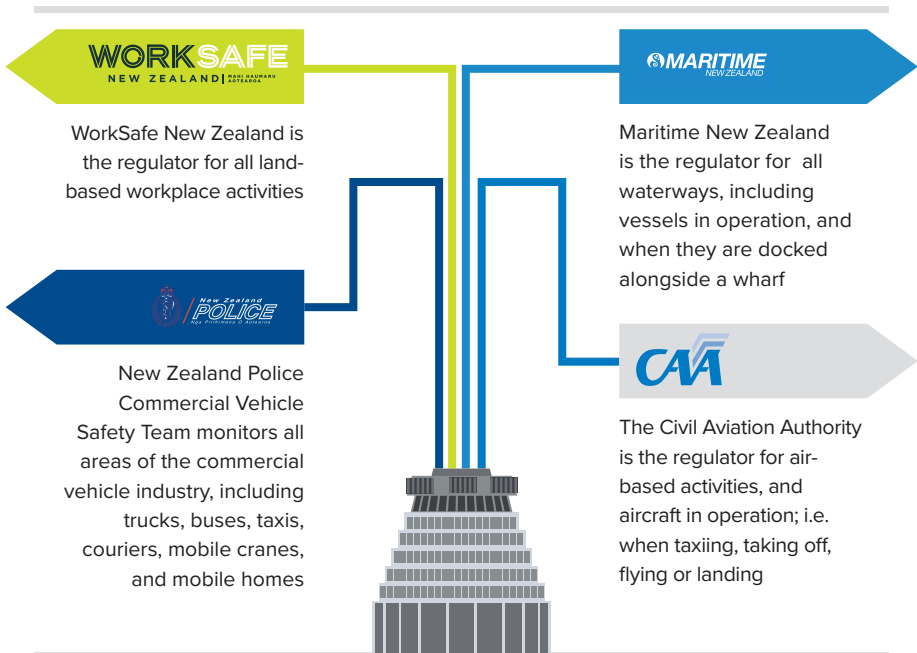


KEY POINT

You cannot refuse to do work that, because of its nature, usually carries an understood risk, unless that risk has increased beyond the understood risk. You must do work that is within the scope of your employment contract. The PCBU and worker and HSRs (if in place) must co-operate in good faith to resolve these issues.

WORKSAFE AND OTHER REGULATORS

WorkSafe is the government agency that is the primary work health and safety regulator. WorkSafe collaborates with PCBUs, workers and other duty holders to embed and promote good workplace health and safety practices, and enforce health and safety law. Other government agencies can be designated to carry out certain health and safety functions, for example, Maritime New Zealand and the Civil Aviation Authority.



THE ROLE OF THE REGULATOR

The role of Worksafe and other regulators is to **educate** everyone about health and safety legislation, **engage** with duty-holders to ensure they understand their duties, and to **enforce** health and safety law.

MANAGING RISK

KEY TERMS

HAZARDS

Hazards are situations or things that have the potential to cause harm. Hazards at work may include many things, such as machinery, vehicles, chemicals, electricity, gravity, noise, dust, radiation, a sharp edge, a repetitive movement, an angry and abusive person, or an infectious disease.



HAZARDS ARE NOT RISKS OR RISK FACTORS

When people try to identify hazards, they often identify other factors that affect risk in a situation, such as a person breaking a rule, rushing or being distracted. These things are not hazards. They are not the source of harm, but rather things that influence likelihood of something going wrong, or how bad the harm could be.



HAZARDS ARE NOT ABSENT OR FAILED CONTROLS

Another common trap when trying to identify hazards is to identify risk control measures that you think should be in place, but are not. Examples are: no hard hats being worn, no traffic management in place, no signs to warn of danger, or a loose handrail. These things are not hazards. They are absent (missing) controls or controls that are not working as intended.

HAZARD CATEGORIES



MECHANICAL / STORED ENERGY

Vehicles, machinery, electricity, pressure, heat, height



CHEMICAL

Irritant, corrosive, toxic or carcinogenic substances



ENVIRONMENTAL

Light, noise, dust, extremes of temperature, radiation



BIOLOGICAL

Bacteria, viruses, fungi, insects, mammals, fish, birds



ERGONOMIC

Interface between human and the task; manual handling, repetitive movements



PSYCHOSOCIAL

Bullying, stressful work conditions, excessive workloads, long hours

HARM

Harm means death, injury and illness, and includes both physical and psychological harm. Useful words to use when talking about harm are:

- + **Acute** - harm that happens immediately
- + **Chronic** - harm that happens gradually
- + **Catastrophic** - harm (either acute or chronic) that results in death or permanent disability, or irreversible condition.

EVENT

An event is when a hazard gets out of control exposing people to harm.

RISK

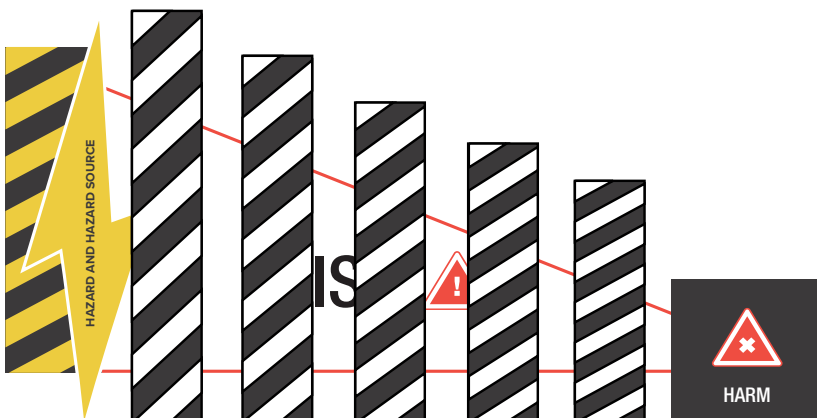
Risk in the context of workplace health and safety is the possibility that harm might occur when exposed to a hazard. When talking about risk, it is useful to describe a specific event in mind where a person can be exposed to a hazard, potentially resulting in harm. When estimating the **level of risk** to prioritise risks or choose between options, risk is often thought of as the likelihood of consequences.

RISK FACTORS

A risk factor is something that affects the likelihood of an event and/or harm. There are many risk factors to take into account. Some are very common, but there will always be unique combinations of risk factors. Examples are: the energy involved (speed, mass, height, pressure, temperature), distraction, fatigue, bad weather, poor visibility, inappropriate equipment, time pressure, lack of information, pre-existing medical conditions, language barriers, etc.

RISK CONTROLS






Risk controls are the resources put in place to manage a risk. Risk can be eliminated altogether by getting rid of the hazard. Risk can be minimised by managing risk factors to reduce likelihood and/or consequences.

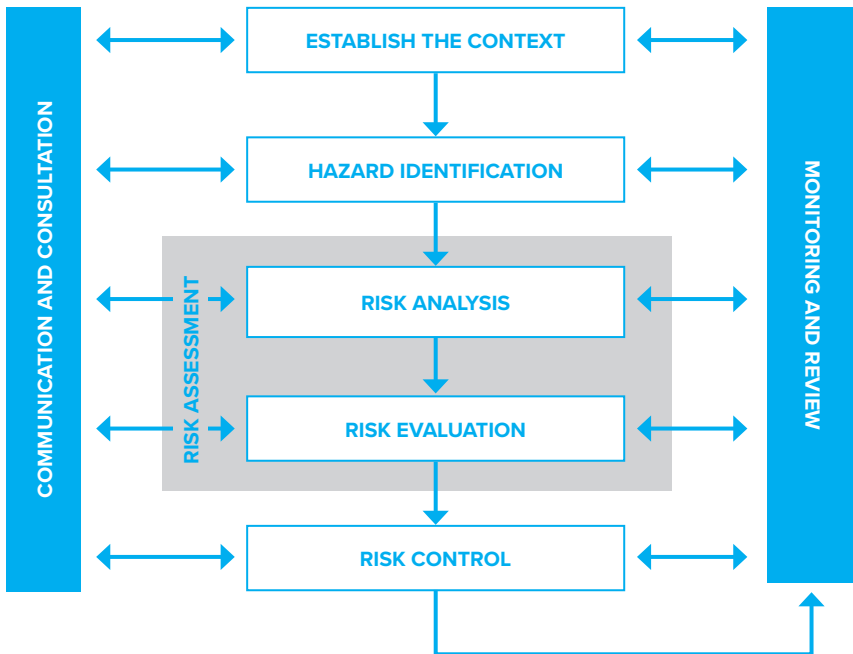


RISK ASSESSMENT PROCESS

Risk assessment is an important decision-making tool. Risk assessments can be done in many different ways but the main aim of risk assessment is to try to understand what we know and don't know about a situation, and work out what resources are needed to get the job done well.

The risk assessment process has **five key stages** and **two on-going activities**. At each stage there are some important questions to answer:

- 1**  **Establish the context:** What is happening, who is involved, when is it happening, where, why and how is it being done?
- 2**  **Identify the hazards:** What are the situations or things that have the potential for harm?
- 3**  **Analyse the risk:** What is most likely to cause the most harm? What are the most important things to prioritise for attention?
- 4**  **Evaluate the risk:** Is the current state OK or can/should we do more to control the risk?
- 5**  **Control the risk:** What is needed to control the risk, and recover without serious consequences if something goes wrong?



THERE ARE ALSO TWO ON-GOING ACTIVITIES THAT SUPPORT RISK ASSESSMENT:

- + Communicating and consulting:** This is important because workers know best about how work is done and without their input the risk assessment probably won't be useful and practical. People involved in the work and exposed to the risk also need to be kept in the loop with decisions about changes to their work and the resources they have available.
- + Monitoring and reviewing:** How, what, when and where are we going to monitor to make sure we keep on top of changes and maintain the risk controls so they stay effective? How, when and who will review the risk assessment to make sure it is still accurate, relevant, and up-to-date?

THE RISK MATRIX—A RISK ANALYSIS TOOL

A risk assessment matrix is a way of analysing the level of risk so that different risks can be compared and prioritised for action.

		LIKELIHOOD				
		Highly Unlikely	Unlikely	Possible	Likely	Almost Certain
CONSEQUENCE SEVERITY	Major (Fatality)	H 18	H 19	E 23	E 24	E 25
	Significant (Permanent disability)	M 13	H 16	H 17	E 21	E 22
	Moderate (Restricted work)	L 6	M 11	M 12	H 15	E 20
	Minor (Medical treatment)	L 4	L 5	M 9	M 10	H 14
	Insignificant (First Aid)	L 1	L 2	L 3	M 7	M 8



KEY POINT

The risk matrix can help with consistency in making team decisions about risk. The key questions are: What are the priorities? Is it OK to proceed?

SEVERITY OF CONSEQUENCES

LEVEL	H&S	FINANCIAL	REPUTATION	ENVIRONMENT
Insignificant	Discomfort	< \$1,000	Negligible	Limited
Minor	Medical treatment	< \$10,000	Minimal	Minor
Moderate	Lost time	< \$100,000	Limited	Moderate
Significant	Debilitating	< \$1 million	Significant	Serious
Major	Fatality	> \$1 million	Un-recoverable	Very serious

LIKELIHOOD OF CONSEQUENCES

LEVEL	DESCRIPTION
Highly Unlikely	May occur only in exceptional circumstances, chances less than 0.1% per year
Unlikely	May occur in the industry, local chances more than 0.1% but less than 1% per year
Possible	Has occurred in the industry, local chances more than 1% but less than 10% per year
Likely	Has occurred locally, chances more than 10% but less than 50% per year
Almost Certain	Known issue, is expected to occur more than 50% of the time

RISK EVALUATION

This means making a judgement about whether the level of risk is OK or not OK, why, and what must happen next. The risk analysis helps us to make this judgement, and also to prioritise risks for action.

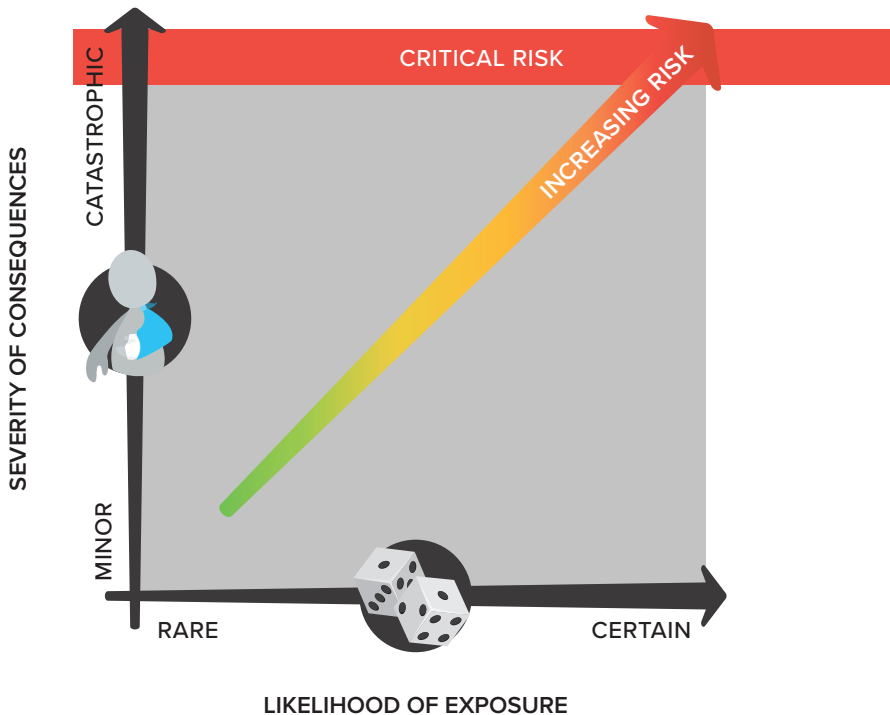
LEVEL OF RISK	WHAT IT MEANS
E (Extreme risk)	Stop activity or process immediately, and don't continue until the risk has been reduced.
H (High risk)	Manage risk immediately.
M (Medium risk)	Action required but not immediate.
L (Low risk)	Manage through continuous improvement.



To test 'SFAIRP' the Court of Law will ask in hindsight - "Could more have been done to control the risk?" The Court will compare actions taken against best practice and the current state of knowledge. Furthermore, SFAIRP in NZ includes governance practices in relation to health and safety risks.

CRITICAL RISK


A critical risk is any risk of catastrophic harm. Catastrophic harm means death(s) or permanently disabling injury or illness. Regardless of the likelihood of harm, these hazards should be taken very seriously. The risk controls required should be evaluated and planned in a more detailed way, for example using Bow Tie diagrams.

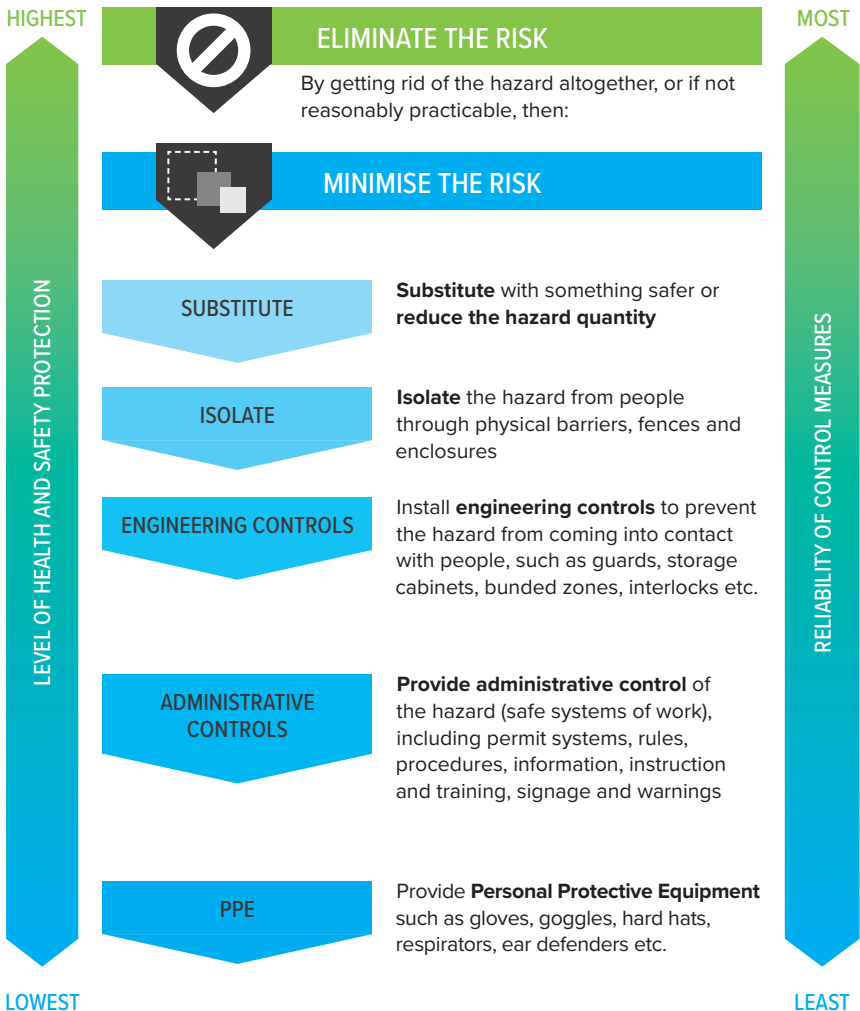


KEY POINT

Critical risks: An organisation must always do everything it can to control risks where the consequences are catastrophic. Always ask the question “What have we done so far, and can we do more to eliminate or minimise the risk?”

THE HIERARCHY OF CONTROL MEASURES

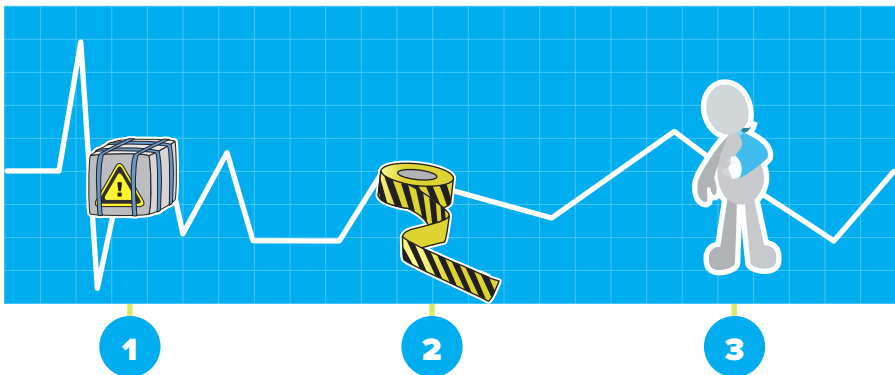
The Health and Safety at Work (General Risk and Workplace Management) Regulations 2016  sets out a preferred order or hierarchy of risk control that duty holders must use.



MONITORING

Monitoring involves planned activities designed to get and regularly update information about hazards, risk controls, and the people who could be affected by the hazards. Effective monitoring should involve three approaches:

- 1 **Inputs:** Monitoring changes to hazards and the work context to ensure we identify new or different risks
- 2 **Processes:** Monitoring and maintaining risk controls to make sure they are being implemented and are working as intended
- 3 **Outputs:** Monitoring for the effects of hazards on health.



HAZARDS AND RISK FACTORS

How well were the hazards and risks understood?
How well were changes anticipated? Was the plan appropriate?

RISK CONTROL MEASURES

Are the risk control resources suitable for the work and the team? Are they enough to control the risk? Are they implemented?

THE EFFECTS OR IMPACTS OF HAZARDS

How many and what types of injuries and illnesses, damage, near misses, and dangerous occurrences were experienced? Were work areas and teams safe and healthy?

MONITORING STRATEGY

The PCBU cannot distance themselves from what is occurring in the workplace simply because the workers are off-site or a contractor is managing day-to-day work. The positive duties of the Health and Safety at Work Act 2015 means that there is a legal reason for work implementation to be monitored and evaluated.

PROACTIVE VS REACTIVE MONITORING



Proactive monitoring is a strategy that involves active collaboration between organisations, where they are regularly sharing information, seeking a second opinion, visiting work sites and talking with workers.

Examples of proactive monitoring are:

PLANNED INSPECTIONS	To identify any new hazards, and to check that control methods are in place for existing hazards and meet the required standards.
CHECKING TRAINING AND COMPETENCE	Speak up when things feel unsafe, unhealthy, or when under-resourced.
PRE-EMPTIVE MAINTENANCE	Of plant and equipment to check, adjust, replace, sharpen, clean, lubricate etc. To find and fix problems before they cause safety or quality problems.
TESTING	(Eg engineering controls, warning alarms, sensors etc.) To make sure they are working and to pick up faults as quickly as possible.
SUPERVISION	To check that behavioural control measures, training and instruction (eg following procedures, wearing PPE) are being followed.
ENVIRONMENTAL MONITORING	(Eg noise, air quality, chemical sampling) to monitor hazards and check that the control measures are actually keeping hazards at safe levels. Where hazards are minimised, the PCBU must measure worker exposure levels to certain hazards in the environment to make sure that the levels are safe. For example, if there is noise in the work environment, the noise levels should be measured to help assess the significance of the hazard, and to make sure that levels do not exceed workplace exposure standards set by the government.

HEALTH/ BIOLOGICAL MONITORING

(Eg hearing tests, lung function tests and x-rays, blood/urine/saliva tests, and health questionnaires). Health monitoring is needed where there is ongoing exposure to hazards which have been isolated or minimised. The idea is to diagnose the early signs of ill-health in workers caused by exposure to a hazard. Any problems can be investigated and fixed. An example is the early signs of hearing damage — which may indicate that noise control measures are not working as they should.



Reactive monitoring is a strategy that relies on the PCBU waiting to be notified of a problem and then stepping in to take action. It is only a small part of an effective monitoring strategy.

Examples of reactive monitoring are:

INVESTIGATE REPORTED INCIDENTS

Investigate property damage, environmental harm, injuries and ill health, and near miss events to identify uncontrolled hazards, new risks, absent or failed risk controls, organisational factors and take action to make improvements

RESPOND TO HAZARD AND NEAR MISS REPORTS

Make changes so they don't cause further danger

ANALYSE DATA

Incident and ill-health records can be used to spot any trends or incident hotspots (eg times, locations, people and tasks) which indicate problems with the hazard management system.

REVIEW

Reviewing involves evaluation of performance data and discussion with key people to identify positives and areas for improvement. It recognises the importance of learning from all relevant experiences and applying what is learned for continual improvement.

Reviewing involves:

- + Evaluating progress towards objectives
- + Considering key performance indicators
- + Benchmarking against best practice, national and international statistics, and the performance of other similar organisations.

REVIEW TIME-SCALES

When to review a risk assessment:

- 1 After a designated time (high risk = shorter review period)
- 2 After an incident
- 3 After any significant change to people, equipment, environment, procedures, and organisation.

INCIDENT INVESTIGATION

WHAT IS AN INCIDENT?

An incident is any uncontrolled, unplanned adverse event, causing (or potentially causing) harm to people, the environment, or the business.

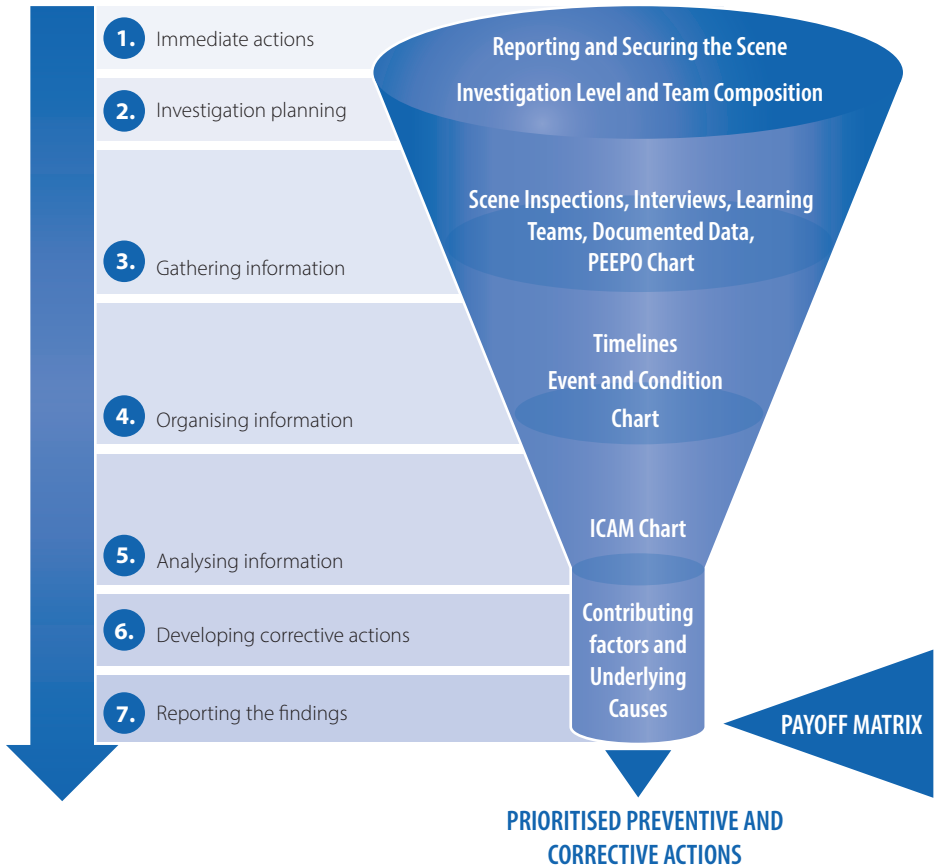
BARRIERS TO REPORTING INCIDENTS

Common reasons why health and safety incident do not get reported include:

- + **Relaxed attitude:** Incidents are seen as no big deal. The culture in the workplace accepts that incidents are just a part of work.
- + **Peer Pressure:** In workplaces, reporting incidents is seen as complaining or a sign of weakness. This pressure to 'fit in' to what everyone else is doing (or not doing) can be very strong.
- + **Performance/Time Pressures:** When there is pressure to meet performance targets at all costs, workers are less likely to take the time to report incidents.
- + **Too much paperwork:** Systems that are overly complex are less likely to be used, especially when there are literacy and language barriers.
- + **Lack of understanding and good faith:** Incidents are less likely to be reported where there is bitterness and no clear information about the reasons why incident reporting is important.
- + **Fear of blame:** Where there is a culture of finding individual blame for incidents, workers at all levels will be unlikely to report them.

INCIDENT INVESTIGATION PROCESS

It is important to have a consistent and planned approach that guides an organisation from the moment an incident happens at work, through to putting the learning opportunities from the incident into practice. The following process represents good practice. The extent of what is done at each stage will depend on the level of the investigation (low/medium/high).



SAFETY CULTURE

Culture is a very broad idea with no one accepted definition. Culture can be seen to include “the social behaviour and norms found in human societies, as well as the knowledge, beliefs, arts, laws, customs, capabilities, and habits of the individuals in these groups”¹.

Culture happens when people live together in groups. Consciously and unconsciously, people develop shared ways of understanding the world around them. Over time they create a sense of group identity. The markers of these group identities can be seen and experienced on the surface but they come from subconscious and unspoken values, beliefs, assumptions and expectations under the surface.



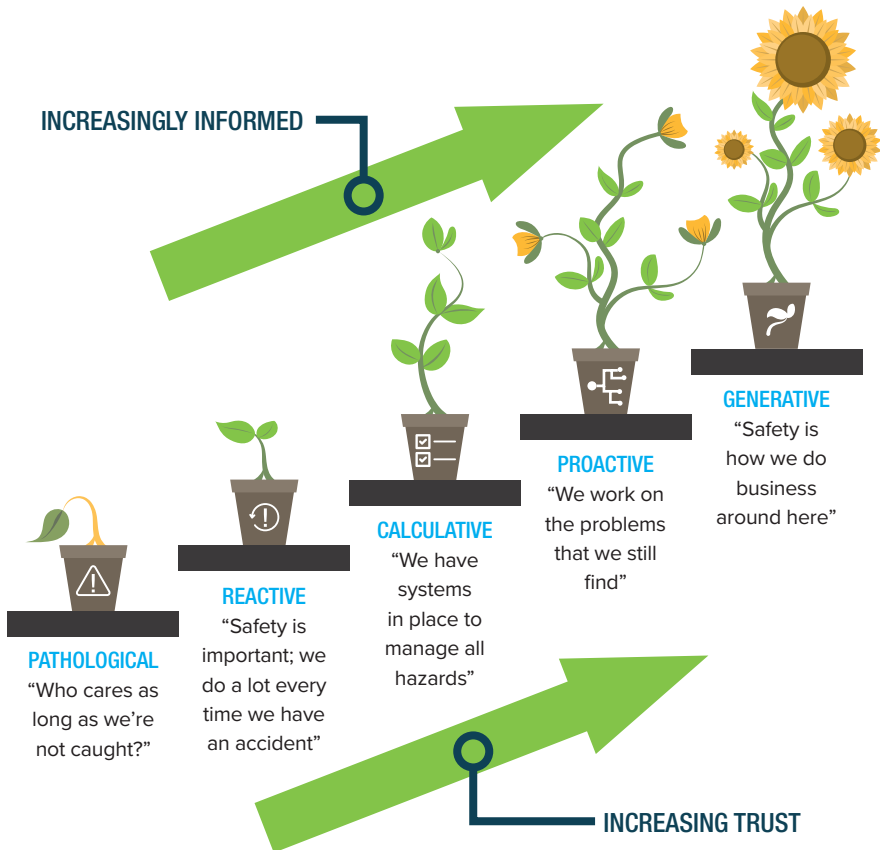
HEALTH AND SAFETY AND WORKPLACE CULTURE

Workplaces have on average become much safer and healthier over the last 100 years through technological advances, as well as through the development of management systems. There is increasing recognition that healthy and safe work also relies on creating organisational cultures that support healthy and safe work.

¹ Tylor, Edward. (1871). Primitive Culture

CULTURE MATURITY JOURNEY

Patrick Hudson¹ developed a model that shows organisational culture as a ladder or steps from immature to mature. The model can be used to estimate the maturity of different teams and work environments within an organisation. Different maturity levels will call for different health and safety leadership styles.



¹ Hudson (2001)



PATHOLOGICAL STAGE

Workers fend for themselves. There is an attitude that if you get hurt or sick from work it is because of something you've done wrong. Legal requirements are seen as a burden.



REACTIVE STAGE

Organisations talk about taking worker health and safety seriously but only take action after something bad happens. Management assumes they have all the answers and workers must just follow the rules.



CALCULATIVE STAGE

Health and safety is driven by structured management systems, risk assessments, procedures and audits. Management believe "we have cracked it", but workers feel health and safety activity is imposed on them.



PROACTIVE STAGE

The organisation anticipates incidents, failures and injuries, and proactively initiates plans to prevent their occurrence. Workers are actively involved in finding solutions. Management takes accountability for health and safety.



GENERATIVE STAGE

The health and safety of work is core to business and there is active participation at all levels. Standards are set that significantly exceed legal compliance requirements. The trust relationship between management and the workforce fosters transparency and open communication channels. Everyone strives to stay informed about daily happenings characterised by "chronic unease". Attention is given to the capacity needed to manage unexpected future events.

APPENDICES

SUPERVISOR CULTURE AND ACTIONS

This activity is based on the ideas of the Shell Hearts and Mind Programmes and has the following five sections:

- 1 Plan work using risk assessment techniques
- 2 Supervise appropriately and adopt the right leadership style
- 3 Recognise early warning signs of trouble, and respond effectively
- 4 Review the work and give performance feedback
- 5 Lock in the learning and tell others

On the following pages circle the statements that best describe your current attitude or approach. The statement to the right of this is what you should aim to achieve over the next 12 months. Repeat in 12 months time.

1. PLAN WORK USING RISK ASSESSMENT TECHNIQUES

PLANNING	You can't plan for everything in my job	I make plans when I need to and as I go along	I plan my day strictly, because I've been trained and told to do so	I try to cover and plan for unexpected events as much as possible	There are rarely unexpected events, as the team and I always have alternative plans worked out
PRIORITISING	I give priority to the things that I think are important to production	After an incident, my priority is avoiding the same thing happening again	I prioritise according to whatever procedures there are or what I'm directed to do	I give priority to critical health and safety risks and adjust production around them	Together we prioritise and decide what must be done first, always vigilant of the critical health and safety risks
RECOVERY / PLANNING	I tend to work out what to do once something has gone wrong	I am trained to tackle problems when they arise	I follow the procedures for recovering from incidents	I review the procedures for recovery before starting a job	We are prepared for what might go wrong because our planning is thorough enough to include all recovery measures
URGENT / NON-URGENT WORK	All jobs are urgent	If there has been a problem with a job, then that job becomes urgent	I decide which jobs are urgent according to the plan	I use non-urgent jobs to train my crew for other jobs. For urgent work they revert to their original functions.	There are no urgencies because we are always prepared. The only possible urgency is to prevent escalation of an incident
TIME MANAGEMENT	I am so busy I have no time to think about my own time	I give my attention to whatever seems to demand in most at the time	I divide my time in the way I have been trained to do	I set aside time to working out how to manage tomorrow's activities	It is part of my day to day planning to build in spare time to manage the unexpected

2. SUPERVISE APPROPRIATELY AND ADOPT THE RIGHT LEADERSHIP STYLE

SITE VISITS	I don't have time for site visits	I keep trying to do site visits, but something always comes up	I comply with the site visit plan	I visit sites where there is a high level of activity expected	I am not a visitor; it is part of my job to be where the hazards are
EMPOWERING OTHERS	I can't empower my team to do anything - they are not capable or motivated enough to make their own decisions	When forced to, I let my team make their own decisions	If procedures permit, my team is empowered to make easy decisions for themselves	I empower my crew to take charge of certain tasks and sometimes even challenging tasks after checking with me	My team is fully empowered to make decisions. When they are not sure, I trust that they will come to me
FOCUS ON WHAT TO	I am mainly focused on meeting production targets	My focus is on making sure we don't repeat the same mistakes	My focus is on following the procedures	My focus is on spotting any problems before they arise, and sorting them out	My focus is on making sure that safety and production are balanced, remaining vigilant of the remaining hazards and risks
BUILDING TRUST	I cannot trust my team at all and I end up doing tasks for them frequently	In most cases, I can't rely on my team to get it right alone - they need constant supervision	I rely on my team to do easy tasks, but they need a lot of supervision on more difficult tasks	In most cases I rely on my crew and ask them to come to me for advice on difficult tasks	I have complete trust in my crew as I know they can do a good job
EXPLAINING THE WORK	I only explain the job in broad terms; the team doesn't need to know the details	I explain the job overall. If they ask, I'll explain further, but this is unusual	I explain work in great detail, to comply with the procedures and paperwork	I try to involve my team in the whole process of understanding what they need to do. I encourage them to ask questions when in doubt	Explaining the job to each other is a natural part of the work process

3. RECOGNISE EARLY WARNING SIGNS OF TROUBLE, AND RESPOND EFFECTIVELY

QUESTIONING	<p>I never question my team about what is going on. There's no point because they won't tell me anything</p>	<p>I tend to ask lots of questions when something goes wrong</p>	<p>I question anything that does not conform to the plan or procedures</p>	<p>I think through what we are going to do and freely discuss it with my team, asking probing questions to explore problem areas</p>	<p>There is open and active dialogue within the team and with me where questions are asked continuously and in a state of vigilance</p>
SIGNALS TO PROBLEMS	<p>I never realise there is a problem until an incident has happened</p>	<p>I can sometimes identify problems by remembering previous accidents and what led to them happening</p>	<p>I know when there are problems because of the on-site observations and inspections we do</p>	<p>I know when problems are likely to arise because the team will come to me</p>	<p>I know when to expect problems because we are always prepared for unexpected events</p>
INTERVENTION	<p>It is the team's responsibility to keep out of trouble. I step in if I have to pull someone back into line.</p>	<p>I step in when our production target is on danger</p>	<p>I step in when the plan or procedure says I must, or when asked to by my manager</p>	<p>I step in when I feel uncomfortable about not being prepared for the unexpected</p>	<p>I intervene when there is an opportunity to learn from the situation</p>
REACTION TO TROUBLE	<p>I discipline the person responsible. It's their fault when they mess up or get hurt. Nothing to do with me</p>	<p>I focus on the individual and try to get the dangerous person removed. It's best for the team that way</p>	<p>I send those involved on training and review the procedures</p>	<p>I try to see what else I could have done to prevent a range of similar problems and learn what I can for the future</p>	<p>I am confident that my team can tell me what the underlying causes are so we can make improvements at the organisational level</p>
STOPPING THE JOB	<p>Stopping the job is simply an excuse for not wanting to work</p>	<p>If something bad has happened it is OK for the team to stop the job</p>	<p>There is a procedure that tells us when it is appropriate to stop the job</p>	<p>I tell the team to stop the job if they see any trouble coming our way, so we can sort it out</p>	<p>Everyone knows they can stop the job if they feel it is necessary</p>

4. REVIEW THE WORK AND GIVE PERFORMANCE FEEDBACK

REVIEWING WORK	There is no point in reviewing the way the job went after it is finished - what's done is done	There is no time to review the job unless something serious goes wrong and I'm told to	After a job I plan time for a review, but I don't often do it well	During the job I try to review as much as possible at key points in the plan	We constantly review everything we do, and make adjustments where necessary
OPPORTUNITIES FOR IMPROVEMENT	We know what we are doing, so there is no need to improve	The plan always has to change when something goes wrong	The plan can be improved when the procedures allow it and if there is time	I look for opportunities to improve my plans on a regular basis	There is always a need to improve, and I expect my team to come up with proposals
PROVIDING FEEDBACK	I never ask or receive any feedback from my team	I only provide feedback when production targets have not been met, or there has been an incident	I write a feedback report after every major job and it is expected that the team reads it	After every job I have a feedback discussion using the post-job review	There is open and free communication between myself and the crew, including both positive and negative feedback
FEEDBACK STYLE	I blame the team when production targets have not been met	I give individuals a telling off if I see something during the job	After the job I plan a time to tell the team what I think about how the work went	After the job the team and I have an open discussion about what went right and what went wrong	There is constant collaborative and two-way feedback between the crew and myself
COACHING	It is not my job to coach my team members	After an incident a consultant or another manager is called in to coach the team	Coaching is part of my job description, and I do it when it is in the plan	I like to coach my team whenever there is a good learning opportunity	I coach my team, but they also coach each other and sometimes I am coached by them

5. LOCK IN THE LEARNING AND TELL OTHERS

LEARNING LESSONS	It's impossible to learn when every job and every incident is different.	I take note of the causes of incidents so we can prevent the same thing from happening again	Incident causes are analysed, reported and entered into the incident database	We discuss the causes of incidents in toolbox meetings and post-job reviews, and discuss potential future problems	Everyone makes an active contribution to understanding the immediate and root causes and how we can learn from them
ENCOURAGEMENT AND SUPPORT	Workers have to take care of themselves. It's not my job to look after anyone but myself	I make sure my team is not planning to do something I know has been dangerous in the past	I support my team on how to interpret and follow the plan and procedures	I encourage my crew to find better ways of doing the work	The team supports everyone in the team, they get encouragement and I get support from them
RESPECTING OTHERS	My team makes stupid mistakes and they often need reminding of this fact	I show respect for my team when they get a good result	I show respect for my team when they follow the procedures and do the job they are trained for	I regularly let my team know that I respect them; through pre-job briefings, during work, and at post-job reviews	There is a lot of mutual respect. We trust each other's judgement and this shows through all our communication
REWARDS AND PUNISHMENT	Fear of punishment is the only way to control my team	When my team has done a good job I sometimes reward them. If they mess up, they are punished	I prefer to reward my team, but sometimes people need to be punished	I don't think punishment works well to get better work. Rewards do motivate people. Learning is better when things go wrong.	I don't punish my team. If something has gone wrong, root causes are identified and used as learning points.
TRAINING	There is no special training plan. The team should know what they are doing and we don't have time	After something has gone wrong I organise some on-the-job training on how to avoid a repeat	I send my people on training courses, based on the training plan	There is a lot of on-the-job training, and I try to either train people myself or have it led by an experienced team member	We are all regularly updating our competence, identifying our on-going training needs and up-skilling as we need to

ACTION PLAN

NAME:		POSITION:	DATE:
GOAL - WHAT ARE YOU GOING TO DO?	ACTION STEPS - HOW ARE YOU GOING TO DO THIS?	TARGET DATE	
			<input type="checkbox"/> COMPLETED
			<input type="checkbox"/> COMPLETED
			<input type="checkbox"/> COMPLETED

NOTES



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+IMPAC
Less risk, safe people, better business