Process v Purpose

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More information – www.mysafetythoughts.com

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Books:
Management obligations for health and safety
https://www.crcpress.com/Management-Obligations-for-Health-and-Safety/Smith/p/book/9781439862780
Contractor safety management
https://www.crcpress.com/Contractor-Safety-Management/Smith/p/book/9781466556843
Risky Conversations: The Law, social psychology and risk
http://cart.humandymensions.com/product/risky-conversations/
Risky Conversations is supported by a series of 22 videos, and you can see a sample video at the link below
https://vimeo.com/162034157

Other videos:
Due Diligence
https://www.youtube.com/watch?v=T51tT1TO-mU&t=26s
Health and safety assurance
https://www.youtube.com/watch?v=aRpdWpin8Pc
One off departures from established systems of work
https://www.youtube.com/watch?v=UD-Jo43BvEI&t=20s

Wayland Legal
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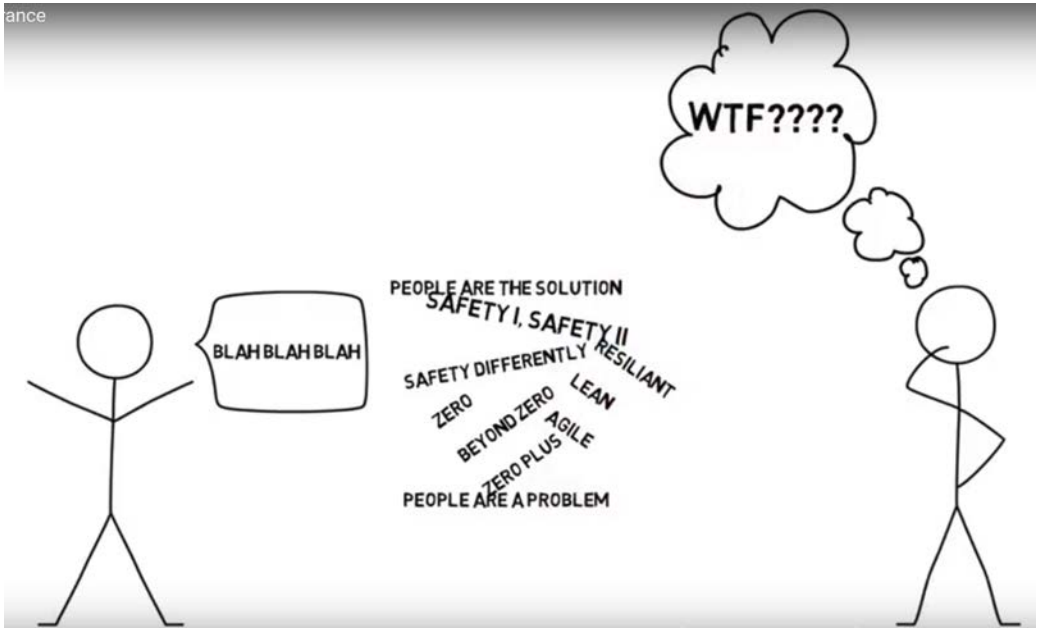
How do you know if the WHS risks in your business are being managed in accordance with your safety management system – whatever that is?

There is a lot of noise about how we “do” safety



And we do a lot of “stuff”

But does it work?

- Safety paradox
- Illusion of safety

QUEENSLAND
COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Cameron Brandt Cole**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2009/1777
DELIVERED ON:	11 September 2015
DELIVERED AT:	Brisbane
HEARING DATE(s):	12 June 2014, 28 July 2014, 1 October 2014, 20 – 24 October 2014 & 28 November 2014

The identification, elimination or minimisation of risks through risk management processes may lead to the production of a suite of documentation that will pass audit requirements. However, the evidence at this inquest suggests that workers in the field may find such documents hard to comprehend and of limited relevance to their daily activities.

Macro – Initiative overload

BP's corporate initiatives have overloaded personnel at its five U.S. refineries, to the possible detriment of process safety

At the day's pre-start toolbox meeting each employee was required to sign a "cover sheet" to the general JSA to acknowledge they were aware of it. Each employee was also required to sign a general safety awareness document called a START card. This is an acronym for Stop, Think, Assess, Review and Talk. Whilst the START cards had space for specific hazard control measures to be added, nothing was noted about this lifting job. As described by the prosecutor, the signings were primarily treated by both Ferro Con and the employees as a 'tick and flick' exercise.

No detailed JSA's for different types of lifts, or lift plans, were required by Adelaide Aqua. Ferro Con took its cue for the level of safety planning it would use in its work from Adelaide Aqua, and not from the foreseeable hazards of its work activities. Ferro Con was more focussed on complying with contractual requirements than taking all reasonably practicable steps to minimise the foreseeable hazards its business created.

The failure to conduct a proper Daily Service Check was most likely a contributing factor

Infrastructure Services Group established a comprehensive Scheduled Maintenance Program for the Unimat Track Machine known as 'Daily Service Checks'.

The extensive checklist required operating crew to perform a number of inspections and checks. The 'On-Start Up Check' contained a requirement to check that all lights were working properly. Yet the mechanical defect relating to the lights on the Track Machine was not discovered on the morning of 7 December 2007, prior to the commencement of work.

I also note that the reversing camera and monitors were not considered to be safety critical items, as evidenced by their absence from the 'Safety Critical Items' on the 'Daily Service Checks'. System failures were to be treated on a needs basis as assessed by individual operators.

Operating crew members stated to the Queensland Transport investigator that a complete adherence to the checklist was time consuming. Consequently, their usual practice was for a random crew member to conduct cursory checks only on the key items relating to lubrication, cooling and workhead mechanisms. The entire checklist would then usually be marked to indicate compliance.

I agree with the Queensland Transport investigator who was of the view that this 'tick and flick' practice, over time, eroded the assurance that was intended to be provided by the checklist. It permitted a technically unserviceable Track Machine to operate in work mode within a worksite. Given that I have found that defective lighting items is likely to have impacted on the visibility of the Track Machine to track workers, and those item were not detected as part of the Daily Service Check; it is my view that this failure is likely to have contributed to the deaths of Mr Adams and Mr Watkins.

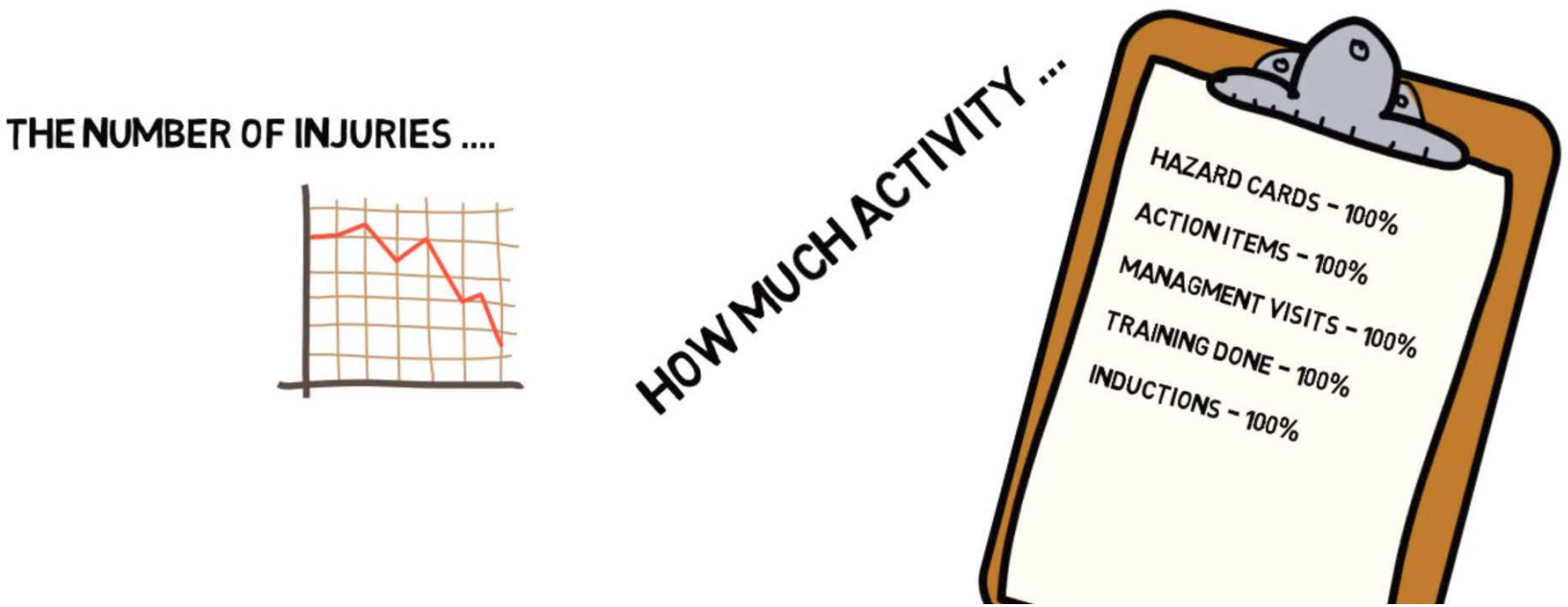
QUEENSLAND COURTS

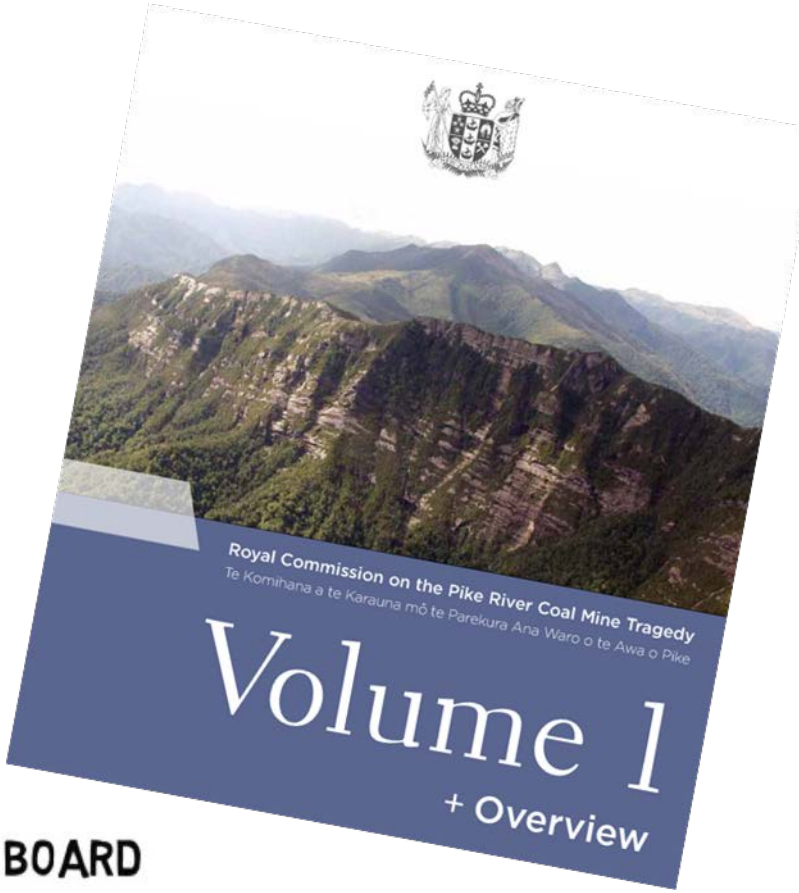
OFFICE OF THE STATE CORONER

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the deaths of Jamie Christopher ADAMS and Gary Robert WATKINS**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
DATE:	19 January 2016
FILE NO(s):	2007/136 and 2007/135
FINDINGS OF:	John Hutton, Brisbane Coroner
CATCHWORDS:	CORONERS: railway incident, Queensland Rail worker struck by train / track machine, Department of Transport and Main Roads investigation, workplace health and safety prosecution, failure of police to prosecute, contributing factors, former State Coroner's direction not to hold an inquest

Most health and safety assurance is about "*numbers*"





THE STATISTICAL INFORMATION PROVIDED TO THE BOARD ON HEALTH AND SAFETY COMPRISED MAINLY PERSONAL INJURY RATES AND TIME LOST THROUGH ACCIDENTS ...

... WAS NOT MUCH HELP IN ASSESSING THE RISKS OF A CATASTROPHIC EVENT FACED BY HIGH-HAZARD INDUSTRIES

THE BOARD APPEARED TO HAVE RECEIVED NO INFORMATION PROVING THE EFFECTIVENESS OF CRUCIAL SYSTEMS ....

We are too busy measuring “process” ….

… but don’t understand if that process has achieved its “purpose”

Highly “documented” process

Harris v Coles Supermarkets Australia Pty Ltd [2017] ACTSC 81	Video and face to face training with documented checklists signed by workers confirming they understood. No evidence of comprehension or understanding of the hazards.	More than $1 million in damages awarded to an injured employee.

System not documented – “buddy” system

Inspector Shepherd v Desiya Pty Ltd [2013] NSWIRComm 9	Training not documented. Buddy system used. No evidence of comprehension or understanding of the hazards.	Convicted of breaches of health and safety legislation.
Safe Work NSW v Wollongong Glass P/L [2016] NSWDC 58	Training not documented. Buddy system used. Defendant could show evidence of comprehension and understanding of the hazards.	Acquitted of breaches of health and safety legislation

System not documented

Moore v SD Tillett Memorials Pty Ltd [2013] SAIRC 47	System not documented, but hazards and correct system of work understood by the workers.	Acquitted of breaches of health and safety legislation
Fry v Keating [2013] WASCA 109	System not documented, and hazards and correct system of work not understood by the workers.	Convicted of breaches of health and safety legislation

Ask yourself

How many SOPs, JHAs or SWMS were done in your organisation last week?

How many were done to an acceptable standard?

How many achieved the purpose of making sure all of the workers understood the risks of the work (have you asked them)?

Can you "*prove the effectiveness*" of this crucial system?

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