Engagement with Contractors to Continuously Improve Health and Safety

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Nelson Management Ltd.

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Managers of Nelson Forests Limited







Here is the plan!

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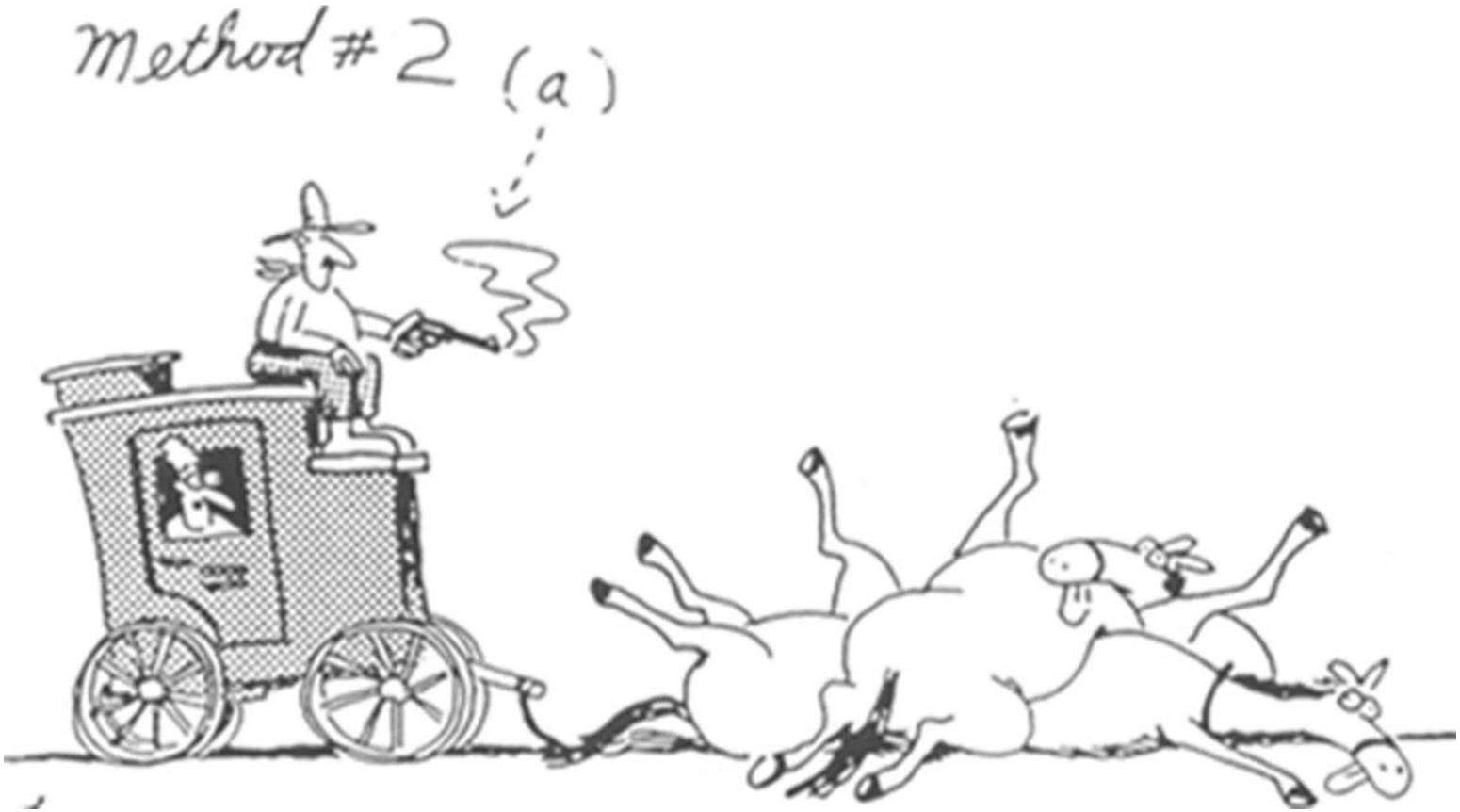
What actually happens in the workplace!



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THE BAD NEWS?

"Why would he do that when he knew the hazard?"

"That's how I was shown to do it."

"She had done it 100 times before with no problem."

"I do riskier stuff than this at home."

"It won't be that bad, let's give it a try."

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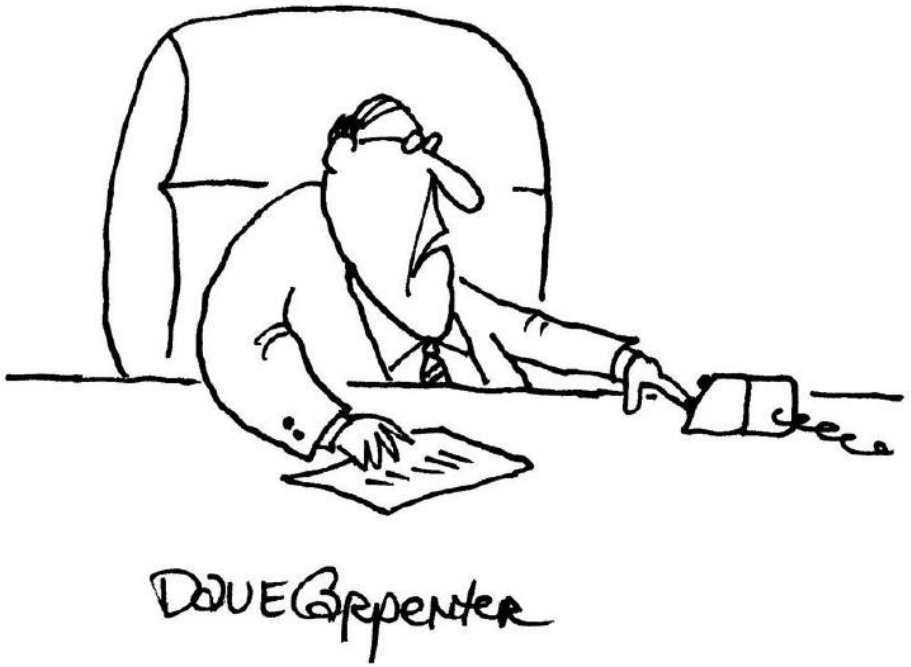

" MISS WILCOX, SEND IN SOMEONE TO BLAME."

HOW IS LOOKING FOR HUMAN FACTORS DIFFERENT FROM BLAME?







"If we learn from our mistakes, shouldn't I try to make as many mistakes as possible?"

Learning for safety: All near misses and incidents are seen as opportunities to learn and improve health and safety

Dealing fairly with safety: Safety achievements are recognised and the actions of staff are dealt with fairly and consistently

Do you learn from incidents?

Do you believe you are getting all of the incidents reported in your business?

MANY PEOPLE WILL ARGUE THE VALIDITY OF THE SAFETY TRIANGLE.

The reality is if you are having high potential incidents then there will definitely be other near misses that have occurred. The triangle is a good indicator.

The important message is that you will get what you ask for or encourage reported.

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The Good News?

HF Philosophy

- Workers don't decide to make errors – they **do reasonable things** given their knowledge, objectives, point of view, focus of attention and resources. Their actions are performed to meet the objectives of their organization.

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The Good News?

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Barriers to Human Factors

1. Did investigation outcome results in actions like “be more aware” or “person needs more training” and my favourite “the cause of the incident was the person did not follow the rules”.
2. I don’t know what the person was thinking?
3. If the person followed the procedure it would never have happened.
4. “its one of those things”, “cant prevent it”. “never happened before”
5. Using measures that motivate people to not share. First response is will they be back to work tomorrow.

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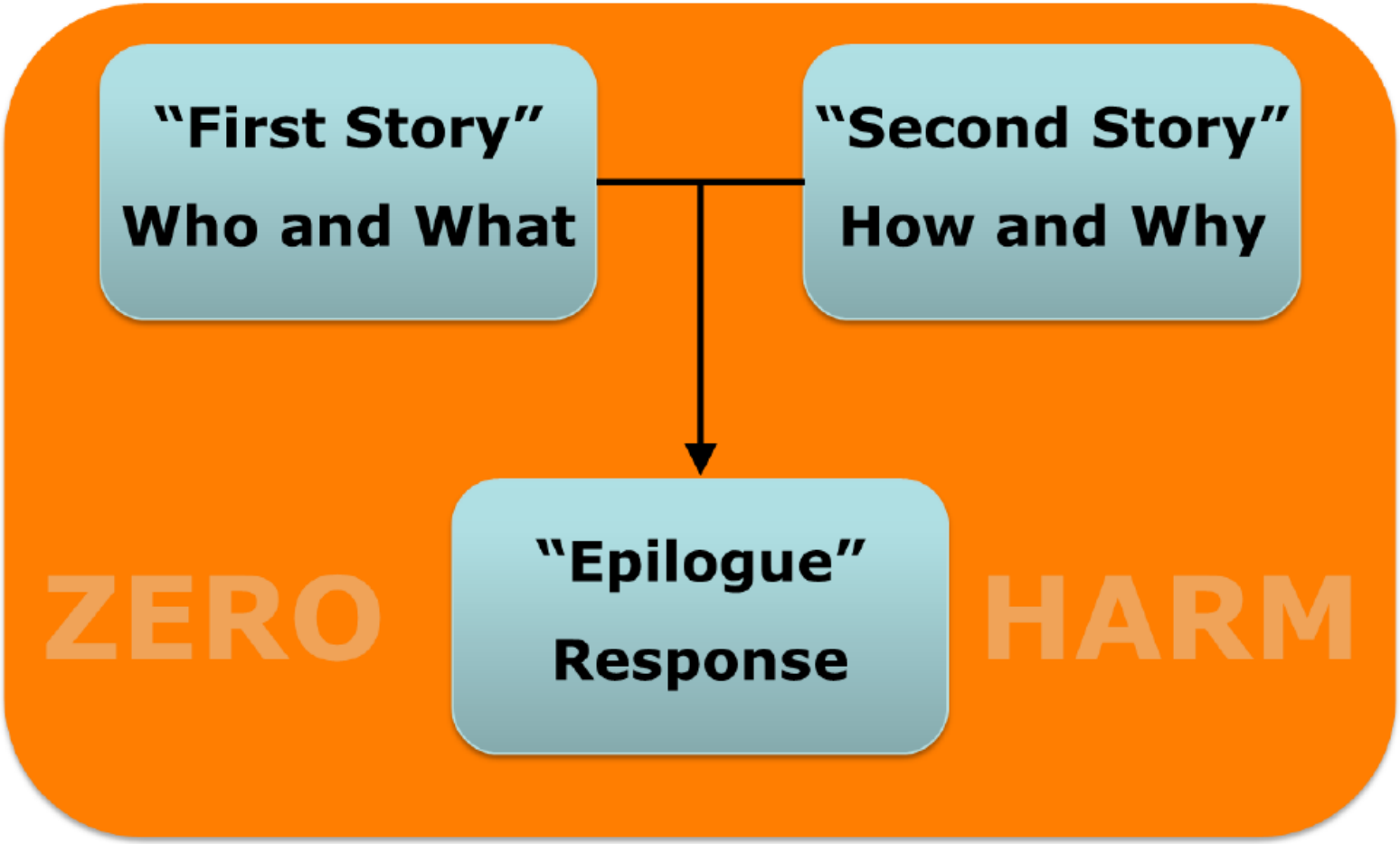
SENSEMAKING


SENSEMAKING









Questions to Understand Human Factors

1. How is the person?
2. That decision made perfect sense…. How did we get it wrong?
3. What was going on at that particular time that resulted in error when it has been done without incident a number of times?
4. Others in this same position could make the same decision what can we do to avoid this?
5. How as a leader did I affect the decision that was made?
6. How do others manage this situation not involved with the incident?

"Smart people learn from their own mistakes, wise people learn from other's mistakes."

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Understanding Human Actions

What Happened

Action or Inaction				Expected / Unexpected		
Unintended				**Lapse**	Individual forgets to do something or has inaccurate recall (e.g., leaving out a step in a procedure or not doing something that was meant to be done)	"I forgot that I needed to do that step"
				Slip	Individual does something, but not what they meant to do (e.g., pressing the start button for pump A instead of pump B)	"I turned on the windscreen wipers instead of the indicator lever"
				Sensory failure	Individual misperceives or fails to perceive something (e.g., mishearing an instruction, reading the wrong pressure from a computer screen, not smelling a gas, not hearing an alarm)	"I misread the pressure level"
Intended	**Expected**	Individual does their job the way they should, according to all rules and good practices	"I did what was expected of me"	**Mistake**	Individual makes an error of judgement; doing something they thought they should do but would not do with hindsight (e.g., misjudging distance needed to safely overtake a car in oncoming traffic)	"I made a bad call when overtaking the truck"
	Exemplary	Individual does something exceptional that has a desired outcome	"I went the extra mile"	**Unknowing non-compliance**	Action or inaction that does not comply with rules or procedures because the rules or procedures are not known (e.g., not following correct procedures because you have not been told about changes to the procedures)	"I was not aware I was meant to do it that way"
				Out of the ordinary	Action or inaction that is rare, happening in unusual circumstances, often when something goes wrong (e.g., not following process in an emergency situation)	"I needed to break the rules to stop someone hurting themselves"!
				Making do	Action or inaction that occurs when it is not possible to get the job done by following the rules and procedures (e.g., using an unsuitable tool for a job because it is the only tool available)	"I cannot get the job done following the rules"
				Organisational benefit	Action or inaction that does not comply with rules and procedures taken to benefit the organisation (e.g., taking a short cut to get job finished in time to meet a project deadline)	"It was better for the company for me to do it"
				Personal benefit	Action or inaction that does not comply with rules and procedures taken to benefit the individual (e.g., taking a short cut to get job finished to get home early)	"It helped me meet my needs"
	Sabotage	Action or inaction taken in wilful disregard of rules and procedures with the intention of causing harm (e.g., deliberate damage to equipment/machines to stop work)	"I wanted to damage the machine, so did not follow instructions"	**Reckless**	Action or inaction taken in wilful disregard of rules and procedures without care or consideration of self or others (e.g., playing the fool on a forklift)	"I am not going to do it and I don't care about what happens"

It is possible for many of these actions to become **routine** either for the individual or the work group. You would hear people say things like "we often do it this way" or "this often happens".!







I CHOSE TO LOOK THE OTHER WAY

In the end it's all about……

THE COURAGE TO INTERVENE!

I could have saved a life that day
But I chose to look the other way
It wasn't that I didn't care
I had the time and I was there

But I didn't want to seem a fool
Or argue over a safety rule
I knew he'd done the job before
If I called wrong he'd get sore

The chances didn't seem that bad
I've done the same, he knew I had
So I shook my head and walked on by
He knew the risk as well as I

He took a chance, I closed my eye
And with that act, I let him die
I could have saved a life that day
But I chose to look the other way

Now every time I see his wife
I know that I should have saved his life
The guilt is something I must bear
But it isn't something you need to share

If you see a risk that others take
That puts their health or life at stake
The question asked, or the thing to say
Could help them live another day

If you see a risk and walk away
Then I hope you never have to say
I could have saved a life that day
But I chose to look the other way

Questions?

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