

FEBRUARY 2020

CAT NAP SAFETY

**“IF YOU FALL IT DOESN’T MATTER
WHAT YOUR ATTITUDE OR BELIEFS
ARE WHEN YOU HIT THE GROUND”**

- **GOLDEN SAFETY RULES**
- **SAFETY LEADERSHIP
2-DAY COURSE
17 & 18 MARCH**
- **ERROR MANAGEMENT
WORKSHOP 29 APRIL**



What's new in February?

Welcome to the February edition of Safety Action News!

This month we look at "Cat Nap" safety. This is an update of the original article on this subject we published back in 2013. It provides a new way of looking at safety trends and behaviours in the workplace.

We also provide a set of sample golden safety rules and list our upcoming training.



Andrea Rowe, GM

Stay Safe!

CONSULTING TEAM



Gary



Stephen



Katie



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SUPPORT TEAM



Zara



Sarah



Sherilyn

Cat Nap Safety

Professor Hudson agrees most organisations take safety seriously, want zero accidents and work very hard. However, they rarely achieve the desired safety performance – many by a long way. So why does this happen?

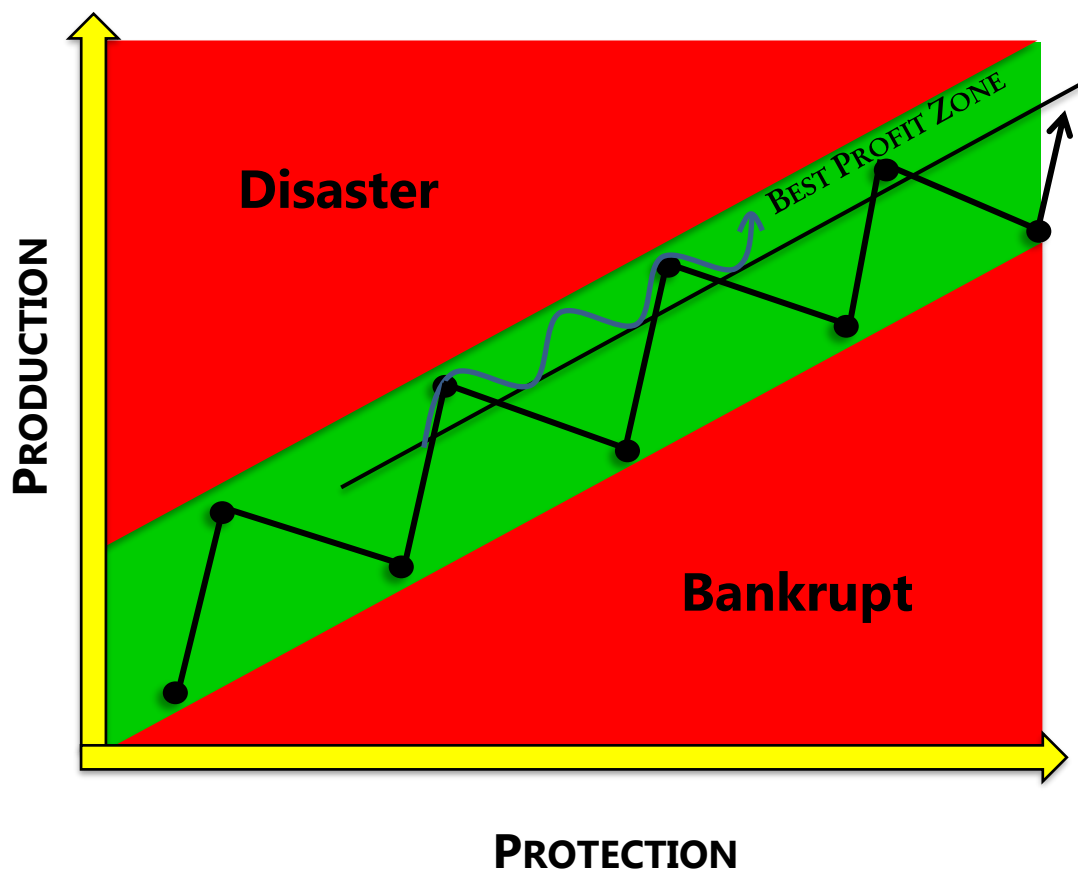
Accident reporting typically provides good data on the persons affected and their injuries with a brief description of what happened. But often there is little if any follow up or analysis on how to prevent similar accidents in the future.

Most antecedent factors for accidents describe the 'immediate' causes *e.g. breaking rules or fell asleep*. However, many omit or provide little information about the 'latent conditions' *e.g. the long-standing problems that have been hidden in the organisation for some time, which promote and support the existence of 'at-risk' practices*.

Many organisations that have experienced risky or competitive operating environments for a long period of time have evolved practices which conform to the principles of '**Cat Nap**'. Cat Nap is another way of saying:

'Cheapest available way to narrowly avoid prosecution or going broke'.

Trajectory of Cat Nap Safety



The previous graph represents the typical fluctuation zone that most organisations operate in. Even government departments and churches (eg not-for-profits), who may have a strong moral commitment to look after people have limited resources and cannot spend unlimited amounts on safety.

As a result, they bounce between trying not to spend so little that they could cause disaster or spending so much that they risk going broke. Most organisations operate closer to “disaster” as they don’t believe “bad things” will happen to them, or in the near future, but can predict financial difficulties more accurately.

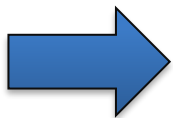
When companies get away with lower standards for a period of time, they are more likely to “normalise” the lower level of safety until something goes wrong.

Another problem is scorecard driven businesses. Having clear objectives or KPIs is good, but many organisations over-focus on things like; LTI rate, cost reduction, or slip, trip falls and not on what might cause a catastrophic accident.

Most approaches to safety culture focus on attitudes and beliefs, and as a result any gains tend to be short lived.

Effective safety programs on the other hand, focus on behaviours – good and bad, not attitudes or beliefs.

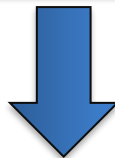
If you fall, it doesn't matter what your attitude or beliefs are when you hit the ground



Question: Why wear PPE?

Answer: So we can go into hazardous areas and do jobs quickly.

But an even better answer would be: so that no-one gets hurt!



Remember that attitude follows behaviour

SAFETY CULTURE LADDER

- HSE is how we do business around here **5. GENERATIVE**
- We work on problems that we still find **4. PROACTIVE**
- We have systems in place to manage hazards **3. CALCULATIVE**
- Safety is important; we do a lot every time we have an accident **2. REACTIVE**
- Who cares, as long as we don't caught! **1. VULNERABLE**



Ref: Prof. Hudson

Despite being at the opposite ends of the spectrum, generative and vulnerable cultures have a lot in common. It is the subtle differences in each organisation which make the differences.

A major characteristic of larger organisations is their tendency to plan, but not implement. Sound familiar? This is because strategy has a higher status in most organisations than tactics and action.

Transition from calculative to proactive culture is difficult, as it requires a change of many fundamental processes, systems and especially ways of thinking.

Deepwater Horizon Case Study

In relation to the Deepwater Horizon oil spill disaster in the Gulf of Mexico in 2010, Professor Hudson concluded that BP was 'loss averse', unlike its main competitors (Shell & Exxon) who were 'risk averse'.

BP have spent more than \$14 billion on response activities as a result of the Deepwater Horizon disaster and has been fined \$4.5 billion for eleven felony charges (11 fatalities), which equates to approximately \$41m per fatality. This is more expensive than fines under any Australian workplace safety laws.

Personal Safety vs. Process Safety

Personal safety is often and understandably the primary focus of the workforce, but unfortunately in high-risk circumstances this can and has led to catastrophic accidents. This can cause greater impact than many personal safety issues e.g. over focus on PPE.

Frequently there is an over-focus on PPE

In the lead up to the Deepwater Horizon disaster it is understood that workers were issuing one hundred (100) STOP cards per day on the rig, on primarily minor issues.

Some suggest this level of stop card activity shifted the focus of the team to dealing with the paperwork and local safety issues and contributed to relevant managers not seeing the warnings of imminent catastrophic events.

Professor Hudson has stated that zero accidents is the only acceptable target. But how, he asks?

1. Hope? or
2. Make a sacrifice to the gods? or
3. Manage the risk by understanding what the critical factors are?

Schrodinger's Cat

Kitty = ½ Alive + ½ Dead



Schrodinger's cat is a term arising from a thought experiment dating back to 1935. It postulates in part that after an accident, all other possibilities immediately become non-existent, leaving a simple causal link.

This makes others believe that those who were involved had some level of certainty of knowledge before the event, just like those who witness the event after. Investigators always look back with the benefit of '20/20 hindsight' and all seems clear and simple *e.g. Theories 2 & 3 look like Theory 1.*

Hudson points out that success with risk makes people more willing to accept greater risks.

Acknowledgement: This article is based on an earlier Safety Action News article and work by Professor Patrick Hudson arising from his 2013 Australian seminars, and updates.

Question of the Month

***WHAT HAPPENS IF YOU GET SCARED
HALF TO DEATH – TWICE?***



Golden Safety Rules

Many leading organisations have established a set of “golden rules” or non-negotiable safety rules to help workers focus on the key things they need to remember during day-to-day work.

The “golden” or “cardinal” rules vary by; industry, organisation, processes and task and equipment specific circumstances. Below are a sample set of golden safety rules.

GOLDEN SAFETY RULES

SAMPLE CORE RULES

- 1) Only perform work and operate equipment you are trained and authorised for.
- 2) Always conduct pre-start checks / risk assessment and don't proceed if the work area or equipment is unsafe.
- 3) If you feel unwell or unable to continue working safely for any reason, stop and escalate to your supervisor / manager.
- 4) If you don't have an agreed safe work procedure for a task, stop and escalate to your supervisor/manager.
- 5) If you can't follow the agreed safe work procedure, stop and escalate to your supervisor / manager.
- 6) Enforce the same safety standards for contractors as we apply to our workers.
- 7) Talk about safety regularly at work and at home.
- 8) Look out for the safety of others.

SAMPLE TASK SPECIFIC RULES

- 1) Drive defensively.
- 2) Never work on “live” electrics.
- 3) Isolate all sources of energy and test effectiveness before working on equipment.
- 4) Assess loads before manual lifting and use mechanical aids or assistance where required.
- 5) Ensure fall protection is in place before accessing any area where someone could fall 2m or more.
- 6) Do not approach within 3m of manoeuvring equipment, unless plant is stopped, and driver signals OK.

Call or [email us](mailto:info@safetyaction.com.au) for a full copy of our suggested core and task specific golden safety rules.

WorkSafe Victoria - Dangerous Goods Notification is now online

Dangerous Goods storage and handling (DSH) notifications are no longer submitted in the paper form. You now need to lodge your notification on the new myWorkSafe portal.

Via the online myWorkSafe account to manage individual and organisational licences, notifications and communications.

Create your account at <https://www.myworksafe.vic.gov.au/s/login>

BREAKFAST BRIEFING

Practical Look at the Manslaughter Laws

Wednesday 15th April

Safety Action Conference Room, Clayton Vic.

We are fortunate to have Andrew Douglas, Principal FCW Law, join us to explain how the new workplace manslaughter laws are likely to pan out, and Gary Rowe, CEO Safety Action, will provide practical tips on safety leadership and governance to help avoid these risks.

7.30am Light breakfast and networking

8am Workplace Manslaughter & How to Avoid it

9am Close

Safety Leadership Workshop

17 & 18 March

Do you want **brave & bold** safety leaders?

Most organisations have safety programs and rules in place. That's not the issue. The issue is **getting others to listen**.

Get the skills to spot unsafe behaviour and learn how to change it **quicker** and **easier** than you ever thought possible!

Tuesday 17th & Wednesday 18th March 2020

Safety Action, Clayton

[Click here to register.](#)