Preventing Fatal & Life Changing Injury Events

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N3L3

Is about changing the way we think about Risk, and how we manage it.

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The Next 3 Seconds

What is the most critical time period in the evolution of your Safety Program?

Answer: **The Next 3 Seconds!**

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The Next 3 Seconds

May be the **L**ast **3** seconds…

Before you have a life changing event (or a fatality)

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It's all about how we manage *RISK…*

1. Change our perception of Risk and where it occurs
2. Recognize that <u>no organization is absent of risk</u> just because they have a "good" safety record
3. Take an active role in implementing strategies that will change the outcomes
4. Using Root Cause Analysis to maximize the effectiveness of hindsight in managing future risk

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Key Strategies to Change the Outcomes

- **<u>Changing the Perception/Awareness of Risk</u>**
- Conscious Thought vs. Intuitive Thought
- Pre-work Planning
- Crew Resource Management via Internal Culture and Safety Climate
- Risk Assessments
- Root Cause Investigations

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It's all about how we manage *RISK…*

It is an <u>ongoing process</u> that takes place at all levels within an organization (Enterprise Wide):

- ***Identify*** weaknesses in our organization that place resources (human, financial, assets, reputation, continuity) at risk
- ***Analyze*** the risks to determine the potential impact
- ***Evaluate*** the adequacy of current controls
- ***Treat*** the residual risk using Loss Prevention and Loss Control techniques
- ***Monitor*** the process and outcomes – repeat if necessary

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(How severe is the undesired outcome?)

Consequence

(Likelihood of the event occurring)

X Probability

RISK

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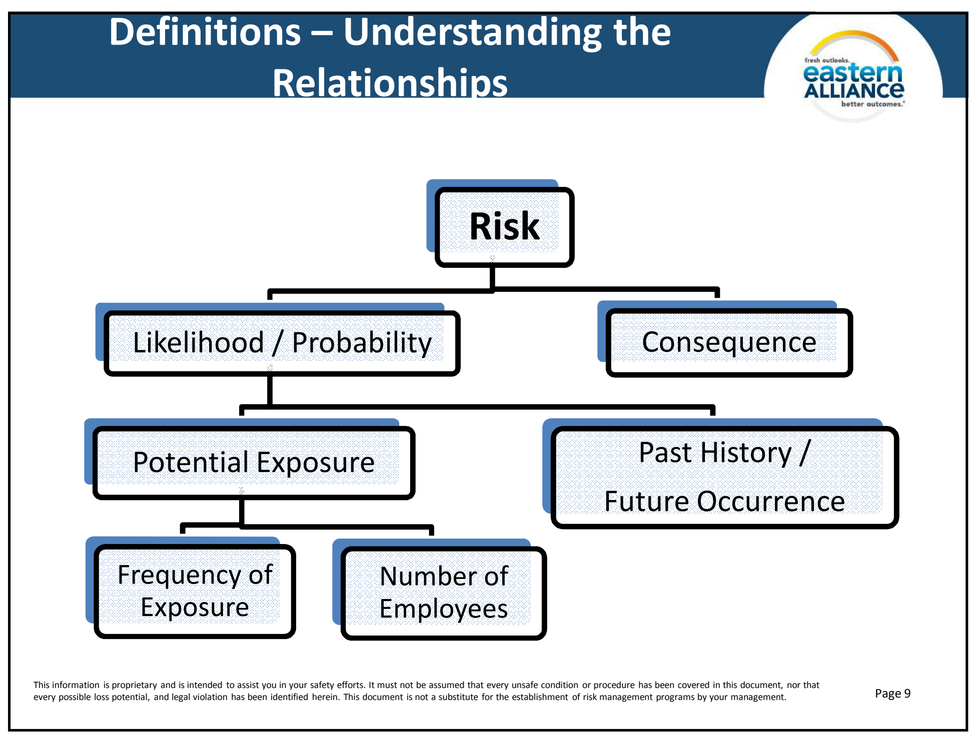
Definitions – Understanding the Relationships
fresh outlooks.
eastern ALLIANCE
better outcomes.
Risk
Likelihood / Probability
Consequence
Potential Exposure
Past History / Future Occurrence
Frequency of Exposure
Number of Employees
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Perception of Risk
fresh outlooks.
eastern ALLIANCE
better outcomes.
Risk to the turkey looks different the day after Thanksgiving. This can happen to organizations as well
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What is your Perception of Risk?

- Nothing really bad has ever happened – so why worry?
- Accidents are inevitable the "Cost of doing business"
- Investigations place blame
- See the relationship between processes and risk
- Understand and actively manage risks

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Risk can be good or bad

- Corporate
  - Risks taken to expand the operations
  - Not providing adequate resources to control workplace safety exposures
- Personal
  - Your choice of career or personal hobbies
- Financial
  - Retirement investment selection
  - Day Trading

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How much risk is acceptable?

- This is determined by your "Risk Appetite"
- It is different for every person or organization
- Is key to how conservative or aggressive you can be with decisions
- As you progress through a risk management evolutionary process, the amount of acceptable negative risk should/will decrease

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Differences in Risk Management approaches

- **Frequently** occurring, relatively minor injuries, are generally controllable with:
  - Administrative controls – basic safety rules
  - PPE – Personal Protective Equipment
- **Catastrophic,** "Fatal & Life Changing" (F&LC) injuries are often cause by unusual circumstances involving high potential energy or unforgiving environments
  - Cannot be adequately controlled with low level controls such as safety rules (Admin Policies) or PPE
  - <u>Can only be effectively controlled through Engineering Controls, Substitution or Elimination of hazards</u>

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The Numbers …

- Overall, the rates of non-fatal and less severe injuries have fallen over the past 40 years
- The rates of Fatal injuries have remained the same. We are still killing on average 5,000 workers every year and permanently changing the lives of countless others

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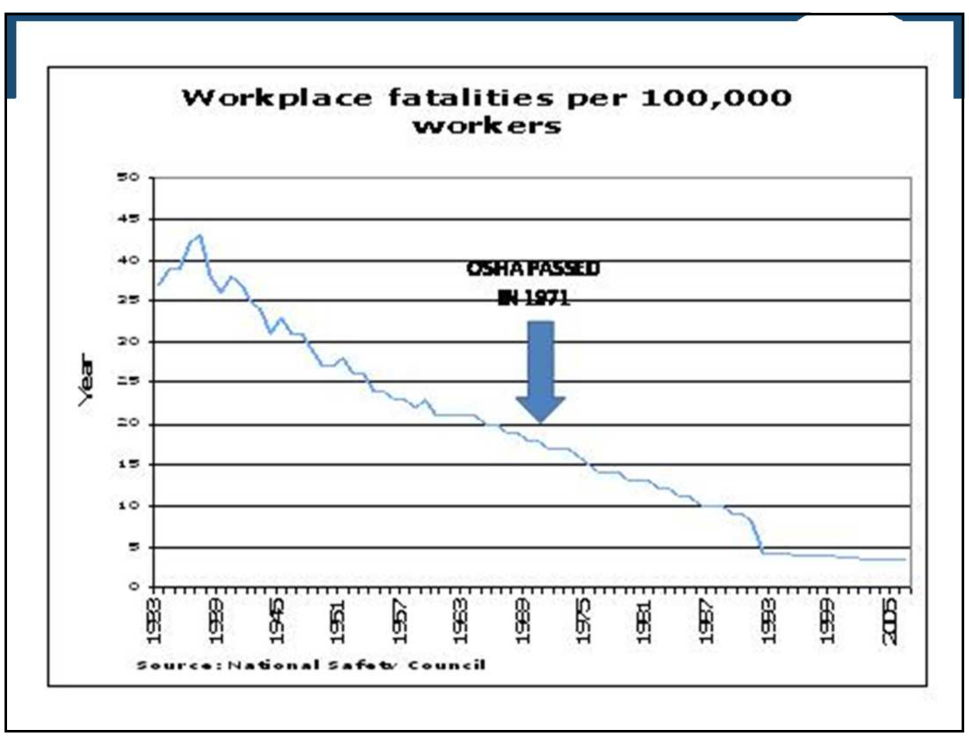

Why focus on F&LC Events?

- Past results are not always predictive of future F&LC events
- F&LC injuries change lives forever
- The rates of non-fatal and less severe injuries have fallen over the past 40 years – *based on the traditional compliance approach*
- The rates of Fatal & Life Changing injuries have remained relatively unchanged over the last 15 years. *The compliance approach is not having an impact here!*
  - (We are still killing on average 5,000 workers every year)

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Why focus on Fatal & Life Changing Events?

- Must follow the hierarchy of controls
  - Avoidance / Elimination
  - Substitution
  - Engineering
  - Administrative
  - PPE
- Low level controls (such as PPE and Administrative Controls) are not proving effective at preventing these incidents

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Why Focus on Fatal & Life Changing Events?

- Incorrect assumptions that most injuries are caused primarily by unsafe acts of employees
  - We need to be better at Root Cause Analysis
- Severity is 50% of the math calculation when measuring risk

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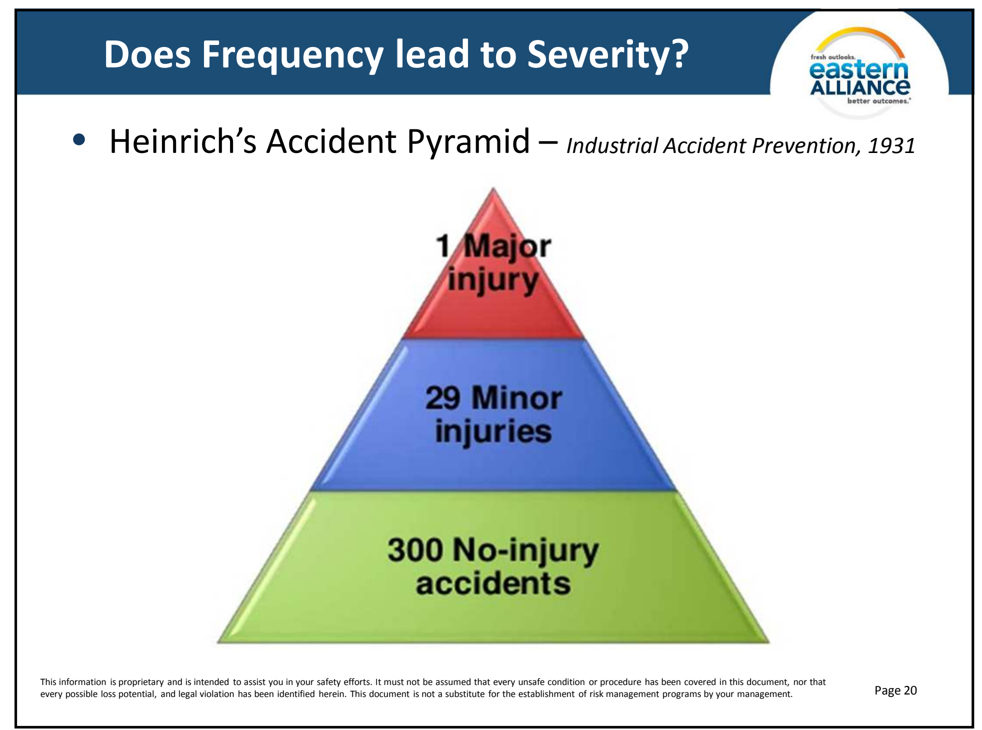
Does Frequency lead to Severity?

- Heinrich's Accident Pyramid – *Industrial Accident Prevention, 1931*



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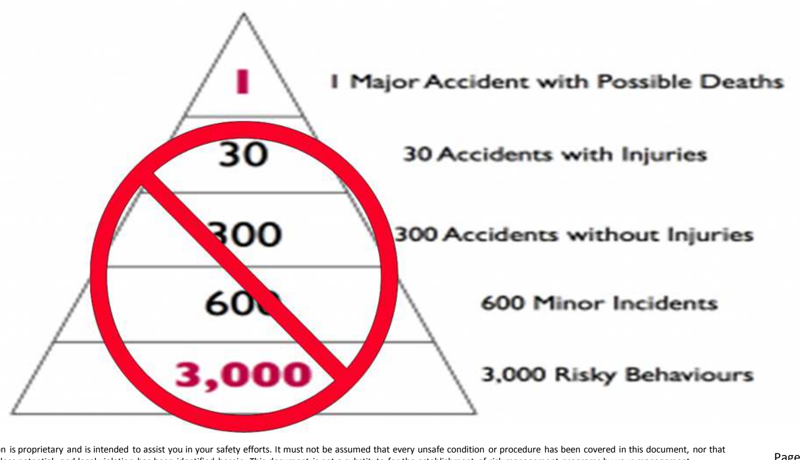

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Common F&LC Event ***Precursors***

- Motor Vehicle operations (#1 cause Occ. Fatalities)
- Falls (#2 leading cause of Occ. Fatalities)
- Manual Material Handling – Repetitive and Acute
- High Voltage contact or work
- Mobile equipment (forklifts, Bobcats, tractors, mowers)
- Non-routine work during emergency or planned shut downs
- Construction work by "other" employees
- Confined Space Entry
- Trenching
- Crane / Hoist activities
- Chemical Applications

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Other F&LC Risk Factors

- Rushing to complete the task
  - to get to something more fun for me!
  - get done with something less enjoyable
- Fatigue
  - Late in the day / week
  - Excessive overtime
- Aging Workforce
- Younger Workers

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Why do we make certain decisions or choices?

- Easiest pathway to the goal
- Often the fastest way to complete the task
- Has always worked in the past – so why not this time
- Reward driven

PIC	NUF
Positive	Negative
Immediate	Future
Certain	Uncertain

- Organizational Drivers?

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Organizational Drivers of Unwanted Behavior

- Good or Bad? - Behaviors occur within the context of the organization that reinforces it
- Piece rate pay system
- Unachievable output demands
- Supervisor or Peer Pressure
- Lack of proper training or tools to perform the work
- Safety is a **Priority** and not a **Value** within the organization

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90% Intuitive vs. 10% Conscious Thinking

- **Intuitive Thinking** – decisions are arrived at without conscious thought. More of a reactionary response based upon input from prior experiences
- **Conscious Thinking** – critical or analytical decision making where facts or data are applied and weighed. Consequences or outcomes are considered in the process

Conscious or *Critical Thinking* works best when you ask the following questions:

- Does this make sense?
- If so, why?
- If not, why not?

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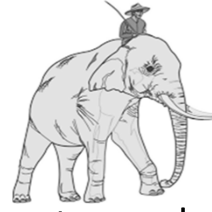
Most of the time the elephant is in charge …

- Easier – takes a lot less energy
- We evaluate the world based on associative learning
- If we don't know the mind creates a story
- We tend not to see risk



- We need to remove the barriers to good decision making by removing opportunities to fail

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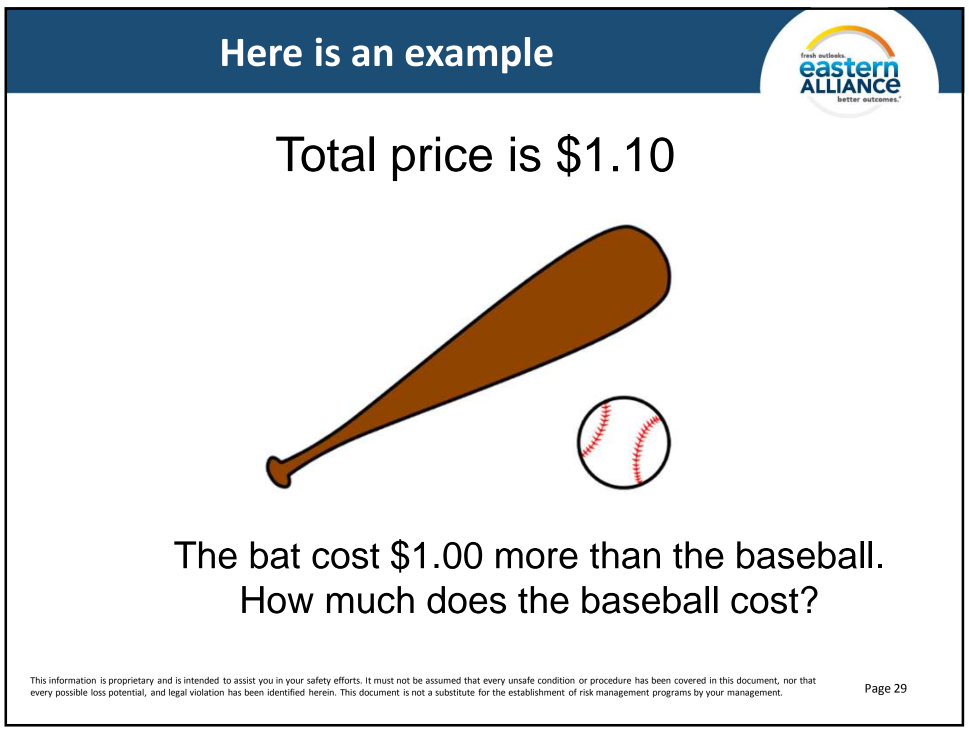
Here is an example
fresh outlooks.
eastern
ALLIANCE
better outcomes.
Total price is $1.10
The bat cost $1.00 more than the baseball.
How much does the baseball cost?
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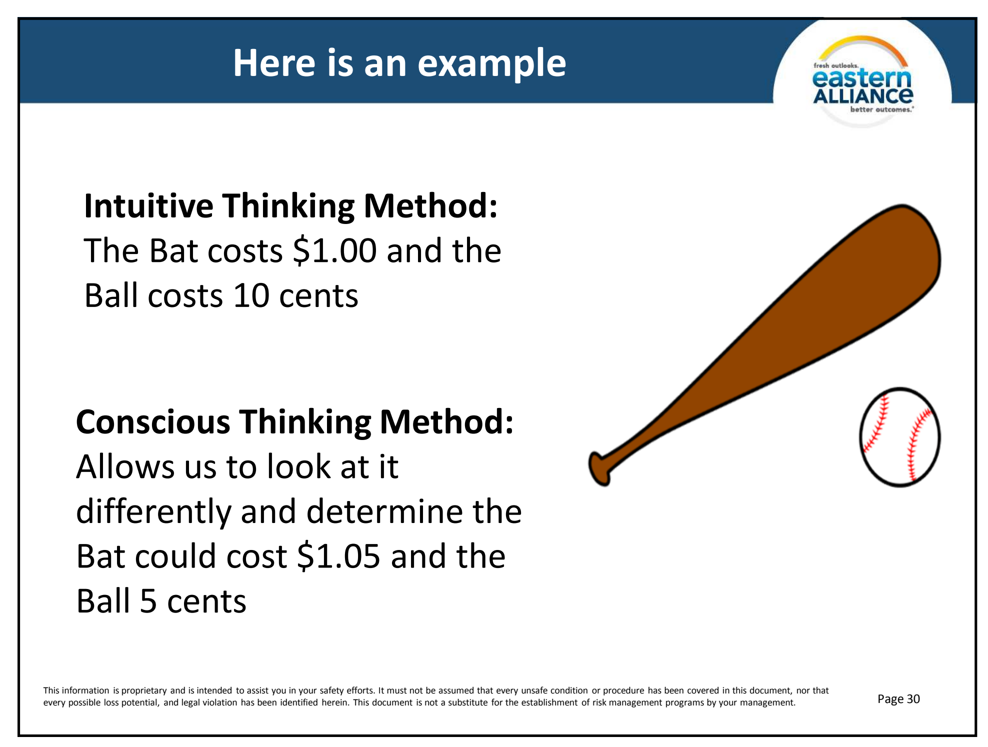
Here is an example
fresh outlooks.
eastern
ALLIANCE
better outcomes.
Intuitive Thinking Method:
The Bat costs $1.00 and the
Ball costs 10 cents
Conscious Thinking Method:
Allows us to look at it
differently and determine the
Bat could cost $1.05 and the
Ball 5 cents
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- Conscious Though vs. Intuitive Thought
- **<u>Pre-work Planning</u>**
- Crew Resource Management via Internal Culture and Safety Climate
- Risk Assessments
- Root Cause Investigations

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Pre-Work Planning

- Actively engage in pre-job, pre-task, pre-shift huddles or meetings
- Conduct a Risk Assessment
- Job Hazard Analysis (JHA) that Identifies:
  – People involved,
  – Resources that will be needed,
  – Hazards anticipated,
  – Proper control procedures to be used,
  – Safety concerns / Issues

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From The Employee's Point of View

Take Time To Think About The Consequences

- Take a few seconds to think about what you are going to do.
- What could go wrong?
- What do I need to do to protect myself?

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Crew Resource Management

- The concept was developed in a NASA workshop in 1979 to help improve air travel safety
- Many aircraft incidents were the result of:
  - Failures of interpersonal communication,
  - Leadership,
  - And decision making in the cockpit
- Purpose was to optimize available resources (equipment, procedures and people) to promote safe operations and enhance efficiency

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Crew Resource Management

Key Points from many of the airline crash investigations:

- Someone likely recognized a problem
- No one spoke up – *not empowered*
- No one listened – *authoritarian culture*

- How would these points apply to any of your prior workplace incidents?

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Crew Resource Management

- Empowerment
  - See something – Say something!
- Stop Work Policy
  - Written
  - Prevents bullying
  - Appropriate management response

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How does CRM fit in?

- CRM is a critical component to a mature Safety Climate/Culture
- It is intended to promote the teamwork and trust needed for each person to speak up when something is not going as it should
- **Goals:**
  - Promote teamwork to achieve common goals
  - Empower all members to speak up or question issues they feel are unsafe by breaking down barriers to communication

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How would you rate your Safety Culture?

Category	5	4	3	2	1
Mgmt Commitment	Mgmt actively leads process	Safety is an agenda item for management	Policy & procedure unique to company	Off the shelf programs	No written programs or materials
Safety Mgmt System	Full program with staff	Assigned person >50% of their job	Assigned person <25% of their job	Rely on outside consultant only	Nothing in place
Safety Innovation	Zero accident focus	Working to improve safety process	Average Safety Committee activity	Focus on compliance issues only	View safety as an added operating cost
Perception of Risk	Understand and manage risks	See relationship of risk to process	Investigations place blame on employees	See accidents as inevitable	See no risks that would impact the
Behavior Based Safety	Near miss reporting program – root cause	Monitoring critical items	Traditional training	Compliance / Enforcement driven	Nothing
Employee Engagement	High trust / jointly set goals	Caring mgmt. / engaged employees	Warm & fuzzy HR focus	Low turnover, but Unionized	High turnover, and/or low skill workforce
Safety Training Methods	Associative learning based	Competency based	Show & Tell	Show videos	None
Accountability	Process improvement in place	Use leading indicators to measure safety	Use outcomes to measure safety perf.	Punish safety violators	No enforcement of safety rules
Drug Testing	Full program with EAP	Pre hire, post accident, for cause	Pre-hire only	Post accident only – fire positive empl.	No testing at all
Health & Wellness	Incentivized programs	Screenings	Some activity	Nothing yet, but may consider in future	Scoff at the concept
Return to Work	Will always do – 100% policy	Generally will do – have in the past	Will try if restrictions easy to accommodate	May or may not – case by case	Will not – don't see the benefit

Elements of a mature safety culture - KCRAF

- **Knowledge** – technical ability to recognize and evaluate risk exposure potentials
- **Competency** – knowledge, skills and abilities based on active training the measures outcomes
- **Resources** – management commitment, time, $, buy-in, accountability, equipment, process changes, engineering
- **Audit** – follow a Plan, Do, Check, Act (PDCA) cycle for projects, monitor outcomes, internal auditing process
- **Feedback** – Root Cause Analysis, observation program, mentoring/coaching, formal frameworks

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Essential elements of a mature safety culture

- Employees are empowered to challenge the "status quo" when they perceive a safety issue
  - See something – Say something!
- Management actively invites open dialogue to promote organizational improvement – they listen
- We remove opportunities for failure
- Integrate safety into all aspects and at all levels of the organization

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Risk Assessments

- To understand our risks, we must first identify what they are
- Techniques vary from very simple to extremely complex
- ANSI Z690 / ISO 31010 standard identifies 31 different methods available – depending upon the scope of the problem
- Most often used is the standard Job Safety Analysis (JSA) or Job Hazard Analysis (JHA)
- We can then apply quantitative methods to measure how "bad is bad" and prioritize our efforts to control them

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What does the Risk Assessment tell us?

- Areas of potential risk to our organizations
  - Hazards
  - At Risk Behaviors
  - Trigger Events
- Current controls in place to address those risks
- Consequences (Potential or Actual) of an event
- Helps to identify "acceptable" vs. "unacceptable" risk
- Where to focus our control efforts

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Root Cause Investigations

- Critical part of preventing recurrence of any unwanted or unplanned event
- Complexity of the investigation varies with the complexity of the event
- Most often used involve:
  - 5 Why Technique
  - Cause and Effect Diagrams – Fishbone
- Looking for the breakdowns or shortfalls in the management systems that control our operations

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Why do a Root Cause Investigation?

- Benefits
  - Creates a record to learn from and prevent recurrence
  - Identifies corrective actions
  - Helps with accountability for managing change
  - Changes our future safety communication
- Close the loop – connect the event to other aspects of the operation to modify them as well
- No need to have an accident/incident to do a Root Cause! The principles can be applied to anything …

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Critical Management Investigation Questions

- Is this the first time the employee acted in an unsafe manner?
- Did you know the unsafe behavior was occurring?
- If so, what did you do about it?
- If not, why not?

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Have we been good or just lucky?

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Safety Climate

- People are empowered to speak up.
- We are conditioned to listen.
- We remove opportunities for failure.
- We talk about safety and reward it.
- N3L3 is a core value.

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One Final Note ….

When Discussing Safety With Your Employees

- ***Make it personal …..***
  - Who is waiting for you at home?
  - Who is depending on you being there?
  - What are the potential consequences of your behavior?
  - How do we change unwanted behaviors?
  - Who is responsible for your safety?
  - You don't want to be the one that has to make that phone call ….

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How well are you prepared for the next 3 seconds?

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Questions on N3L3?

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