Preventing Fatal & Life Changing Injury Events

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

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N3L3

- Fatal &Life Changing Injuries (F&LC) impact lives forever
- Pro-actively focus on:
  - The precursors which cause F&LC events
  - Management systems to control them
- The Past Does Not Always Predict The Future

N3L3

*The **N**ext **3** Seconds:*

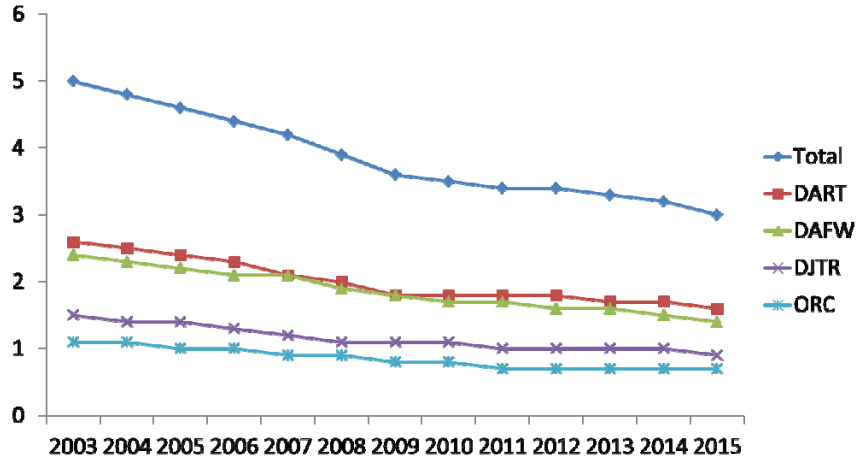
*Protects Your **L**ife,*

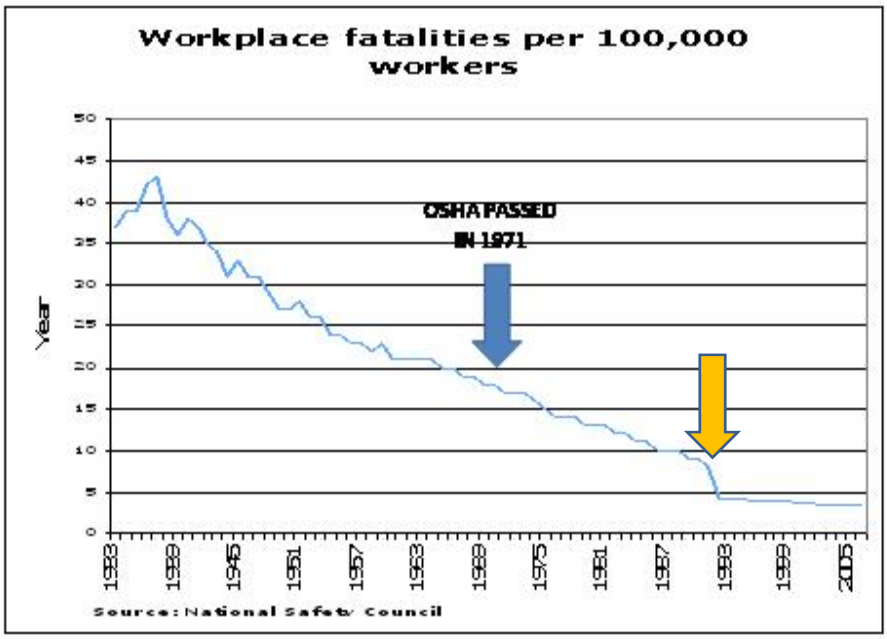
*Your **L**oved Ones and*

*Your **L**ivelihood ®*

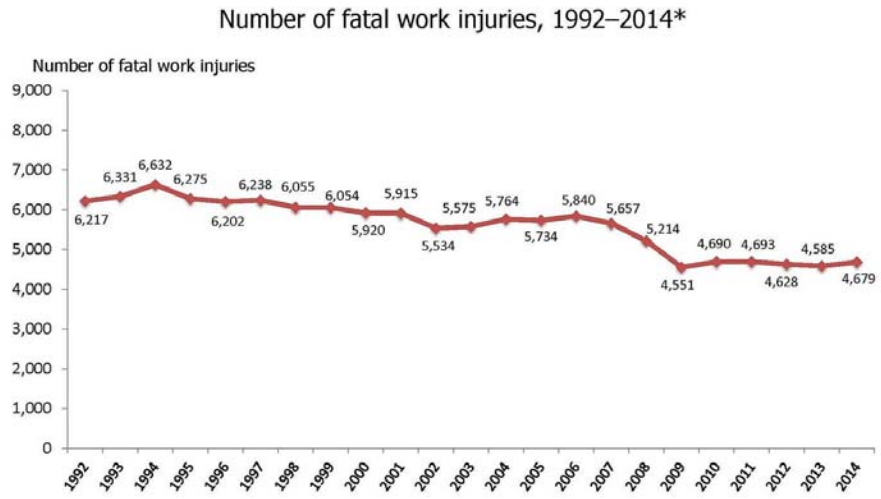
The Numbers

Non-Fatal Injury Rates





U.S. Fatality Statistics



Does Frequency Lead To Severity?

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

Not always predictive when it comes to F&LC events.
- *The past does not always predict the future*.

Perception of Risk

What is your Perception of Risk?

Understand and actively manage risks

See the relationship between processes and risk

Investigations place blame

Accidents are inevitable the "Cost of doing business"

Nothing really bad has ever happened – so why worry?

How would you rate your Safety Climate?

Category	5	4	3	2	1
Management Commitment	Management 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	Inconsistent post-accident drug testing - firing "+" workers	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

N3L3 is about how we manage *RISK*…

- Changing our perception of Risk and where it occurs.
- Recognizing that no organization is absent of risk – just because they have a "good" safety record.
- Taking an active role in implementing strategies that will change the outcomes.

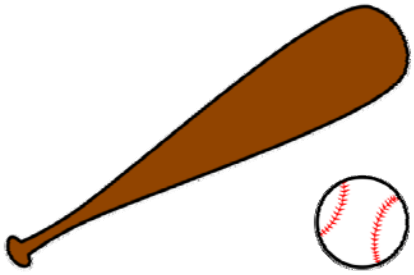
Conscious vs. Intuitive Thought

Intuitive vs. Conscious Thinking

- **Intuitive Thinking:**
  - Decisions made without conscious thought
  - Reactionary response based upon prior experiences
  - Less concerned about the process
- **Conscious Thinking**:
  - Critical or analytical decision making
  - Facts and data are applied and weighed
  - Consequences or outcomes are considered
  - More concerned about the process

Baseball Bat & Baseball

Total price is $1.10

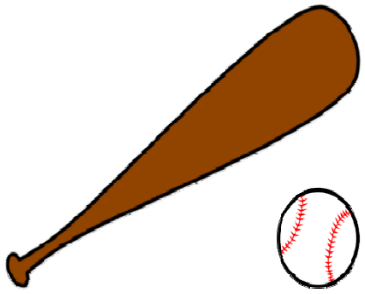


The bat cost $1.00 more than the baseball.
How much does the baseball cost?

Baseball Bat & Baseball

Intuitive Thinking Method:
The Bat costs $1.00 and the Ball costs 10 cents

Conscious Thinking Method:
The Bat could cost $1.05 and the Ball 5 cents



Why do we make certain decisions?

- Easiest
- Fastest
- Always done it that way
- Incentives
- Organizational Drivers?

Organizational Drivers of Unwanted Behavior

- Behaviors: (good or bad) occur within the organization that reinforces it
- Piece rate pay
- Unachievable output demands
- Supervisor or Peer Pressure
- Lack of proper training or tools
- “Doesn’t matter what I do, I will be blamed”
- Not about “fixing” employees

Focus on Management Systems

Deflated Systems?

Safety as the Absence of Injuries

- Traditional safety - where the number of things that go wrong is acceptably small
- What do our incidence rates measure?
- Safety is <u>not</u> just the absence of injuries

Does this make sense?

- We have measured how "safe" an organization is by the number of people we hurt!!!
- If ZERO is achieved, were we Good or Lucky?
  - How close were we to failure and didn't know it?
  - Absence of safety issues give us no reason to assume something is amiss
  - Serious issues can exist with no outward symptoms

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):

Precursors and Risk Factors

Common F&LC Precursors

Often “high-energy” potentials…

- Motor Vehicle operations (#1 cause Occ. Fatalities)
- Falls (#3 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

Other F&LC Risk Factors

- Hurrying
- Fatigue
- Aging Workforce
- Younger Workforce
- Less experienced employees
- Distractions, or
- Frustrations
- Workplace Violence (#2 Cause of Occ. Fatalities)

What's Wrong With This Picture?

Look A Little Closer

Pre-Work Planning

Pre-Work Planning

- Pre-job, pre-task, pre-shift
- Pre-project meetings
- Formal Risk Assessment processes
  - e.g. Job Hazard Analysis (JHA)
- What to include?:
  - What's the scope of the job, task, etc?
  - Who's involved?
  - Safety Requirements
  - What could possibly go wrong?

Risk Assessments

Purpose of Risk Assessment

The process attempts to answer:

- Areas of potential risk?
- Current controls in place?
- Potential consequences?
- Probability of their future occurrence?
- Factors that mitigate the consequence of the risk, or that reduce the probability of the risk?
- Level of risk **"Acceptable"** or **"Unacceptable"?**
- Prioritizing ongoing efforts?

Root Cause Analysis

Root Cause Analysis

"Those Who Do Not Learn From History Are Doomed To Repeat It"

- George Santayana (Spanish Philosopher)

Why Root Cause?

- Why? To prevent a recurrence!
- Not about the blame game
- Identifies preventive & corrective actions
- Most effective when done by teams
- Looking for the breakdowns or shortfalls in the management systems

Any guesses as to the next slide?

Thinking About Potential Consequences?

Crew Resource Management

Crew Resource Management

- Concept developed in a NASA workshop in 1979
- Goal to improve air travel safety
- Many aircraft incidents were the result of:
  - Failures of interpersonal communication,
  - Leadership,
  - And decision making in the cockpit

Lessons Learned

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*

Stop Work Policy

- Stop Work Policy
  - Written & detailed
  - Clearly defined roles
  - Everyone has a voice
  - Appropriate management response every time

Flipping the Switch in our thinking!

- Focus not on what goes wrong, but what goes right!
- We must begin analyzing and critiquing normal everyday work!
- We must seek out and recognize the weak signals (aka: precursors)
- Make safety a core value and not just a priority

How well are you prepared for the next 3 seconds?

Questions on N3L3?