



Focus where it counts

Reducing LTIs is important, but not at the expense of overlooking critical risks that can kill, disable or severely compromise health. **ALAN COOPER** suggests how to get the balance right.

Over the last year, WorkSafe chief executive Nicole Rosie has been urging industry leaders to identify and focus on critical risks, and this message has also been given by WorkSafe staff in their engagement with stakeholders.

Critical risk is not defined in the Health and Safety at Work Act 2015 (HSWA), rather, it is a pragmatic approach that WorkSafe is using to help PCBUs check that:

- all their risks are identified;
- there is a proportionate approach to dealing with the range of workplace health and safety risks; and
- sufficient effort is directed to the most pressing health and safety risks.

Critical risks are those which, if realised, could result in death, a life-shortening illness, or severe permanent disability. A critical risk focus enables the highest proportion of effort to be directed toward the most significant risks. A critical risk focus

will also drive the right conversations at a leadership level and ensure that the risks with the highest consequences and most significant harm are monitored effectively.

I had a conversation recently with a PCBU about whether the potential of finger amputations by small band saws meant their use in the workplace met the threshold for them to be considered a critical risk. The bottom line is that if a business operates band saws, the

risk of that has to be managed. If finger amputation is a persistent issue for your industry or business then managing the risk should be a priority, and your senior managers and board members ought to be aware of that.

Trying to define exactly what is and isn't a critical risk beyond the above definition adds little value. The fact remains that the legislation sets an expectation that PCBUs manage all risks appropriately, and in particular those with the most significant consequences.

INFREQUENT HARMS OVERLOOKED

As the work health and safety regulator, our observation is that businesses are more inclined to be reactive to events that have already resulted in workplace incidents. The focus is almost entirely on managing down accident and injury rates and channelling most effort to doing this. They often overlook risks from which harm occurs infrequently or develops over an extended period of time. This is particularly so for work-related health risks such as dust and chemical exposures, and for catastrophic risks such as chemical reactions, explosions and fires.

Further, some people still believe there is a proportional relationship between the number of near miss or minor injury events and the most severe or fatal accidents. This relationship is sometimes described using 'Bird's triangle'. While it is likely that a business will experience more minor injuries than severe, this does not mean that the minor events are a precursor or signal for a major event. Focusing solely on the causes of high frequency/low consequence incidents will not prevent less frequent but more severe harm from occurring (see Fig 1 for a useful enhanced triangle).

Also, reducing overall injury rates may have little if any impact on the risk of a severe accident occurring. For example, resolving manual handling risks will not prevent workers from falling from roofs, which is likely to result in a serious injury rather than a minor one.

Some estimates are that only 15% to 25% of critical risks share underlying causes with typical lost time injury events.

PCBUs should take a step back, engage with their workers and consider what workplace incidents could result in death, a life shortening illness, or severe permanent disability. Critical risks vary by sector and organisation. A PCBU must identify and understand the risks

Figure 1: The enhanced Safety Triangle

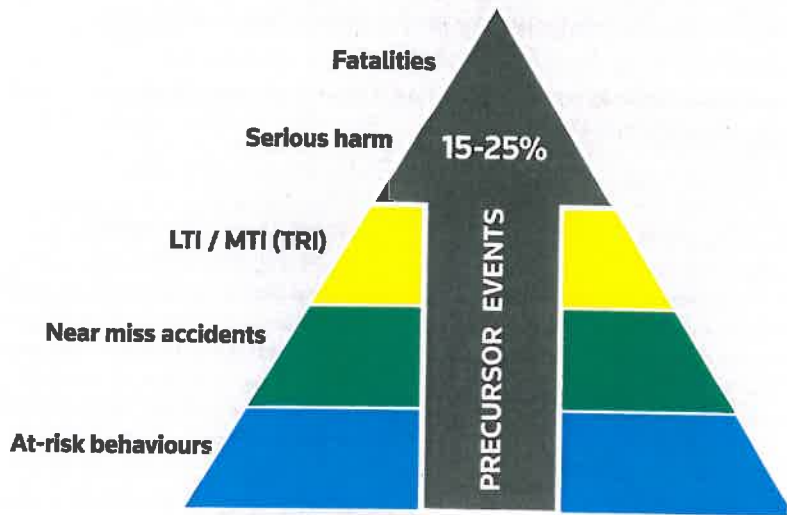
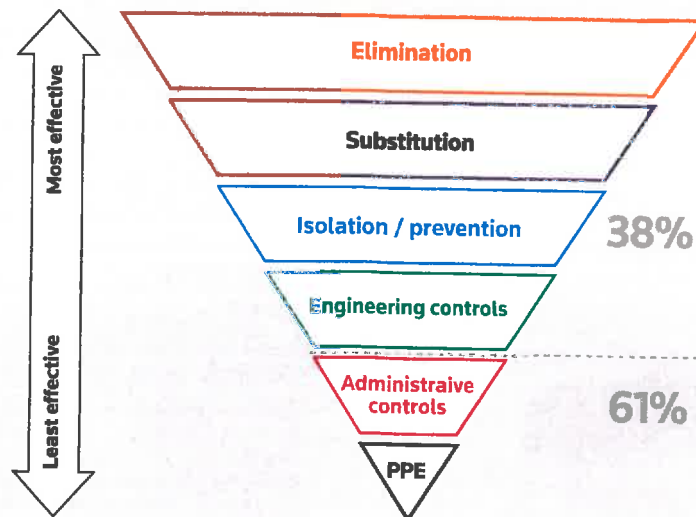


Figure 2: Effectiveness of target interventions



arising from their work activity and work environment(s). While there may be some common ground, their risk profile will likely be different from that of other businesses.

UNDERSTAND THE CONTROLS

When you are dealing with critical risks it is essential that you understand the controls and the differences between control effectiveness. The HSWA legislation provides a hierarchy of controls for people to consider, with the most effective being elimination, followed by substitution, isolation and then engineering controls. An example of applying this practically using the example earlier would be:

- Elimination – not using the band saw.
- Substitution – using a better protected or alternative cutting device.
- Isolation or engineering – guarding the machine more effectively and/or putting in automatic detection or other devices that stop the machine when it comes into contact with fingers (an engineering control currently in operation in a number of freezing works).

These are referred to as above-the-line controls and are the key controls you should have in place when managing your critical risks (see Fig 2).

Only when above-the-line controls are unavailable or not reasonably practicable should one defer solely to using

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administrative or PPE controls (below-the-line controls). Evidence suggests five to seven administrative controls need to be in place and working effectively each time a person is exposed to the risk for these controls to be as effective as a single above the line control.

As this suggests, administrative controls are generally not adequate controls for the most significant critical risks in New Zealand workplaces.

WorkSafe expects a PCBU to increase its efforts to implement above-the-line controls (where they exist) for their critical risks. The reason for this additional focus on high-end controls is simple: below-the-line administrative controls will inevitably fail and the consequences for critical risks will likely be severe. Invariably, administrative controls rely on people consistently following rules and procedures and we know that, despite the best intentions, human beings make mistakes.

A PRAGMATIC APPROACH

People working in the business, senior managers and board members should all know what the business's critical risks are and how they are controlled. Management teams and boards ought to be discussing critical risks and seeking additional assurance that controls have been effectively implemented and that there are ongoing reviews of the adequacy of the risk controls.

To reiterate, the critical risk approach is a pragmatic one to help PCBUs check that all their risks are identified, that there is an appropriate focus on preventing death, life shortening illness and severe disability, and that sufficient effort is directed to the most pressing health and safety risks.

However, this is not an excuse for allowing workers to be unreasonably exposed to risks categorised as non-critical. Applying a critical risk lens enables effective prioritisation and

apportioning of effort. It is not a reason to ignore other health and safety issues.

For senior management teams and boards it enables focused discussion regarding risks with potential to cause the most harm. Managing injury rates down continues to be important, as is managing non-critical business risks. For example, noise-induced hearing loss or musculoskeletal injury may not be categorised as critical risks but the impact of such harm can still be significant for a worker and the business.

I know from my own experience managing workplace health and safety that it is all too easy to be captured by incidents and events happening around you. It is essential that PCBUs take the time to engage with workers and ensure that they have identified and are robustly controlling acute, chronic and catastrophic critical risk in their business. ■



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Dave Williams, QHSE Manager, GEA Process Engineering

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