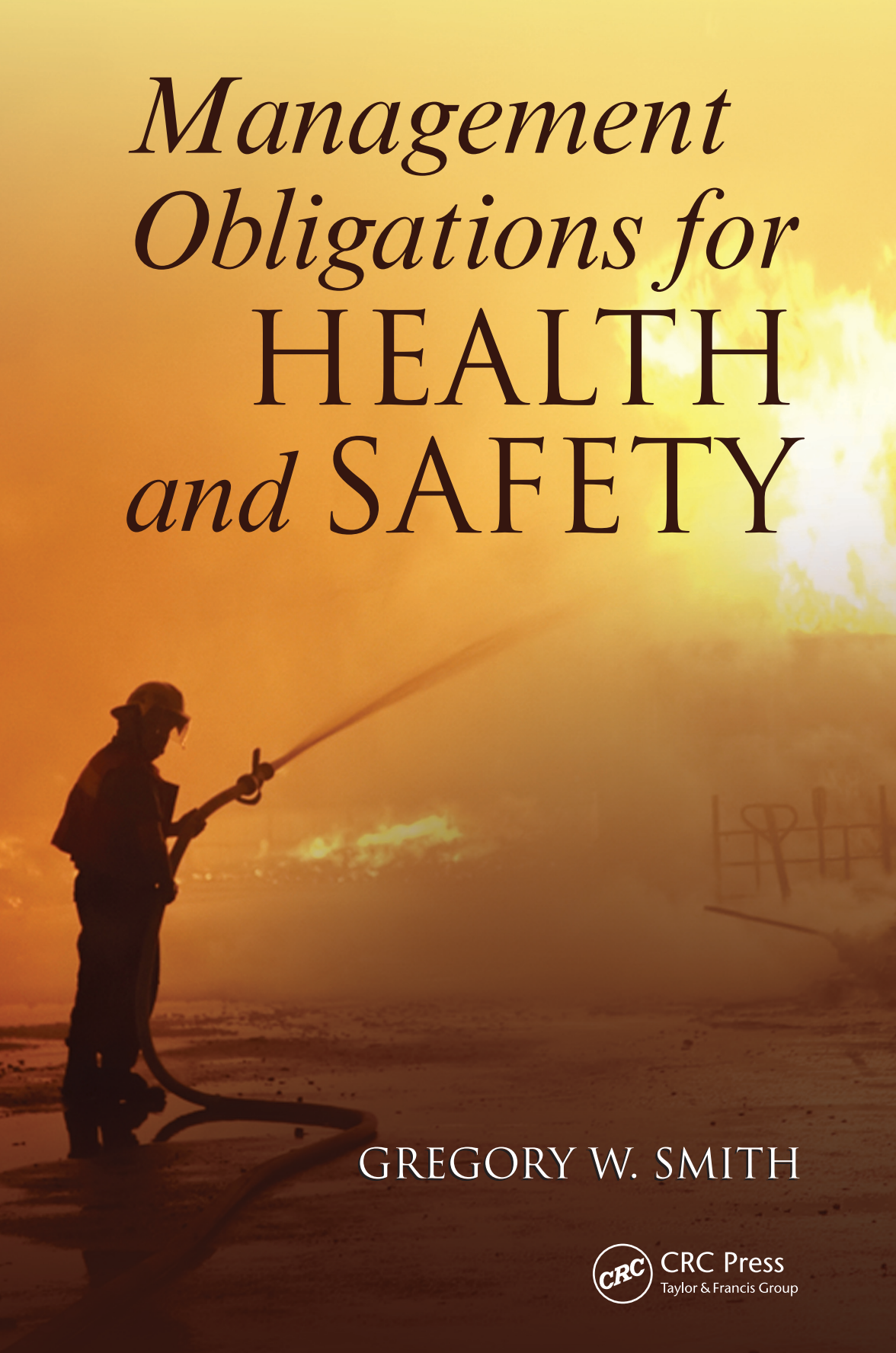
Management Obligations for HEALTH *and* SAFETY



GREGORY W. SMITH

CRC Press
Taylor & Francis Group

Management Obligations for HEALTH *and* SAFETY

Management Obligations for HEALTH *and* SAFETY

GREGORY W. SMITH

CRC Press
Taylor & Francis Group
Boca Raton London New York

CRC Press is an imprint of the
Taylor & Francis Group, an **informa** business

CRC Press
Taylor & Francis Group
6000 Broken Sound Parkway NW, Suite 300
Boca Raton, FL 33487-2742

Version Date: 2011913

International Standard Book Number-13: 978-1-4398-6279-7 (eBook - PDF)

Contents

Preface

> "BP gets it and I get it too—I recognize the need for improvement."*

Maybe. Maybe not.

The idea for this book was not inspired by any one event. It is the culmination of many, many years of working at first with organisations but more lately with individuals as they have had to come to terms with the consequences of workplace accidents—particularly fatalities.

No one person ever reacts the same to finding him- or herself responsible for managing the aftermath of a death at work, or having to deal with the immediate pressure of being subject to interviews and investigation by safety regulators (much less the drawn-out experience of the legal process), but one of the most constant reactions is "*Why didn't anybody tell me about this?*" It is the same reaction that I get from managers and supervisors whenever I am running training about their individual responsibilities for safety and health in the workplace:

Why didn't anybody tell me about this?

What they are talking about is their personal, individual, and legal responsibilities as a manager for safety and health in the workplace.

Although, as I said, no one event motivated me to sit down and write about individual responsibilities for workplace safety and health, when I started to write this book, oil was continuing to spill into the Gulf of Mexico many months after the catastrophic explosion and fire on board the Deepwater Horizon drilling rig. The political, commercial, and environmental consequences of this event could never be understated, but it should never be forgotten that 11 people lost their lives in the incident—the ultimate price to be paid for a failure of effective safety management in the workplace. It had been only six years since BP suffered an earlier

* Lord John-Browne, CEO of BP, in a teleconference with reporters shortly after the release of the Baker Panel Review into the causes of the BP Texas City Refinery explosion

catastrophic workplace accident when an explosion at their Texas City refinery killed 17 people and injured over 170, and no doubt the inquiries and investigations will examine the parallels.

The images from the Gulf of Mexico had a special impact on me because I had only just finished my involvement in a frighteningly similar event in Australia (albeit with less disastrous consequences), the uncontrolled escape of hydrocarbons from the West Atlas drilling rig in the Timor Sea and subsequent public inquiry, the Montara Inquiry.*

Much has been written and no doubt will continue to be written about the organisational causes of catastrophic workplace accidents. But when all is said and done those organisations are nothing more than the sum of their parts: people. Organisations do not cut budgets; they do not write safety procedures or processes, or determine training programs. People do. And so it is people who have an impact on safety and health in the workplace.

In 2009 I was presenting at the APPEA conference in Perth, Western Australia, about my views on the minimum expectations that courts and tribunals have of managers and their obligations concerning safety and health. Following the presentation, I was approached by a number of organisations to give similar presentations internally, which ultimately led to a very busy year running workshops on management obligations for safety and health. Routinely I was told that I should write a book on the topic quite simply because none of the participants had ever had their legal obligations, and the relationships between these legal obligations and effective safety management, explained to them—and they felt that there was nowhere that they could go to get this information.

After about 12 months of running training programs, I was involved in a case with an electrical supervisor who was being prosecuted over an incident involving an electrical apprentice. The apprentice had been tasked to do a routine check on a piece of equipment. The equipment had been isolated and de-energized, but the apprentice had gone to the wrong part of the plant and worked on a live piece of machinery. Although he suffered a minor electrical shock, he was not badly injured and was back at work within a few hours. The organisation involved in the incident carried out its normal investigations as part of their routine safety management processes, and the relevant authorities were notified. As far as everyone was concerned the matter was finalised.

Two and a half years later, however, it was the electoral supervisor who was served with a summons and prosecuted.

Ultimately we achieved a good legal outcome for the supervisor, although I am sure that the experience left a mark in its own way.

But during the course of preparing for the trial, he commented to me that although he had been in supervising roles for the best part of 15 years

* See http://www.montarainquiry.gov.au/

he had never been exposed to any specific discussion or guidance about his responsibilities as a supervisor. Nothing beyond such clichéd, motherhood statements as "duty of care", "leadership", "leading by example", and the ubiquitous "walking the talk". And he left me with that ringing comment: "*Why didn't anybody tell me about this?*"

My hope for safety managers, line managers, senior executives, chief executive officers, and board members alike is that this book can at least provide a first step to helping them understand the true nature of the expectations that are placed on them by virtue of the obligation to provide a safe workplace.

And if I may, I would also make a plea to the community of safety professionals: just because this is a book written by a lawyer, do not write it off as nothing more than a guide to legal compliance or backside covering. Look at what the cases and inquiries tell us about the expectations of managers. Ask yourself, would the safety culture and safety performance of your organisation be better or worse if your managers, supervisors, and executives understood and met these expectations? But, above all, use the real-life examples provided by the cases to educate and influence those that you are charged with advising, and shift your organisation ever forward to improving safety performance.

The author

Greg Smith has spent almost two decades specialising in occupational health and safety (OHS) within Australian law. His focus is on assisting clients to develop and deliver management obligation programs, particularly to the mining and oil and gas industries.

As a leading OHS practitioner, Greg Smith has deep technical expertise, providing some of Australia's largest and most significant employers with strategic advice on health and safety compliance, incident investigation, management and response, contractor safety management, and representation in health and safety prosecutions. His industry experience is broad: he has applied his OHS expertise to the mining, oil and gas, construction, telecommunications, banking, manufacturing, defence, local and state government, and transport sectors.

From 2007 to 2009, he was employed as the Principal Safety Advisor for Woodside Energy Limited. Reporting to the Vice President for Safety and Health, he was responsible for the ongoing development and implementation of Woodside's global safety management strategy.

In 2010 he acted for a number of parties in the Montara Commission of Inquiry, investigating the blowout and uncontrolled release of hydrocarbons from the West Atlas drilling rig in the Timor Sea off the coast of Western Australia in August 2009.

He has also devised and delivers comprehensive safety and health training programs on behalf of Freehills, a leading Australian-based international commercial law firm, where he is currently a consultant. He also teaches accident prevention at the School of Public Health, at Curtin University in Perth, Western Australia.

Greg Smith graduated from the University of Western Australia in 1990 with a Bachelor of Jurisprudence and a Bachelor of Laws and is admitted to practice in the Supreme Court of Western Australia and the High Court of Australia.

He currently works in Perth, Western Australia.

Introduction

> "You will always have to bear the burden of knowing that Tony Krog died, leaving his wife a widow, because you did not care enough to train him adequately and because you sent him out in a truck when you knew it had inadequate brakes."*

On 12 February 1991, Tony Krog was killed when the truck that he was driving ran out of control and overturned. The truck was a second-hand truck and had been delivered to the work site only about a week before the accident. The mechanic who fitted a radio to the truck driven by Mr Krog identified that the brakes were in poor condition and reported that fact to Timothy Nadenbousch.

Mr Krog was employed by Denbo Pty Ltd, a small family construction company run by Timothy and Ian Nadenbousch, who were the only shareholders of the company. At the time of the accident Timothy Nadenbousch was responsible for overseeing the relevant operations, the maintenance of the plant and vehicles, and training drivers and plant operators.

The company was charged with and pleaded guilty to manslaughter. Timothy Nadenbousch was charged with and pleaded guilty to two breaches of the Victorian Occupational Health and Safety Act 1985 in his capacity as an officer of the company, for failing to maintain a safe working environment. He was fined $40,000.

In passing sentence, the Court said:

> The company, as the employer of the deceased, was responsible for ensuring that the condition of the vehicles it required its employees to drive were safe and that the drivers were given proper instructions. The company's work on the project was behind time.

* R v Denbo (1994) 6 VIR 157 (Denbo)

> Putting the trucks into work was obviously given a higher priority than the safety of the workers.
>
> There was criminal negligence on the part of the company in failing to establish an adequate system for maintenance for its plant and vehicles, in failing to properly train its employees, in permitting [the truck] to be put into use without proper maintenance and in creating a situation where [the truck], with its grossly defective brakes, was capable of being allowed on to the steep track where it was not capable of being kept under control.
>
> Timothy Nadenbousch acknowledged that he had been given and had accepted the responsibility within the company for the maintenance of vehicles and the training of its employees as part of the company's duty to provide and maintain a safe working environment for its employees. However, he did not act responsibly. He was aware of the poor state of the brakes on both trucks but he directed that they may be used. Moreover, the training which he gave the deceased and the other truck drivers was quite inadequate. There was willful neglect in the terms of s52 of the Occupational Health and Safety Act.*

When accidents happen there is a very natural tendency to try to identify someone at fault, and in cases like Denbo, is seems fairly straightforward to be able to assign blame and hold individuals accountable. Clearly no responsible manager should allow workers to operate machinery that he or she knows to be unsafe. The position is not always so straightforward, particularly when it comes to looking at the role of individual managers who are very often quite removed from the day-to-day operations of the businesses that they are responsible for, and who are all too often engaged for their skills and experience in areas unrelated to safety. This dilemma and the changing approaches to it over time are well summed up by Professor Kletz (2001: 5–6):

> In fact very few accidents are the result of negligence. Most human errors are the result of a moment's forgetfulness or aberration, the sort of error we all make from time to time. Others are the result of errors of judgment, inadequate training or instruction or inadequate supervision.

* Ibid

Accidents are rarely the fault of a single person. Responsibility is usually spread amongst many people. To quote from an official UK report on safety legislation:

The fact is—and we believe this to be widely recognised—the traditional concepts of the criminal law are not readily applicable to the majority of infringements which arise under this type of legislation. Relatively few offences are clear cut, few arise from reckless indifference to the possibility of causing injury, few can be laid without qualification at the door of a single individual. The typical infringement or combination of infringements arises rather through carelessness, oversight, lack of knowledge or means, inadequate supervision, or sheer inefficiency. In such circumstances the process of prosecution and punishment by the criminal courts is largely an irrelevancy. The real need is for a constructive means of ensuring that practical improvements are made and preventative measures adopted.

In addition, as we shall see, a dozen or more people have opportunities to prevent a typical accident and it is unjust to pick on one of them, often the last and most junior person in the chain, and make him the scapegoat.

The views I have described are broadly in agreement with those of the UK Health and Safety Executive. They prosecute, they say, only 'when employers and others concerned appear deliberately to have disregarded the relevant regulations or where they have been reckless in exposing people to hazard or where there is a record of repeated infringement.' They usually prosecute the company rather than an individual because responsibility is shared by so many individuals.

However, since the earlier editions of this book were published, the advice just quoted has been forgotten and attitudes have hardened. Though penalties have increased there are demands for more severe ones and for individual managers and directors to be held responsible. Many of these demands have come from people and publications that have shown sympathy for thieves, vandals and other lawbreakers. We should understand, they say, the

> reasons, such as poverty, deprivation and upbringing that have led them to act wrongly. No such excuses, however, are made for managers and directors; they just put profit before safety.
>
> The reality is different, as the case histories in this book will show. Managers and directors are not supermen and superwomen. They are just like the rest of us. Like us they fail to see problems, do not know the best way to act, lack training but do not realise it, put off jobs until tomorrow and do not do everything that they intend to do as quickly as they intend to do it. There are, of course, criminally negligent managers and directors, as in all walks of life, but they are the minority and more prosecutions will not solve the real problems.

If anything, the attitudes towards managers and the expectations of them seem to have hardened further.

Of course, in some cases managers are negligent, even criminally so.

On 25 March 1911, 146 women working at the Triangle Shirtwaist Factory were killed in a fire that tore through the eighth, ninth, and tenth floors of the Asch Building in New York City. Most of the women died from the fire itself or from jumping from the building to escape it. Many of the women could not escape from the burning building because the managers would lock the doors to the stairwells and exits to keep the workers from leaving early. The company's owners were put on trial, but a jury acquitted them of criminal charges, although they did lose a subsequent civil suit.

Eighty years later, in 1991, 25 workers died in a fire at the Hamlet chicken processing plant in North Carolina. One of the contributing factors to the number of fatalities was that some of the emergency doors had been locked shut—history, it seems, is destined to repeat. The owner of the company, his son (the operations manager), and the plant manager were all charged with non-negligent manslaughter; there was no trial, however, as the owner pleaded guilty to 25 counts of voluntary manslaughter while his son and the other man went free as part of a plea bargain. He received a prison sentence of 19 years and 11 months but was released just less than four years into his sentence.

However, more often than not, line management accountability is less clear.

In September 2002 the yacht Excalibur was sailing down the east coast of Australia, returning to Victoria after competing in ocean racing events off the coast of Queensland. On 16 September 2002, while off the coast of New South Wales, the yacht capsized and four crewmembers died.