



*Management
Obligations for*
HEALTH
and SAFETY

GREGORY W. SMITH



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Contents

Preface.....	ix
The author	xiii
Introduction	xv
Chapter 1 Managers and safety management	1
Introduction	1
Safety management systems.....	5
The illusion of safety	5
BP Texas City	6
Longford	8
Montara and Deepwater Horizon	10
Montara.....	10
Deepwater Horizon.....	12
Safety culture	13
References	18
Chapter 2 Bata Industries.....	21
Introduction	21
Background.....	21
Thomas Bata.....	23
Remuneration strategies	24
Reliance on “the system”	27
Douglas Marchant.....	28
Keith Weston.....	28
On cross examination.....	29
Final comments	32
References	33
Chapter 3 Management line of sight	35
Introduction	35
BP Texas City	35
Montara	39
Deepwater Horizon	43

Understanding management line of sight.....	45
References	46
Chapter 4 Understanding rules	49
Introduction	49
Why rules don't always work	49
BP Texas City	52
Montara	52
Texting and driving.....	53
The Herald of Free Enterprise	54
Western Power.....	56
Black Hawk 221	58
Final thoughts about rules	60
References	61
Chapter 5 Training and competence.....	63
Introduction	63
Relying on training and competence	64
Longford.....	65
BP Texas City	68
The hazard of overfilling the tower	68
Computer-based training	70
Training for supervisors.....	71
Piper Alpha	72
Permit to work	72
Training in emergency response.....	75
Deepwater Horizon	76
The negative pressure test.....	77
Sounding the general alarm	78
Fleytas	78
Conclusion	80
References	81
Chapter 6 Everyone has the right to stop the job	83
Introduction	83
How do you know it is bad enough to act?	85
Stopping the oil on Piper Alpha.....	85
Claymore.....	86
Tartan	86
Activating the EDS on the Deepwater Horizon	87
Conclusion	89
References	89

Chapter 7 Delegation 91
 Introduction 91
 Commercial Industrial Construction Group 93
 HMAS Westralia 94
 The Ritchie Decision 95
 Conclusion 97
 References 97

Chapter 8 Warning signs..... 99
 Introduction 99
 Peter Kite 100
 The Herald of Free Enterprise 101
 The Space Shuttle Challenger..... 104
 Findings..... 104
 Texas City 105
 Montara 107
 Deepwater Horizon 109
 Conclusion 111
 References 112

Chapter 9 Learning lessons 113
 Introduction 113
 BP Texas City 113
 Piper Alpha 115
 Deepwater Horizon—Transocean 117
 Conclusion 118
 References 119

Chapter 10 Managing change 121
 Introduction 121
 The Herald of Free Enterprise 121
 Longford 124
 Montara and the Deepwater Horizon..... 124
 Montara 125
 Complexity of change 127
 Deepwater Horizon..... 128
 Bad decisions?..... 129
 References 130

Chapter 11 Production before safety 133
 Introduction 133
 Risk assessment 134
 The Herald of Free Enterprise 135
 Home insulation 136

Deepwater Horizon 137
Montara Inquiry 141
Conclusion 144
References 145

Chapter 12 Managing the obligations 147
Introduction 147
Bata 148
Montara 148
Deepwater Horizon 149
Repeated failures..... 151
Managing expectations 152
What risks?..... 153
Moura..... 154
References 156

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, it 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.