Cultures of safety: Preventing serious injuries and fatalities
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Accidents don't just happen within a [Culture of Safety](.).

There is normally more than one root cause to a serious injury incident, or worse, a fatality. On almost every occasion there are "cues" or "precursors" that play significant roles in the incident. These factors go beyond simple human mistakes or calculated risks.

Unfortunately, many companies live in denial. They often embrace complacency when they have overall injury rates that are low, often better than average for their industry. They believe their safety program is working well. Leaders in many of these companies do not think often, or talk much, about safety. They go about their day-to-day business believing the odds are very slim of a life-altering serious injury or a death on their worksite.

Statistics tell a different story. Approximately 270 million work-related accidents occur annually worldwide, claiming 37 million lives, according to the International Labour Organisation (ILO).

States the ILO: Preventive safety culture is pivotal for all stakeholders.

It does not make sense to have excellent overall results in the primary safety measurements organizations track (total number of injury cases per year), and yet at the same time have the organization stunned and traumatized by a serious injury and fatality.

Causes

Specific types of work activities and safety controls are most closely associated with incidents that have serious injury and fatality (SIF) potential.

Injuries involving equipment and pipe opening of hazardous chemicals, lockout/tagout, machine guarding, confined space entry, and use of hot work permits tend to have higher SIF risks; likewise for operation of mobile equipment, working under suspended loads, and working at heights. Successful Cultures of Safety carefully study employee exposures to high risk, high-gravity injuries, or worse yet, fatalities to design controls and interventions to prevent serious injuries and fatalities. This research requires patience. Years of incident data analysis, near miss research, auditing and interviewing employees are a few of the techniques used to uncover these "precursors" or potential causes to the worst kind of safety incidents.

In a Culture of Safety, measures such as these are taken:

1) Actual serious injuries and fatalities along with less serious injuries that do have SIF potential are tracked as a separate safety performance measure — one not necessarily required by the government but critical for internal improvements;

2) Process, policies and programs to reduce SIFs engage employees, analyze data to identify and address workplace factors leading to SIFs, and do not blame workers for serious safety incidents; and

3) Operational process safety practices are not ignored, but considered potential contributing causes. Cultures of Safety track operational interruptions, design flaws and catastrophic fires, for example, along with personal safety measurements.

Leading companies in recent years have developed specific strategies to reduce SIFs. These strategies start with studying records on risks to workers, which can often be uncovered in reports of injuries, near misses, safety observations and audit findings.

Taking action

The steps below are intended as SIF reduction guidelines, and should be customized for your own unique Culture of Safety.

1) A system to measure the frequency of SIFs and high-risk potentials must be in place.

2) All recordable injuries must be evaluated for SIF potential, as well as near misses and audit findings. It is critical to uncover the risks leading to SIFs and potential SIFs.

3) This requires brutal honesty and self-assessment. Potential risks could be management decisions to increase work hours, reduce staff, and put off maintenance of equipment.

4) Conduct focus groups with employees and question them about the condition of equipment and compliance with safety protections.

Through this kind of transparent and intense study, Cultures of Safety learn that SIFs and near misses with high potential to be SIFs emanate from two primary factors:

1) Work activities and work circumstances, such as operating mobile equipment, working at heights, and working under suspended loads; and

2) Sources of high-gravity risks and the effectiveness of safety measures such as lockout-tagout, chemical exposure controls, and confined space entry.

Cultures of Safety understand that the kinds of safety practices likely to reduce SIFs are different than those that will decrease non-SIFs. It is almost like designing two types of safety processes operating daily on parallel tracks, one for SIFs and one for non-SIFs. Each has its own way of keeping records and controlling risks. Both are administered by the same group of safety and health professionals. Both call for employee input and leadership safety emphasis.

In these Safety Cultures, specific, targeted safety resources are invested in well thought-out ways to reduce the worst of incidents — serious injuries and fatalities. And in the most successful — and enduring — Cultures of Safety, the efforts are the results of firm, lasting decisions from the top of the organization through all levels to commit the resources — time and money — that will eliminate all injuries and drive zero harm. An enduring Culture of Safety is achievable, and all of those in safety owe our best efforts so that each worker and family will benefit from its realization.