Is safety an important organisational function or a cosmetic feature?

Maintaining profitable and sustainable safe operational balance between production and protection in practice is a black art of managing safety and risk, writes **Goran Prvulovic**

An increased number of reports and analyses conducted by various consultancies across major industries are indicating that over the last couple of years, more and more Australian companies are "delegating" their HSE function internally to other functions to manage, much more than what has traditionally been the case. Mass scaling down of HSE support teams has significantly degraded meaningful HSE support across many organisations, and representation of the HSE function at executive levels has rapidly declined to the point where experienced and qualified senior HSE professionals are increasingly hitting the glass ceiling career-wise. Many are kept at lower management levels and are now reporting through other support functions.

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Ironically, the "safety first" philosophy so commonly used to promote safety in the past seems to have also been applied in a similar fashion when it comes to cost cutting, restructuring and "streamlining" support functions. The HSE function has been consistently hit first and hard, marginalised and undermined, often without obvious immediate effects but with easily foreseeable significant risk and latent disabling effects to people and organisations.

There are countless stories of HSE executives and managers who assisted and even drove successful organisational restructures to minimise costs, only to be made redundant and their portfolio allocated to financial, human resources or other support functions. Interestingly, even Australia's most popular employment site, SEEK, does not have a dedicated category for health and safety professionals; it is listed under human resources.

Some fundamental HSE questions

What does that really say about the industry, and more notably about the importance and equality of safety as a business function? A number of fundamental questions can be asked at this point:

- Why does perception exist that management of HSE risks and critical support this function provides to the business is a second-tier function, apparently the one which can be managed by any other "mainstream" or support functions?
- Is this perception and common practice effective, and is this supported by any real safety statistical data on the national level?
- Can HSE be really important in an organisation where the HSE function is of secondary importance?

It is surprising how many senior executives who are responsible for the HSE function in various organisations do not have any formal safety qualifications, or practical or technical experience in management of HSE risks. A quick browse around some of the biggest organisations in Australia and overseas is enough to prove this point. A large number of those executives come from a range of other professional backgrounds such as engineering, accounting, metallurgy, human resources or law, just to name a few. Quite often they are surrounded by technically strong HSE professionals, advising, coaching, leading, doing the legwork, developing, and influencing decision-making processes, however, the invincible "glass ceiling" is still there, restricting them to lower stratum levels, just beyond the executive and board levels.

There is a range of motivational factors and "reasons" used to explain this approach at senior and executive levels, ranging from "training" the upcoming managers and executives in safety to seeing HSE as a "people-based" function, hence the reason why HSE so often comes under the executive HR banner. Needless to say, it should be common knowledge that management of HSE risks is not something that someone can learn on the fly, especially by managing it on senior


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organisational levels. Similarly, although people are certainly an important factor, human resources and safety are vastly different subjects in this context. Due to depth and complexity of each, neither function can effectively manage the other without obtaining in-depth knowledge in each particular discipline.

Aside from being a complicated, multidisciplinary scientific discipline requiring a great deal of generalist knowledge, leadership and experience, management of safety and risks also requires a specific technical and operational HSE knowledge. Above all, it requires independence in thinking and reporting, to be able to effectively communicate risk-based information and in turn create and enact critical organisational defences, systems and processes, as well as enable and support critical thinking and risk-wise decision making at the most senior organisational levels. This independence is an absolutely critical factor and the common failure of the organisational structure model described in this article.

A view from other functions

It is perfectly natural and understandable that in many cases senior executives from finance, operations, HR or any other function have conscious and unconscious conflict of interest and bias in the way they perceive risks, which is often evident and visible in how critical risk information is interpreted, delivered and how decisions about management of risks is made. Again, this is perfectly normal, as safety and protection on one side and production and profitability on the other are often at natural odds. Balancing those is the key in safe and productive operations, as so widely acknowledged in safety and management literature. After all, we are human and prone to a variety of bias, often developed and deeply entrenched from our upbringing, professional training and years of professional experience under the consistent emphasis of what is important, driven by our individual professions and functional goals.

As an example, how often do we see extreme reluctance to invest capital in safety-related improvements, even when there is a clear picture and solid evidence of long-term benefits, purely due to achieving short-term savings, or rather an illusion of it? Imagine cognitive dissonance and bias occurring internally within a finance executive (an accountant) who also "looks after" the HSE function in terms of managing priorities such as controlling short-term costs and their immediately seen and felt benefit, against unseen and uncertain but very real HSE-related risks. Imagine this level of unconscious bias in decision making. It is not difficult to see the human factors involved and challenges this allocation of responsibilities presents. An old Eastern European saying describes this conflict of interest and an internal struggle by stating that "rabbits are generally poor guardians of cabbage".

Similarly, delegating HSE and risk-management functions to human resources due to HSE being seen as a "people-based" function is riddled with issues. Although people and relationships are important in management of risks, management of HSE risks is not about managing or controlling people or their performance. On the contrary, people are the solution to HSE issues and only one factor of the overall causational mechanism. In many cases, the HSE function is allocated to HR purely due to the "close enough" factor in this particular space, which really speaks volumes about senior organisational decision making. Although they deeply care about people, most HR professionals even at executive levels do not have adequate technical, tactical or strategic knowledge in HSE to adequately guide the business in the management of HSE risks.

HSE in Australia

In Australia, we have a large pool of highly educated, experienced and business-savvy HSE executives capable of providing critical organisational risk balance and guiding the organisations towards safer and more productive waters. In many ways, we lead the world in management of safety. Based on that, we must conclude that most motives for keeping HSE as a second-tier organisational function are based around what senior people in organisations truly believe about safety itself, often at unconscious levels. This is the core issue. If we leave verbalisation of safety and formal organisational advertised positions aside and look at this issue with brutal honesty, the fundamental assumptions and beliefs involved in decisions to "second-tier" HSE functions are the ones where safety is perceived as a function of lesser complexity, easier to manage by others, or is simply a function of lesser importance. Actions speak louder than any words to the contrary.

So, how is this approach working for us on the national scale?

Safe Work Australia statistics indicate that from 2003 to 2015, a total of 3207 Australian workers died as a result of workplace incidents. In 2015 alone, 195 workers died, in 2016, 178, and this year to date, 57 workers lost their lives. Just in 2013-2014, there were 113,965 serious compensation claims.

Despite some reduction in fatality rates over the years, it simply cannot be argued that our

current approaches in management of HSE risks are working, at least not in the way they should be, morally and legally. It seems that we have reached the point in time where we really need to think differently and strongly consider regulation of the safety profession and legislating presence of senior HSE advice in organisations, very much along the lines of statutory functions prescribed in some regulatory jurisdictions for electrical, quarrying and classified plant activities. Surely competent HSE advice is just as critical for safe operations, or one would at least hope so.

There is one logical question that should be asked at this point. If safety and management of HSE risks are critical business goals and objectives, as so commonly professed, is it possible that one of the reasons for poor performance in this area is precisely the practice of "second tiering" of the HSE function in organisations, especially in the way risks are communicated, discussed and prioritised at the executive and board levels? The evidence and experience of many safety practitioners indicates that this is indeed a crucial barrier to further improvement in safety performance on the national level. As an example, how often do we see financial function in the organisation delegated to other functions to manage?

The simple answer is – never, because it is simply seen as too important, yet tragicomically, health and safety of people is seen as something almost anyone can do. As the above figures representing dead and disabled directly contradict this belief, the only logical but sad conclusion is that safety really isn't that important after all.

One of two most senior and influential organisational roles which is specifically structured to ensure the criticality and importance of its function is the role of a Chief Financial Officer. This is perfectly appropriate as the function is indeed important, specifically in terms of decision making and communication to senior decision makers and the board itself. The point is, shouldn't safety and information about risks be just as important, and more to the point, can safety be important in an organisation if the very function intended to drive its focus, support and promote it within the organisation is suppressed and marginalised? It doesn't seem likely, as there appears to be no other example available where a highly ranked organisational goal has been consistently achieved while at the same time its support function was consistently marginalised and managed by people with no relevant skill and experience.

The hard reality for HSE

Organisations sometimes do some really strange things with management of safety and its functions. Imagine the situation where a bridge is being built and the engineer reports to a person with no understanding of engineering. The engineer delivers design advice, instruction and analysis, only to be told by his boss that he "does not agree" and that a different approach

will be taken. And so the engineer watches as the bridge is built which has no chance of being stable or ever reaching the other side. It is hard to imagine such foolishness, but unfortunately this is precisely what happens in safety, all the time.

As a consequence, in environments where HSE is not represented at executive levels, true risk-related information and discussion is often lacking in quality and balance. Even more importantly, this information often does not reach board level, at least not in its most accurate form, which often results in decisions which do not benefit the organisational long-term interests.

On the other hand, competent senior HSE executives and managers are able to promote conversations at the most senior levels around true forms of leadership, people and human factors, systems, processes, safety myths, ownership and accountability, and in turn set not only what is truly important at the executive level, but also create the same perceptions of importance in the mindset of senior and middle managers. Those are key owners of safety, able to drive key operational processes and direct people and resources, and are truly in a position to change organisational performance and culture of safety.

Organisations are essentially social institutions, made up of people working at various stratum levels. All of them have perceptions of what is really important in the organisation, and those perceptions are true organisational reality, being crucial factors for creation of the culture of safety. Contrary to what many senior decision makers believe, this perception is not set by language, slogans, intranet pages, KPIs, goals and posters. Rather, it is set by organisational practices, visual cues and observable and practical actions. Employees pay much closer attention to a practical display of hierarchical power in the workplace and what importance is given to functions in organisations rather than any formal organisational structures and charts. This practical status or importance has critical influence when it comes to operational decision making at the work execution level, specifically around the balance between production and protection, operational discipline and safety-related workplace behaviours such as occurrences of system violations and risk trading for convenience.

Where safety managers sit alongside their peers with remuneration, office availability and location, status and reporting structure, as well as

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the presence of safety professionals at executive levels, do in fact demonstrate organisational commitment to HSE as a whole.

Safety cannot become an "overriding commitment", "first priority" or a "primary value" in an organisation if the principal function intended to drive, structure, promote and guide it is downgraded and treated as a second-tier, auxiliary function. How safety professionals and safety functions are treated sit on the organisational reporting matrix and their status is of major significance, because it matters to employees working on the sharp end with risks. Without people and their engagement, management of HSE risks is nothing more than an illusion. Risks and priorities in organisations are defined formally but often viewed, communicated, perceived and executed very informally.

Safety's never-ending journey

If we think of safety as a continuous and never-ending, organised effort to maintain the balance between production and protection as two fundamentally conflicting goals, achieving good safety performance in an organisation is a matter of appropriately allocating time, knowledge and resources, which is in turn critically dependent on what is perceived as "important" in an organisation. What characterises advanced and resilient organisations is this setting and priming of safety as "the important function" on the organisational level and resulting risk-wise decision making this approach produces. This comes mostly from the influence of mature leadership, usually led by competent and educated safety professionals who promote diversity in thinking, technical competence, appropriate risk language, coaching, methods of risk communication and risk awareness throughout the organisation.

This is not to say that members of other functions are not able to do this effectively, however, management of HSE risks is one of most difficult organisational functions to manage. It requires broad multidisciplinary knowledge in technical risk management, operational knowledge and advanced human factors, in addition to general psychology, toxicology, epidemiology, and many other areas. This is why the safety profession and tertiary education in safety exists, to provide this level of competence and critical support to organisations on their journey of discharging ethical, moral and legal obligations.

So, if safety is really that critical in organisations, shouldn't we be demonstrating this importance by having that importance visible at the board and executive levels, instead of obtaining risk view, information and advice through secondary means, and by inadvertently filtering, screening and potentially distorting and misrepresenting critical information?

If safety does not deserve to sit at the table at that level, how is safety to influence and obtain a seat at the table at lower, operational levels where execution of work and balance of priorities creates safety in practice? So with that in mind, if you are a chief executive officer, managing director or a senior decision maker in an organisation, ask yourself the following questions:

- How do you know that you are getting accurate HSE risk-related information, uncontaminated with bias from other, often naturally goal-conflicting business functions?
- Can you reasonably expect that your direct reports, their managers and supervisors have a seat at their table for a HSE expert if you have not applied the same approach?
- Do you believe that the executive team does not need high-level HSE advice, mentoring and support and that all of your executives "know" safety? If so, why do you employ them?
- Is it possible that the absence of high-level professional HSE advice at executive levels is causing imbalance between productive and protective activities and decision-making processes? Are there any warning signs?
- Is your current organisational structure organised in such a way that it inadvertently undermines and supresses risk-related communications, technical advice, and objective risk view from reaching the most senior organisational levels?
- Does your current structure truly demonstrate your organisational commitment to management of HSE risks, and does this align with the company advertised position on safety?

Just like in creating organisational culture, diversity or equality in the workplace, what is really important in organisations is not what we say it is, but rather the things to which we are paying close and systematic attention to. Safety is only important if people working with risks believe it is, and for this to occur, it needs to be demonstrated in practice top down and through strong leadership and sound decision-making processes. It is very difficult to demonstrate this level of commitment in safety if the organisational HSE support function becomes secondary importance, even if this is only a visual impression.

Maintaining profitable and sustainable safe operational balance between production and protection in practice is a black art of managing safety and risk. It requires a great degree of knowledge and skill. To achieve it and sustain it, every organisation pursuing this valuable state should not only invest in competent and educated HSE professionals, but also ensure their equal status at all organisational levels and enable this advice and risk voice to penetrate all stratum levels and reach the most senior levels without filters, translations and functional interpretations. ■

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