insight

QRMC NEWSLETTER

QRMC Risk Management

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Insight aims to provide useful information, links and tips in the areas of Risk Management, Occupational Health and Safety, Business Continuity Management, and other areas relating to management systems and corporate governance.

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- Are we Communicating Safety? ... or is vital information being lost?
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Are we Communicating Safety? ... or is vital information being lost?

Effective communication is a fundamental component of all management systems. Good communication will make a well-crafted system effective. Bad communication will ensure the system fails, no matter how well it is designed.

Whether communications are in written or verbal format, it's important to be confident that the communication processes are effectively and efficiently providing the right information to the people who need it.

Our modern technological life has habituated us to short and sharp, 'byte-sized' snippets of information. But this has a negative side-effect on our attention span. Studies have shown that the 'window of opportunity' where everyone is focussed and 'switched on' is diminishing –it would appear that around 5 minutes is now an optimal length for pre-start or toolbox talk.

In terms of written communications, it is no longer sufficient to pin a Safety Notice to a cork board and argue that it's the worker's responsibility to read it. Under the WHS Regulation (sec 39) information and instructions need to be provided in a manner that is ' readily understandable' to all workers. Some organisations have assessed their workers' capacity to understand safety communications, and recognised that more effective communication of key safety messages can be achieved using videos, photos, symbols, visual language flowcharts and process mapping.

Safety professionals can learn from the advertising industry, using their well-honed principles for the communication of critical safety messages:

- **Know your audience** & **use their language** – this may include consideration of the level of literacy, rethinking the use of jargon or tech-speak, and catering for those whose first language is not English.
- **Keep it short and sharp** – remember that 5 minute 'window of opportunity' and be concise. For written information, use dot points, subheadings and line spacings to lay out the message.

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- **Communicate early and continually** – advertisers recognise that the audience need a message to be repeated at least 3 times for it to be registered, so repeat, repeat and repeat the message.
- **Clearly detail what is required** – give the workers clear, simple instructions.
- **Explain 'what is in it for them'** – make the message about the worker (not you).
- Reinforce the key messages through actions – lead by example.
- **Double check** – that the message has been received and 100% understood.

It is also absolutely essential that any communication, written or verbal, one-on-one or to the whole team, is delivered in a genuine and 'believable' manner.

Please contact QRMC if you would like assistance with WHS communication processes, plans and strategies.

Business Continuity Management – Business Impact Analysis Woes

The Business Impact Analysis, or BIA (defined as the process of analysing business activities and the effect that a business disruption might have upon them), is a critical part of successful business continuity management.

Without a thorough and reliable BIA process, an organisation cannot have confidence that they have accurately identified their areas of vulnerability, the possible disruptions they might suffer, or the extent to which they are prepared to respond.

So what do you need to do, or not do, in order to get this process right?

Below is a range of the most common problems that stymie good BIA processes.

1. Critical business functions or activities are not correctly identified

   It's important to involve all relevant stakeholders in a preliminary exercise of listing all work functions and discussing these lists in teams, to ensure that nothing is inadvertently overlooked.

2. Estimated business impacts are overstated

   It's a common response to assume the worst case scenario when considering the potential impact on the business from the loss of a function or resource. However, an objective assessment looking at what current controls are in place will often result in a less catastrophic outcome.

3. The length of time a critical resource or function can be down without impact is inaccurately estimated

   Again objectivity must be brought to bear when considering how long a function can be done

without. Just because something is usually done, say, daily or within a week of a triggering event, doesn't necessarily mean that it must be restored within a day or a week. Ask the question, what happens when the office closes down at Christmas time? If it's possible to reschedule or do without the function in holiday time, it's possible to do the same during a crisis.

4. Too many resources or functions are prioritised as requiring immediate restoration

Classing too many functions as requiring immediate restoration in the event of a business disruption makes for an almost certain failure to achieve the deadline for everything. A realistic assessment of the timeframe for which a function can be done without or worked around is important to allow for better prioritisation and a more achievable distribution of effort during the restoration phase.

5. The "key man dependency" phenomenon

Many organisations have functions that can only be authorised or carried out by a small group, or even one individual. There is a tendency in such cases for the organisation to identify this as a business continuity risk that can't be managed. However, similar to item **Error! Reference source not found.** above, work-arounds have likely been developed for periods of annual leave or illness.

6. Interdependencies between business functions/activities are not recognised

This is where silos within an organisation can be a real risk. Teams within an organisation that rely on information or action from another area to achieve their critical functions must recognise this and work closely with the other team(s) to develop work-arounds. Separate BIA workshops for different teams or areas within large organisations are common, but it's vital to build cross-team collaboration into the BIA process.

7. Everyday tools such as common software are taken for granted (e.g. email, internet)

Everyday tools that are so ubiquitous that they are taken for granted can sometimes be forgotten when identifying the tools and processes upon which critical functions rely. Take a step back and consider whether every resource used in a critical function has been remembered.

8. Extrapolation is difficult

Imagining the impacts on an organisation of the loss of a function for a day might be relatively straightforward, but how does the impact change if it becomes 2 days, or 5, or 10? Cross-team collaboration in the BIA process is again important to ensure the extrapolation of the imagined impacts over time are realistic.

The results of the Business Impact Analysis process must be an accurate prioritisation of critical functions and resources, in order to allow the organisation to invest in and implement the right business continuity arrangements that maximise resilience and efficacy.

Please contact QRMC if you would like assistance with your Business Impact Analysis.

SNG Meeting Report – May 2016

At the May Safety Networking Group meeting Damian Hegarty, Senior Associate from Kaden Boriss Legal, presented the details of a number of legal proceedings that provide insights into how the harmonised legislation.

is being interpreted and applied as part of recent prosecutions.

To date, 72 matters have been prosecuted by WHSQ under the (harmonised) 2011 Work Health & Safety Legislation; however only 3 have proceeded to trial (with the rest accepting a guilty plea). Unfortunately, with these matters being heard within the Magistrates Court there is typically only limited commentary of the particulars of each case.

There have also been 2 WHS prosecutions of company directors, the most interesting of which related to an 'Officer' who failed to exercise due diligence in managing the risks associated with pedestrians working around forklifts and vehicles in a warehouse environment. The 'Officer' pleaded guilty to the charge.

The financial penalties that are currently imposed are very similar to those under the 1995 Act (e.g. a fracture injury typically incurs a $50,000 fine). The Courts are also utilising the alternatives available under the Act, such as Training Orders and Good Behaviour Bonds, in addition to the monetary penalties to reflect the increase in the maximum penalty under the 2011 Act.

There are also some learnings that can be gleaned from cases in other harmonised jurisdictions, for example:

- A recent WorkCover Tasmania prosecution charged a Principal Contractor with failing to manage and maintain a safe system of work after an on-site fatality. A successful defence was established, based on the Principal Contractor's ability to rely on sub-contracted 'specialist' expertise. While this case referred to the precedents set from the Baiada case it should be noted that determining what is 'reasonably practicable' is dealt with on a case-by-case basis.
- WorkCover NSW recently charged the PCBU with a category 2 offence after a fatality within a glass factory, however the magistrate found that the foreseeability of the risk to the worker from the activity is an element, but a single breach in the established workplace system resulting in an injury will not render the employer liable for a failure to ensure safety.

Damian detailed that some organisations have partially mitigated their risks in relation potential penalties, by being pre-emptive and committing resources to corrective actions and training.

We thank Kaden Boriss for their ongoing support of the Safety Networking Group, and we will endeavour to keep the Group informed of pertinent legal cases that may continue to clarify how the regulators are applying the legislation.

ABOUT THE SNG:

In 2005 QRMC founded the Safety Networking Group for senior safety professionals working in the greater Brisbane metropolitan area. QRMC continues to coordinate and arrange for speakers to present at quarterly meetings and discuss information on contemporary WHS issues. Group members also share information from their workplaces or industries, which other members frequently find interesting and useful.

More information on the Safety Networking Group can be found on our website. Senior safety professionals contemplating attending meetings in Brisbane can contact QRMC to express an interest.

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