

Thought Leadership

# How NOT to manage safety

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## **Blame the victim, ignore standards, roll the dice**

Whether you use ISO 45001, ANSI Z10, OSHA's Voluntary Protection Program or another management system, there are common elements. The most important are management commitment and leadership, and employee acceptance and participation in the system.

On the other hand, there are methods not to use to manage safety and health.

## **"There better not be any more injuries"**

A textile plant had brought in a new plant manager to "turn the place around." Production and quality and costs all underperformed acceptable corporate goals. The safety record

was dismal and had continued to get worse. The safety manager had heard this new plant manager could work miracles and was very interested about what he had to say at the first safety meeting since his arrival.

*There is quite a bit of chance in the safety and health field, but I don't think I have ever seen it played so brazenly.*

The new plant manager started by saying "We are going to do something about the safety record. Let's speak with the last employee who got hurt – it looks like Jane." Jane was brought in, her finger still in a bandage and seated at the head of the table. The plant manager said, "Tell us about your accident." Quite nervous and sure she was about to be fired, Jane explained what happened. The new plant manager said, "Now tell everyone what you did wrong." Jane simply got her finger caught in an unguarded machine doing her proper duties. Jane, of course, broke down in tears while the rest of us either looked down at the floor or considered taking the plant manager outside for a whooping.

After being told by the plant manager that she would get a second chance to keep her job, he told his superintendents "There will be no more injuries at this plant."

And there were no more injuries. It was amazing the gimmicks the superintendents came up with to hide all those injuries that kept occurring. Corporate dismissed that plant manager about three months later.

### **The red doors**

In the early 1990s, a plant manager, a plant safety manager and I walked through a manufacturing plant conducting an inspection. I noticed all of the electrical panel doors had been painted red. Some doors had minor damage and others didn't seem to fit properly. Eventually, I came upon one circuit breaker panel door that was about six inches too short at the top and was exposing the live electrical parts. I told the plant manager the exposed opening should be covered, and asked him why all of the doors were red. He explained the plant had numerous incidents where forklift drivers were running into electrical panels and causing damage; even knocking panels off the walls. He decided to paint all the panels red so they could be seen better. I felt like asking, "Was that to make a better target for the drivers?" Apparently, additional training for the forklift drivers, installing barriers, and providing more space for forklift operations hadn't crossed his mind, or were too expensive.

### **Applicable standards**

There is a reason for OSHA standards 1910.303(b) (1)(ii) and 1910.303(g)(2).

1910.303(b)(1) Examination. Electric equipment shall be free from recognized hazards that are likely to cause death or serious physical harm to employees. Safety of equipment shall be determined using the following considerations: 1910.303(b)(1)(ii) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided;

1910.303(g)(2) Guarding of live parts.

1910.303(g)(2)(i) Except as elsewhere required or permitted by this standard, live parts of electric equipment operating at 50 volts or more shall be guarded against accidental contact by use of approved cabinets or other forms of approved enclosures...

### **Lesson to learn**

A very effective hazard recognition technique: If something doesn't look right, smell right or sound right (red doors), it probably isn't right. Use your experience and your expectations of the workplace to identify differences that are clues to potential hazards or unacceptable risks. If a difference is noted and it is unclear as to whether an unacceptable risk is present, start asking someone who would know.

### **A gambling man**

Twenty years ago, I visited a client out west to help with a potential fall protection problem. This was a sister plant to one back east with similar fall hazards from rail cars. The plant out west recently had an employee fall from the top of a rail car and was injured severely enough that the employee had missed about a month of work, and it appeared that medical costs were going to be more than \$30,000. The eastern plant had recently installed a fall arrest system for their workers on rail cars and had spent about \$30,000 installing that system.

The western plant manager and I discussed OSHA's requirements, best practices and the risks of this condition. He was interested in probabilities of incidents occurring as well. Finally, he reasoned that his plant had suffered one employee falling which had cost somewhat over \$30,000. The sister plant back east had not had anyone fall and it too had spent about \$30,000. He decided that the odds were that no more workers would fall on his plant site, so why spend the money? He decided the other plant site was the plant due for someone to fall, based on the odds, and they had already spent the money to install the fall arrest system.

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